DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS-5522-P]

RIN 0938-AT13

Medicare Program; CY 2018 Updates to the Quality Payment Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program for eligible clinicians. Under the Quality Payment Program, eligible clinicians can participate via one of two tracks: Advanced Alternative Payment Models (APMs); or the Merit-based Incentive Payment System (MIPS). We began implementing the Quality Payment Program through rulemaking for calendar year (CY) 2017. This rule provides proposed updates for the second and future years of the Quality Payment Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 21, 2017.

ADDRESSES: In commenting, please refer to file code CMS-5522-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-5522-P,

P.O. Box 8013,

Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-5522-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining

an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Molly MacHarris, (410) 786-4461, for inquiries related to MIPS.

Benjamin Chin, (410) 786-0679, for inquiries related to APMs.

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Acronyms

Because of the many terms to which we refer by acronym in this rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

ABC™	Achievable Benchmark of Care
ACO	Accountable Care Organization
API	Application Programming Interface
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
ASC	Ambulatory Surgical Center
ASPE	HHS' Office of the Assistant Secretary for Planning and Evaluation
BPCI	Bundled Payments for Care Improvement
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBSA	Core Based Statistical Area
CEHRT	Certified EHR technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CJR	Comprehensive Care for Joint Replacement

COI	Collection of Information
CPR	Customary, Prevailing, and Reasonable
CPS	Composite Performance Score
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
CY	Calendar Year
eCQM	Electronic Clinician Quality Measure
ED	Emergency Department
EHR	Electronic Health Record
EP	Eligible Professional
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
FR	Federal Register
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Health
HPSA	Health Professional Shortage Area
HHS	Department of Health & Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IT	Information Technology
LDO	Large Dialysis Organization
MACRA	Medicare Access and CHIP Reauthorization Act of 2015

MEI	Medicare Economic Index
MIPAA	Medicare Improvements for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MLR	Minimum Loss Rate
MSPB	Medicare Spending per Beneficiary
MSR	Minimum Savings Rate
MUA	Medically Underserved Area
NPI	National Provider Identifier
OCM	Oncology Care Model
ONC	Office of the National Coordinator for Health Information Technology
PECOS	Medicare Provider Enrollment, Chain, and Ownership System
PFPMs	Physician-Focused Payment Models
PFS	Physician Fee Schedule
PHI	Protected Health Information
PHS	Public Health Service
PQRS	Physician Quality Reporting System
PTAC	Physician-Focused Payment Model Technical Advisory Committee
QCDR	Qualified Clinical Data Registry
QP	Qualifying APM Participant
QRDA	Quality Reporting Document Architecture
QRUR	Quality and Resource Use Reports
RBRVS	Resource-Based Relative Value Scale
RFI	Request for Information
RHC	Rural Health Clinic
RIA	Regulatory Impact Analysis

RVU	Relative Value Unit
SGR	Sustainable Growth Rate
TCPI	Transforming Clinical Practice Initiative
TIN	Tax Identification Number
VBP	Value-Based Purchasing
VM	Value-Based Payment Modifier
VPS	Volume Performance Standard

I. Executive Summary and Background

A. Overview

This proposed rule would make payment and policy changes to the Quality Payment Program. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015) amended title XVIII of the Social Security Act (the Act) to repeal the Medicare sustainable growth rate (SGR), to reauthorize the Children's Health Insurance Program, and to strengthen Medicare access by improving physician and other clinician payments and making other improvements.

The MACRA advances a forward-looking, coordinated framework for clinicians to successfully take part in the Quality Payment Program that rewards value and outcomes in one of two ways:

- Advanced Alternative Payment Models (Advanced APMs).
- Merit-based Incentive Payment System (MIPS).

These policies are collectively referred to as the Quality Payment Program. Recognizing that the Quality Payment Program represents a major milestone in the way that we bring quality measurement and improvement together with payment, we have taken efforts to review existing policies to identify how to move the program forward in the least burdensome manner possible. Our 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. We believe our existing APMs alongside the proposals in this proposed rule provide opportunities that support state flexibility, local leadership, regulatory relief and innovative approaches to improve quality accessibility and affordability. By driving changes in how care is delivered, we believe the Quality Payment Program supports eligible clinicians in improving the health of their patients and increasing care efficiency. To implement this vision, the Quality Payment Program emphasizes high-value care and patient outcomes while minimizing burden on eligible clinicians; the Program is also designed to be flexible, transparent, and structured to improve over time with input from clinicians, patients, and other stakeholders. We have sought and continue to seek feedback from the health care community through various public avenues such as rulemaking, listening sessions and stakeholder engagement. Last year, when we engaged in rulemaking to establish policies for effective implementation of the Quality Payment Program, we did so with the explicit understanding that technology, infrastructure, physician support systems, and clinical practices will change over the next few years. For more information, see the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period (81 FR 77008, November 4, 2016), hereinafter referred to as the "CY 2017 Quality Payment Program final rule." In addition, we are aware of the diversity among clinician practices in their experience with quality-based payments. As a result of these factors, we expect the Quality Payment Program to evolve over multiple years in order to achieve our national goals. To date, we have laid the groundwork for expansion toward an innovative, outcome-focused, patient-centered, resource-effective health system that leverages health information technology to support clinicians and patients and builds collaboration across care settings. This proposed rule is the next part of a staged approach to develop policies that are

reflective of system capabilities and grounded in our core strategies to drive progress and reform efforts. We commit to continue evolving these policies.

CMS strives to put patients first, ensuring that they can make decisions about their own healthcare along with their clinicians. We want to ensure innovative approaches to improve quality, accessibility and affordability while paying particular attention to improving clinicians and beneficiaries experience when interacting with CMS programs. The Quality Payment Program aims to (1) support care improvement by focusing on better outcomes for patients, decreased clinician burden, and preservation of independent clinical practice; (2) promote adoption of APMs that align incentives for high-quality, low-cost care across healthcare stakeholders; and (3) advance existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

We previously finalized the transition year Quality Payment Program policies in the CY 2017 Quality Payment Program final rule. In that final rule, we implemented policies to improve physician and other clinician payments by changing the way Medicare incorporates quality measurement into payments and by developing new policies to address and incentivize participation in APMs. The final rule established the Quality Payment Program and its two interrelated pathways: Advanced APMs, and the MIPS. The final rule established incentives for participation in Advanced APMs, supporting the goals of transitioning from fee-for-service (FFS) payments to payments for quality and value, including approaches that focus on better care, smarter spending, and healthier people. The final rule included definitions and processes to identify Qualifying APM Participants (QPs) in Advanced APMs and outlined the criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in making comments and recommendations to the Secretary on proposals for physician-focused payment models (PFPMs).

The final rule also established policies to implement MIPS, a program for certain eligible clinicians that makes Medicare payment adjustments based on performance on quality, cost and other measures and activities, and that consolidates components of three precursor programs—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals (EPs). As prescribed by MACRA, MIPS focuses on the following: quality – including a set of evidence-based, specialty-specific standards; cost; practice-based improvement activities; and use of certified electronic health record (EHR) technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.

In this proposed rule, we are building and improving Quality Payment Program policies that will be familiar to stakeholders and are designed to integrate easily across clinical practices during the second and future years of implementation. We strive to continue our focus on priorities that can drive improvements toward better patient outcomes without creating undue burden for clinicians. In this proposed rule, we also address elements of MACRA that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring. We also include proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the Quality Payment Program, including policies related to the All-Payer Combination Option for identifying QPs and assessing eligible clinicians' participation in Other Payer Advanced APMs. To provide unity and consistency across the two paths of the Quality Payment Program, MIPS and APMs, in this proposed rule we have referred to the second year of the program as "Quality Payment Program Year 2."

B. Quality Payment Program Strategic Objectives

As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77010), after

extensive outreach with clinicians, patients and other stakeholders, we created six strategic objectives to drive continued progress and improvement. These objectives guided our final policies and will guide our future rulemaking in order to design, implement, and evolve a Quality Payment Program that aims to improve health outcomes, promote efficiency, minimize burden of participation, and provide fairness and transparency in operations. These strategic objectives are as follows: (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; and (6) to promote IT systems capabilities that meet the needs of users and are seamless, efficient and valuable on the front and back-end. We also believe it is important to ensure the Quality Payment Program maintains operational excellence as the program develops. Therefore we are adding a seventh objective, specifically to ensure operational excellence in program implementation and ongoing development. More information on these objectives and the Quality Payment Program can be found at www.qpp.cms.gov.

With these objectives, we recognize that the Quality Payment Program provides new opportunities to improve care delivery by supporting and rewarding clinicians as they find new ways to engage patients, families, and caregivers and to improve care coordination and population health management. In addition, we recognize that by developing a program that is flexible instead of one-size-fits-all, clinicians will be able to choose to participate in a way that is best for them, their practice, and their patients. For eligible clinicians interested in APMs, we

believe that by setting ambitious yet achievable goals, eligible clinicians will move with greater certainty toward these new approaches of delivering care. APMs are a vital part of bending the Medicare cost curve by encouraging the delivery of high-quality, low-cost care. To these ends, and to allow this program to work for all stakeholders, we further recognize that we must provide ongoing education, support, and technical assistance so that clinicians can understand program requirements, use available tools to enhance their practices, and improve quality and progress toward participation in APMs if that is the best choice for their practice. Finally, we understand that we must achieve excellence in program management, focusing on customer needs, promoting problem-solving, teamwork, and leadership to provide continuous improvements in the Quality Payment Program.

C. One Quality Payment Program

Clinicians have told us that they do not separate their patient care into domains, and that the Quality Payment Program needs to reflect typical clinical workflows in order to achieve its goal of better patient care. Advanced APMs, the focus of one pathway of the Quality Payment Program, contribute to better care and smarter spending by allowing physicians and other clinicians to deliver coordinated, customized, high-value care to their patients in a streamlined and cost-effective manner. Within MIPS, the second pathway of the Quality Payment Program, we believe that integration into typical clinical workflows can best be accomplished by making connections across the four statutory pillars of the MIPS incentive structure – quality, clinical practice improvement activities (referred to as "improvement activities"), meaningful use of CEHRT (referred to as "advancing care information"), and resource use (referred to as "cost") – and by emphasizing that the Quality Payment Program is at its core about improving the quality of patient care.

Although there are two separate pathways within the Quality Payment Program, the Advanced APM and MIPS tracks both contribute toward the goal of seamless integration of the

Quality Payment Program into clinical practice workflows. Advanced APMs promote this seamless integration by way of payment methodology and design that incentivize care coordination, and the MIPS builds the capacity of eligible clinicians across the four pillars of MIPS to prepare them for participation in MIPS APMs and Advanced APMs in later years of the Quality Payment Program. Indeed, the bedrock of the Quality Payment Program is high-value, patient-centered care, informed by useful feedback, in a continuous cycle of improvement. The principal way that MIPS measures quality of care is through a set of clinical quality measures (CQMs) from which MIPS eligible clinicians can select. The CQMs are evidence-based, and the vast majority are created or supported by clinicians. 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.

Through MIPS, we have the opportunity to measure quality, not only through evidence-based quality measures, but also by accounting for activities that clinicians themselves identify: namely, practice-driven quality improvement. MIPS also requires us to assess whether CEHRT is used meaningfully. Based on significant feedback, this area was simplified to support the exchange of patient information, engagement of patients in their own care through technology, and the way technology specifically supports the quality goals selected by the practice. The cost performance category was simplified and weighted at zero percent of the final score for the transition year of CY 2017 to allow clinicians an opportunity to ease into the Quality Payment Program. We further note the cost performance category requires no separate submissions for participation which minimizes burden on clinicians. The assessment of cost is a vital part of ensuring that clinicians are providing Medicare beneficiaries with high-value care. Given the primary focus on value, we indicated in the CY 2017 Quality Payment Program final rule our intention to align cost measures with quality measures over time in the scoring system (81 FR 77010). That is, we established special policies for the first year of the Quality Payment

Program, which enabled a ramp-up and gradual transition with less financial risk for clinicians in the transition year. We called this approach "pick your pace" and allowed clinicians and groups to participate in MIPS through flexible means while avoiding a negative payment adjustment. In this proposed rule, we continue the slow ramp-up of the Quality Payment Program by establishing special policies for Program 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 (CY 2021 payment year).

D. Summary of the Major Provisions

1. Quality Payment Program Year 2

We believe the second year of the Quality Payment Program should build upon the foundation that has been established which provides a trajectory for clinicians to value-based care. This trajectory provides to clinicians the ability to participate in the program through two pathways: MIPS and Advanced APMs. As we indicated in the CY 2017 Quality Payment Program final rule (81 FR 77011), we believed that a second transition period would be necessary to build upon the iterative learning and development period as we build towards a steady state. We continue to believe this to be true and have therefore crafted our policies to extend flexibilities into Quality Payment Program Year 2.

2. Small Practices

The support of small, independent practices remains an important thematic objective for the implementation of the Quality Payment Program and is expected to be carried throughout future rulemaking. For MIPS performance periods occurring in 2017, many small practices are excluded from new requirements due to the low-volume threshold, which was set at less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients. We have heard feedback, however, from many small practices that challenges still exist in their ability to participate in the program. We are proposing 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 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. We believe that these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the Quality Payment Program.

In keeping with the objectives to provide education about the Quality Payment Program and maximize participation, and as mandated by the statute, 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 at https://qpp.cms.gov/docs/QPP_Support_for_Small_Practices.pdf.

As discussed in section V.C. of this proposed rule, we have also performed an updated regulatory impact analysis, accounting for flexibilities, many of which are continuing into the Quality Payment Program Year 2, that have been created to ease the burden for small and solo practices. We estimate that at least 80 percent of clinicians in small practices with 1-15 clinicians will receive a positive or neutral MIPS payment adjustment. We refer readers to section V.C. of this proposed rule for details on how this estimate was developed.

3. Summary of Major Provisions for Advanced Alternative Payment Models (Advanced APMs)

a. Overview

APMs represent an important step forward in our efforts to move our healthcare system from volume-based to value-based care. APMs that meet the criteria to be Advanced APMs provide the pathway through which eligible clinicians, who would otherwise fall under the MIPS, can become Qualifying APM Participants (QPs), thereby earning incentive payments for their Advanced APM participation. In the CY 2017 Quality Payment Program final rule (81 FR 77516), we 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. 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, we anticipate higher numbers of QPs in subsequent years of the program. We currently estimate that approximately 180,000 to 245,000 eligible clinicians may become QPs for payment year 2020 based on Advanced APM participation in performance year 2018.

b. Advanced APMs

In the CY 2017 Quality Payment Program final rule (81 FR 77408), to be considered an Advanced APM, we finalized that an APM must meet all three of the following criteria, as required under section 1833(z)(3)(D) of the Act: (1) The APM must require participants to use CEHRT; (2) The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and; (3) 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.

We are proposing to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the estimated average total Parts A and B revenue of eligible clinicians in participating APM Entities for QP Performance Periods 2019 and 2020.

c. Qualifying APM Participant (QP) and Partial QP Determination

QPs are eligible clinicians in an Advanced APM who have met a threshold for a certain percentage of their patients or payments through an Advanced APM. QPs are excluded from MIPS for the year, and receive a 5 percent APM Incentive Payment for each year they are QPs beginning in 2019 through 2024. The statute sets thresholds for the level of participation in Advanced APMs required for an eligible clinician to become a QP for a year. For Advanced APMs that start or end during the Medicare QP Performance Period and operate continuously for a minimum of 60 days during the Medicare QP Performance Period for the year, we are proposing to make 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. Eligible clinicians who participate in Advanced APMs but do not meet the QP or Partial QP thresholds are subject to MIPS reporting requirements and payment adjustments.

d. All-Payer Combination Option

The All-Payer Combination Option, which uses a calculation based on both the Medicare Option and the eligible clinician's participation in Other Payer Advanced APMs to conduct QP determinations, is applicable beginning in performance year 2019. To become a QP through the All-Payer Combination Option, an eligible clinician must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM. We identify Other Payer Advanced APMs based on information submitted to us by eligible clinicians, APM Entities, and in some cases by payers, including states and Medicare Advantage Organizations. In addition, the eligible clinician or the APM Entity must submit information to CMS so that we can determine whether other payer arrangements are Other Payer Advanced APMs and whether the eligible clinician meets the requisite QP threshold of participation. To be an Other Payer Advanced APM, as set forth in section 1833(z)(2)(B)(ii) and (C)(ii) of the Act and implemented in the CY 2017 Quality

Payment Program final rule, a payment arrangement with a payer (for example, payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models) must meet all three of the following criteria: (1) CEHRT is used; (2) the payment arrangement must require the use of quality measures comparable to those in the quality performance category under MIPS and; (3) the payment arrangement must either require the APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures, or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

We are proposing modifications pertaining to the third criterion that the payment arrangement must either require the APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act. Specifically, we are proposing 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.

We are proposing modifications to our methodologies to determine whether eligible clinicians will meet the QP thresholds using the All-Payer Combination Option. Specifically, we are proposing to conduct all QP determinations under the All-Payer Combination Option at the individual eligible clinician level and are seeking comment on any possible exceptions to this proposed policy that would be warranted, such as a determination based on APM Entity group performance under the All-Payer Combination Option for eligible clinicians participating in CMS Multi-Payer Models. We are also proposing to establish an All-Payer QP Performance Period to assess participation in Other Payer Advanced APMs under the All-Payer Combination Option, and to rename the QP Performance Period we established in rulemaking last year as the

Medicare QP Performance Period.

We are proposing to modify the information submission requirements for the All-Payer Combination Option. Specifically, we are proposing modifications to the information we require to make APM Entity or eligible clinician initiated determinations of Other Payer Advanced APMs after the All-Payer QP Performance Period, as well as the information we require to perform QP determinations under the All-Payer Combination Option. We are also proposing policies on the handling of information submitted for purposes of assessment under the All-Payer Combination Option.

We are proposing a Payer Initiated Other Payer Advanced APM Determination Process, which would allow certain other payers, including payment arrangements authorized under Title XIX, Medicare Health Plans, and payers with payment arrangements in CMS Multi-Payer Models, to request that we determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter.

e. Physician-Focused Payment Models (PFPMs)

The PTAC is an 11-member federal advisory committee that is an important avenue for the creation of innovative payment models. The PTAC is charged with reviewing stakeholders' proposed PFPMs, and making comments and recommendations to the Secretary regarding whether they meet the PFPM criteria established by the Secretary through rulemaking in the CY 2017 Quality Payment Program final rule. PTAC comments and recommendations will be reviewed by the CMS Innovation Center and the Secretary, and we will post a detailed response to them on the CMS website. We are seeking comments on broadening 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. This broadened definition might be more inclusive of potential PFPMs that could focus on areas not generally

applicable to the Medicare population, and could engage more stakeholders in designing PFPMs. In addition, as we gain experience with public submission of PFPM proposals to the PTAC, we are seeking comments on the Secretary's criteria and stakeholders' needs in developing PFPM proposals aimed at meeting the criteria.

4. Summary of Major Provisions for the Merit-based Incentive Payment System (MIPS)

For Quality Payment Program Year 2 which is the second year of the MIPS and includes the performance periods in 2018 and the 2020 MIPS payment year, we are proposing the following policies:

a. Quality

We previously finalized that the quality performance category would comprise 60 percent of the final score for the transition year and 50 percent of the final score for the 2020 MIPS payment year (81 FR 77100). For the 2020 MIPS payment year, now we are proposing to maintain a 60 percent weight for the quality performance category contingent upon our proposal to reweight the cost performance category to zero for the 2020 MIPS payment year as discussed in section II.C.6.b.(2) in this proposed rule. Quality measures are selected annually through a call for quality measures, and a final list of quality measures will be published in the **Federal Register** by November 1 of each year. Except as discussed in section II.C.6.b.(3)(a)(iii) of this proposed rule with regard to the CAHPS for MIPS survey, we are not proposing any changes to the submission criteria for quality measures in this proposed rule. We are proposing for the CAHPS for MIPS survey for the Quality Payment Program Year 2 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. In addition, we are proposing for the Quality Payment Program Year 2 and future years to remove two Summary Survey Modules (SSM), specifically, "Helping You to Take Medication as Directed" and "Between Visit Communication" from the CAHPS for MIPS survey.

For the 2018 MIPS performance period, we previously finalized that the data completeness threshold would increase to 60 percent for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims. We noted that these thresholds for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims would increase for performance periods occurring in 2019 and future years. However, as discussed in section II.C.6.b. of this proposed rule, we are proposing for the 2018 MIPS performance period to maintain the transition year data completeness threshold of 50 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims to provide an additional year for individual MIPS eligible clinicians and groups to gain experience with the MIPS before increasing the data completeness threshold. However, we are proposing to increase the data completeness threshold for the 2021 MIPS payment year to 60 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims. We anticipate that for performance periods going forward, as MIPS eligible clinicians gain experience with the MIPS, we would further increase these thresholds over time.

b. Improvement Activities

Improvement activities are those that support broad aims within healthcare delivery, including care coordination, beneficiary engagement, population management, and health equity. In response to comments from experts and stakeholders across the healthcare system, improvement activities were given relative weights of high and medium. For the 2020 MIPS payment year, we previously finalized that the improvement activities performance category would comprise 15 percent of the final score (81 FR 77179). For performance periods occurring in 2018, we are not proposing any changes in improvement activities scoring as discussed in the CY 2017 Quality Payment Program final rule (81 FR 77312).

As discussed in the appendices of this proposed rule, we are proposing new improvement

activities (Table F) and improvement activities with changes (Table G) for the 2018 MIPS performance period and future years for inclusion in the Improvement Activities Inventory. Activities proposed in this section would apply for the 2018 MIPS performance period and future performance periods unless further modified via notice and comment rulemaking. We refer readers to Table H of the CY 2017 Quality Payment Program final rule for a list of all the previously finalized improvement activities (81 FR 77817 through 77831).

As discussed in section II.C.6.e.3.(c) of this proposed rule, we are proposing to expand our definition of how we will recognize an individual MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice. We finalized at §414.1380(b)(3)(iv) in the CY 2017 Quality Payment Program final rule that a certified patient-centered medical home includes practice sites with current certification from a national program, regional or state program, private payer or other body that administers patient-centered medical home accreditation. We are proposing in section II.C.6.e.(3)(b) of this proposed rule that eligible clinicians in practices that have been randomized to the control group in the CPC+ model would also receive full credit as a Medical Home Model. In addition, for group reporters, for the 2018 MIPS performance period and future performance periods, we are proposing to require that at least 50 percent of the 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 the improvement activities performance category.

As discussed in section II.C.6.f.(2)(d) of this proposed rule, in recognition of improvement activities as supporting the central mission of a unified Quality Payment Program, we propose to continue to designate activities in the Improvement Activities Inventory that will also qualify for the advancing care information bonus score. This is consistent with our desire to recognize that CEHRT is often deployed to improve care in ways that our programs should recognize.

c. Advancing Care Information

For the Quality Payment Program Year 2, the advancing care information performance category comprises 25 percent of the final score. However, if a MIPS eligible clinician is participating in a MIPS APM the advancing care information performance category may comprise 30 percent or 75 percent of the final score depending on the availability of APM quality data for reporting. Objectives and measures in the advancing care information performance category focus on the secure exchange of health information and the use CEHRT to support patient engagement and improved healthcare quality. While we continue to recommend that physicians and clinicians migrate to the implementation and use of EHR technology certified to the 2015 Edition so they may take advantage of improved functionalities, including care coordination and technical advancements such as application programming interfaces, or APIs, we recognize that some practices may have challenges in adopting new certified health IT. Therefore we are proposing that MIPS eligible clinicians may continue to use EHR technology certified to the 2014 Edition for the performance period in CY 2018. We are proposing minor modifications to the advancing care information objectives and measures and the 2017 advancing care information transition objectives and measures. We are also proposing to add an exclusion for the e-Prescribing and Health Information Exchange Objectives. We are proposing to modify our scoring policy for the Public Health and Clinical Data Registry Reporting Objectives and Measures for the performance score and the bonus score.

We are also proposing to implement several provisions of the 21st Century Cures Act (Pub. L. 114-255, enacted on December 13, 2016) pertaining to hospital-based MIPS eligible clinicians, ambulatory surgical center-based MIPS eligible clinicians, MIPS eligible clinicians using decertified EHR technology, and significant hardship exceptions under the MIPS. We are also proposing to add a significant hardship exception for MIPS eligible clinicians in small practices.

d. Cost

In this proposed rule, we are proposing to weight the cost performance category at zero percent of the final score for the 2020 MIPS payment year in order to improve clinician understanding of the measures and continue development of episode-based measures that will be used in this performance category.

For the 2018 MIPS performance period, we are proposing to adopt for the cost performance category the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period. For the 2018 MIPS performance period, we are not proposing to use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Although data on the episode-based measures has been made available to clinicians in the past, we are in the process of developing new episode-based measures with significant clinician input and believe it would be more prudent to introduce these new measures over time. We will continue to offer performance feedback on episode-based measures prior to potential inclusion of these measures in MIPS to increase clinician familiarity with the concept as well as specific episode-based measures.

Specifically, we intend to provide feedback on these new episode-based cost measures in the fall of this year for informational purposes only. We intend to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018, consistent with section 1848(q)(12) of the Act. In addition, we intend to offer feedback on another set of newly developed episode-based cost measures in 2018 as well. Therefore, clinicians would have received feedback on cost measures at several points prior to the cost performance category counting as part of the final score.

e. Submission Mechanisms

As discussed in section II.6.a. of this proposed rule, we are proposing additional

flexibility for submitting data. Individual MIPS eligible clinicians or groups would be able to submit measures and activities, as available and applicable, via as many mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories. We expect that this option will provide clinicians the ability to select the measures most meaningful to them, regardless of the submission mechanism.

f. Virtual Groups

There are generally three ways to participate in MIPS: (1) as an individual; (2) as a group; and (3) as a virtual group. In this proposed rule, we are proposing to establish requirements for MIPS participation at the virtual group level. We propose to define a virtual group as a combination of two or more TINs composed of a solo practitioner (a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN) or a group (as defined at §414.1305) 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.

To provide support and reduce burden, we intend to make technical assistance (TA) available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group for the first 2 years of virtual group implementation applicable to the 2018 and 2019 performance years. Clinicians can access the TA infrastructure that they may be already utilizing. For Quality Payment Program Year 3, we intend to provide an electronic election process if technically feasible. Clinicians who do not elect to contact their designated TA representative would still have the option of contacting the Quality Payment Program Service Center. We believe that our proposal will create an election process that is simple and straightforward.

g. MIPS APMs

In the CY 2017 Quality Payment Program final rule (81 FR 77246), we finalized that

MIPS eligible clinicians who participate in MIPS APMs will be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard. For the 2018 performance period, we are proposing modifications to the quality performance category reporting requirements and scoring for MIPS eligible clinicians in most MIPS APMs, and other modifications to the APM scoring standard. For purposes of the APM scoring standard, we are proposing to add a fourth snapshot date that would be used only to identify APM Entity groups participating in those MIPS APMs that require full TIN participation. Along with the other APM Entity groups, these APM Entity groups would be used for the purposes of reporting and scoring under the APM scoring standard described the CY 2017 Quality Payment Program final rule (81 FR 77246).

h. Facility-based Measurement

For the transition year of MIPS, we considered an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the MIPS eligible clinician's performance in the quality and cost performance categories. However, we did not propose an option for the transition year of MIPS because there were several operational considerations that needed to be addressed before this option could be implemented. After consideration of comments received on the CY 2017 Quality Payment Program proposed rule (81 FR 28192) and other comments received, we have decided to implement facility-based measures for the 2018 MIPS performance period and future performance periods to add more flexibility for clinicians to be assessed in the context of the facilities at which they work. As discussed in section II.C.7.b. of this proposed rule, we are proposing facility-based measures policies related to applicable measures, applicability to facility-based measurement, group participation, and facility attribution.

For clinicians whose primary professional responsibilities are in a healthcare facility we present a method to assess performance in the quality and cost performance categories of MIPS

based on the performance of that facility in another value-based purchasing program. While we propose to limit that opportunity to clinicians who practice primarily in the hospital, we seek to expand the program to other value-based payment programs as appropriate in the future. We discuss that new method of scoring in section II.C.7.b.(4) of this proposed rule.

i. Scoring

In the CY 2017 Quality Payment Program final rule, we finalized a unified scoring system to determine a final score across the 4 performance categories (81 FR 77273 through 77276). For the 2018 MIPS performance period, we propose to build on the scoring methodology we finalized for the transition year, focusing on encouraging MIPS eligible clinicians to meet data completeness requirements.

For quality performance category scoring, we are proposing to extend some of the transition year policies to the 2018 MIPS performance period and are also proposing several modifications to existing policy. For the 2018 MIPS performance period, we are proposing to maintain the 3 point floor for measures that can be reliably scored against a benchmark. We are also proposing, to 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, which does not apply to the CMS Web Interface measures and administrative claims based measures. For the 2018 MIPS performance period, we are also proposing to 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 we propose to continue to assign 3 points if the measure does not meet data completeness. This does not apply to CMS Web Interface measures or administrative claims based measures.

Beginning with the 2018 MIPS performance period, we are proposing to add performance standards for scoring improvement for the quality and cost performance categories. We are also proposing a systematic approach to address topped out quality measures.

For the 2018 MIPS performance period, we are proposing that 3 performance category

scores (quality, improvement activities, and advancing care information) would be given weight in the final score, or be reweighted if a performance category score is not available. We are also proposing to add final score bonuses for small practices and for MIPS eligible clinicians that care for complex patients.

We are also proposing that the final score will be compared against a MIPS performance threshold of 15 points, which can be achieved via multiple pathways and continues the gradual transition into MIPS.

j. Performance Feedback

We are proposing to provide Quality Payment Program performance feedback to eligible clinicians and groups. Initially, we would provide performance feedback on an annual basis. In future years, we aim to provide performance feedback on a more frequent basis, which is in line with clinician requests for timely, actionable feedback that they can use to improve care.

k. Targeted Review Process

In the CY 2017 Quality Payment Program final rule (81 FR 77353), we finalized a targeted review process under MIPS wherein a MIPS eligible clinician or group may request that we review the calculation of the MIPS payment adjustment factor and, as applicable, the calculation of the additional MIPS payment adjustment factor applicable to such MIPS eligible clinician or group for a year. We are not proposing any changes to this process for the second year of the MIPS.

l. Third Party Intermediaries

We believe that third party intermediaries that collect or submit data on behalf of individual eligible clinicians and groups participating in MIPS and allowing for flexible reporting options, will provide individual MIPS eligible clinicians and groups with options to accommodate different practices and make measurement meaningful. In the CY 2017 Quality Payment Program final rule (81 FR 77362), we finalized that qualified registries, QCDRs, health

IT vendors, and CMS-approved survey vendors will have the ability to act as intermediaries on behalf of individual MIPS eligible clinicians and groups for submission of data to CMS across the quality, improvement activities, and advancing care information performance categories. As discussed in section II.C.10.a.(3) of this proposed rule, we propose to eliminate the self-nomination submission method of email and require that QCDRs and qualified registries submit their self-nomination applications via a web-based tool for future program years beginning with performance periods occurring in 2018. We are proposing, beginning with the 2019 performance period, 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 (applicable to QCDRs only), 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. By attesting that certain aspects of their application will remain the same, as approved from the previous year, existing QCDRs in good standing and qualified registries will be spending less time completing the self-nomination application, as was previously required. This process will be conducted on an annual basis.

In addition, we are proposing that the term "QCDR measures" replace the term "non-MIPS measures," without proposing any changes to the definition, criteria, or requirements that were finalized in the CY 2017 Quality Payment Program final rule (81 FR 77375). We are not proposing any changes to the health IT vendors that obtain data from CEHRT requirements.

Lastly, we are proposing for future program years, beginning with performance periods occurring in 2018 that we remove the April 30th survey vendor application deadline. We are proposing for the Quality Payment Program Year 2 and future years that the vendor application

deadline be January 31st of the applicable performance year or a later date specified by CMS. We will notify vendors of the application deadline, to become a CMS-approved survey vendor through additional communications and postings.

m. Public Reporting

As discussed in section II.C.11. of this proposed rule, we are proposing public reporting of certain eligible clinician and group Quality Payment Program information, including MIPS and APM data in an easily understandable format as required under the MACRA.

n. Eligibility and Exclusion Provisions of the MIPS Program

In section II.C.1.f. of this proposed rule, we are proposing to modify the definition of a non-patient facing MIPS eligible clinician to apply to virtual groups. We are also proposing to specify that groups considered to be non-patient facing (more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician) during the non-patient facing determination period would automatically have their advancing care information performance category reweighted to zero. Additionally, in section II.C.3.c. of this proposed rule, we are proposing to modify the low-volume threshold policy established in the CY 2017 Quality Payment Program final rule. As discussed in section II.C.3.c of this proposed rule, we believe that increasing the low-volume threshold to less than or equal to $90,000 in Medicare Part B charges or 200 or fewer Part-B enrolled Medicare beneficiaries would further decrease burden on MIPS eligible clinicians that practice in rural areas or are part of a small practice or are solo practitioners.

E. Payment Adjustments

As discussed in section V.C. of this proposed rule, for the 2020 payment year based on Advanced APM participation in 2018 performance period, we estimate that approximately 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 percent of their Part B allowable charges for

covered professional services. We estimate that the total lump sum incentive payments will be between approximately $590 and $800 million for the 2020 Quality Payment Program payment year. This expected growth in QPs between the first and second year of the program 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.

Under the policies in this proposed rule, we estimate 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. After restricting the population to eligible clinician types who are not newly enrolled, the proposed increase in the low-volume threshold is expected to exclude 585,560 clinicians who do not exceed the low-volume threshold. In the 2020 MIPS payment year, MIPS payment adjustments will be applied based on MIPS eligible clinicians' performance on specified measures and activities within three integrated performance categories; the fourth category of cost, as previously outlined, would be weighted to zero in the 2020 MIPS payment year. Assuming that 90 percent of eligible clinicians of all practice sizes participate in MIPS, we estimate 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. These MIPS payment adjustments are expected to drive quality improvement in the provision of MIPS eligible clinicians' care to Medicare beneficiaries and to all patients in the health care system. However, the distribution will change based on the final population of MIPS eligible clinicians for CY 2020 and the distribution of scores under the program. We believe that starting with these

modest initial MIPS payment adjustments is in the long-term best interest of maximizing participation and starting the Quality Payment Program off on the right foot, even if it limits the magnitude of MIPS positive adjustments during the 2018 MIPS performance period. The increased availability of Advanced APM opportunities, including through Medical Home models, also provides earlier avenues to earn APM incentive payments for those eligible clinicians who choose to participate.

F. Benefits and Costs of Proposed Rule

The Quality Payment Program may result in quality improvements and improvements to the patients' experience of care as MIPS eligible clinicians respond to the incentives for high-quality care provided by MIPS and implement care quality improvements in their clinical practices.

We also quantify several costs associated with this rule. We estimate that this proposed rule will result in approximately $857 million in collection of information-related burden. We estimate that the incremental collection of information-related burden associated with this proposed rule is approximately $12.4 million relative to the estimated burden of continuing the policies the CY 2017 Quality Payment Program final rule, which is $869 million. We also estimate regulatory review costs of $4.8 million for this proposed rule, comparable to the regulatory review costs of the CY 2017 Quality Payment Program proposed rule. We estimate that federal expenditures will include $173 million in revenue neutral payment adjustments and $500 million for exceptional performance payments. Additional federal expenditures include approximately $590-$800 million in APM incentive payments to QPs.

G. Stakeholder Input

In developing this proposed rule, we sought feedback from stakeholders and the public throughout the process, including in the CY 2017 Quality Payment Program final rule with comment period, listening sessions, webinars, and other listening venues. We received a high

degree of interest from a broad spectrum of stakeholders. We thank our many commenters and acknowledge their valued input throughout the rulemaking process. We discuss the substance of relevant comments in the appropriate sections of this proposed rule, though we were not able to address all comments or all issues that all commenters brought forth due to the volume of comments and feedback. In general, commenters continue to support establishment of the Quality Payment Program and maintain optimism as we move from pure FFS Medicare payment towards an enhanced focus on the quality and value of care. Public support for our proposed approach and policies in the proposed rule focused on the potential for improving the quality of care delivered to beneficiaries and increasing value to the public—while rewarding eligible clinicians for their efforts.

We thank stakeholders again for their considered responses throughout our process, in various venues, including comments on the Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (herein referred to as the MIPS and APMs RFI) (80 FR 59102 through 59113) and the CY 2017 Quality Payment Program final rule (81 FR 77008 through 77831). We intend to continue open communication with stakeholders, including consultation with tribes and tribal officials, on an ongoing basis as we develop the Quality Payment Program in future years.

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

A. Introduction

The Quality Payment Program, authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a new approach for reforming care across the health care delivery system for eligible clinicians. Under the Quality Payment Program, eligible clinicians can participate via one of two pathways: Advanced Alternative Payment Models (APMs); or the Merit-based Incentive Payment System (MIPS). We began implementing the Quality Payment Program through rulemaking for calendar year (CY) 2017. This rule provides proposed updates for the second and future years of the Quality Payment Program.

B. Definitions

At §414.1305, subpart O, we propose to define the following terms:

- All-Payer QP Performance Period.
- Ambulatory Surgical Center (ASC)-based MIPS eligible clinician.
- CMS Multi-Payer Model.
- Full TIN APM.
- Improvement Scoring.
- Medicare QP Performance Period.
- Other MIPS APM.
- Virtual group.

We propose to revise the definitions of the following terms:

- Affiliated practitioner.
- APM Entity.
- Attributed beneficiary.
- Certified Electronic Health Record Technology (CEHRT).
- Final Score.

- Hospital-based MIPS eligible clinician.
- Low-volume threshold.
- Medicaid APM.
- Non-patient facing MIPS eligible clinician.
- Other Payer Advanced APM.
- Rural areas.

We propose to remove the following terms:

- Advanced APM Entity.
- QP Performance Period.

These terms and definitions are discussed in detail in relevant sections of this proposed rule.

C. MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician

In the CY 2017 Quality Payment Program final rule (81 FR77040 through 77041), we defined at §414.1305 a MIPS eligible clinician, as identified by a unique billing TIN and NPI combination used to assess performance, as any of the following (excluding those identified at §414.1310(b)): a physician (as defined in section 1861(r) of the Act), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act), a certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act), and a group that includes such clinicians. We established at §414.1310(b) and (c) that the following are excluded from this definition per the statutory exclusions defined in section 1848(q)(1)(C)(ii) and (v) of the Act: (1) QPs; (2) Partial QPs who choose not to report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year; (3) low-volume threshold eligible clinicians; and (4) new Medicare-enrolled eligible clinicians. In accordance with sections 1848(q)(1)(A) and (q)(1)(C)(vi) of the Act, we established at §414.1310(b)(2) that eligible clinicians (as defined at §414.1305) who are not MIPS eligible clinicians have the option to voluntarily report measures and activities for MIPS. Additionally, we established at §414.1310(d) that in no case will a MIPS payment adjustment apply to the items and services furnished during a year by eligible clinicians who are not MIPS eligible clinicians, as described in §414.1310(b) and (c), including those who voluntarily report on applicable measures and activities specified under MIPS.

In the CY 2017 Quality Payment Program final rule (81 FR 77340), we noted that the MIPS payment adjustment applies only to the amount otherwise paid under Part B with respect to items and services furnished by a MIPS eligible clinician during a year, in which we will apply the MIPS payment adjustment at the TIN/NPI level. We have received requests for

additional clarifications on which specific Part B services are subject to the MIPS payment adjustment, as well as which Part B services are included for eligibility determinations. We note 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 us 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.

To further clarify, there are circumstances that involve Part B prescription drugs and durable medical equipment where the supplier may also be a MIPS eligible clinician. In circumstances in which 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 us 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 we are 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.

b. Group Practice (Group)

As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77088 through 77831), we indicated that we will assess performance either for individual MIPS eligible

clinicians or for groups. We defined a group at §414.1305 as a single Taxpayer Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN. We recognize that MIPS eligible clinicians participating in MIPS may be part of a TIN that has one portion of its NPIs participating in MIPS according to the generally applicable scoring criteria while the remaining portion of its NPIs is participating in a MIPS APM or an Advanced APM according to the MIPS APM scoring standard. In the CY 2017 Quality Payment Program final rule (81 FR 77058), we noted that except for groups containing APM participants, we are not permitting groups to "split" TINs if they choose to participate in MIPS as a group. Thus, we would like to clarify that we consider 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. Also, we defined an APM Entity group at §414.1305 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.

c. Small Practices

In the CY 2017 Quality Payment Program final rule (81 FR 77188), we defined the term small practices at §414.1305 as practices consisting of 15 or fewer clinicians and solo practitioners. In section II.C.4.d. of this proposed rule, we discuss how small practice status would apply to virtual groups. Also, in the final rule, we noted that we would not make an eligibility determination regarding the size of small practices, but indicated that small practices would attest to the size of their group practice (81 FR 77057). However, we have since realized that our system needs to account for small practice size in advance of a performance period for operational purposes relating to assessing and scoring the improvement activities performance

category, determining hardship exceptions for small practices as proposed in this proposed rule, calculating the small practice bonus for the final score as proposed in this proposed rule, and identifying small practices eligible for technical assistance. As a result, we believe it is critical to modify the way in which small practice size would be determined. To make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years, we propose that CMS would determine the size of small practices as described in this section of the proposed rule. As noted in the CY 2017 Quality Payment Program final rule, the size of a group (including a small practice) would be determined before exclusions are applied (81 FR 77057). We note that group size determinations are based on the number of NPIs associated with a TIN, which would include clinicians (NPIs) who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.

To make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years, we propose that CMS would determine the size of small practices by utilizing claims data. For purposes of this section, we are coining the term "small practice size determination period" to mean a 12-month assessment period, which consists of an analysis of claims data that spans from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and includes a 30-day claims run out. This would allow us to inform small practices of their status near the beginning of the performance period as it pertains to eligibility relating to technical assistance, applicable improvement activities criteria, the proposed hardship exception for small practices under the advancing care information performance category, and the proposed small practice bonus for the final score.

Thus, for purposes of performance periods occurring in 2018 and the 2020 MIPS payment year, we would identify small practices based on 12 months of data starting from September 1, 2016 to August 31, 2017. We would not change an eligibility determination

regarding the size of a small practice once the determination is made for a given performance period and MIPS payment year. We recognize 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. We considered two options that could address such potential discrepancies. One option would include an expansion of 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. Such an expanded determination period may better capture the real-time size of small practices, but determinations made during the performance period prevent our system from being able to account for the assessment and scoring of the improvement activities performance category and identification of small practices eligible for technical assistance prior to the performance period. Specifically, our system needs to capture small practice determinations in advance of the performance period in order for the system to reflect the applicable requirements for the improvement activities performance category and when a small practice bonus would be applied. A second option would 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. However, this second option would require us to develop several operational improvements, such as a manual process or system that would provide an attestation mechanism for small practices, 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 for the Quality Payment Program 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 individual MIPS eligible clinicians and groups that are not already utilizing

the CMS Web Interface for the Quality Payment Program or administering the CAHPS for MIPS survey. We solicit public comment on the proposal regarding how CMS would determine small practice size.

d. Rural Area and Health Professional Shortage Area Practices

In the CY 2017 Quality Payment Program final rule (81 FR 77188), we finalized at §414.1380 that for individual MIPS eligible clinicians and groups that are located in rural areas or geographic HPSAs, to achieve full credit under the improvement activities performance category, one high-weighted or two medium-weighted improvement activities are required. In addition, we defined rural areas at §414.1305 as clinicians in ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available; and Health Professional Shortage Areas (HPSAs) at §414.1305 as areas designated under section 332(a)(1)(A) of the Public Health Service Act. For technical accuracy purposes, we are proposing to modify the definition of a rural areas at §414.1305 as ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available. We recognize that there are cases in which an individual MIPS eligible clinician (including a solo practitioner) or a group may have multiple practice sites associated with its TIN and as a result, it is critical for us to outline the application of rural area and HPSA practice designations to such practices. For performance periods occurring in 2017, we consider 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, we believe that a higher threshold than one practice within a TIN is necessary to designate an individual MIPS eligible clinician, a group, or a virtual group as a rural or HPSA practice. We recognize that the establishment of a higher threshold starting in 2018 would more appropriately identify groups and virtual groups with multiple practices under a group's TIN or TINs that are

part of a virtual group as rural or HPSA practices and ensure that groups and virtual groups are assessed and scored according to requirements that are applicable and appropriate. We note that in the CY 2017 Quality Payment Program final rule (81 FR 77048 through 77049), we defined a non-patient facing MIPS eligible clinician at §414.1305 as including a group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. We refer readers to section II.C.1.e. of this proposed rule for our proposal to modify the definition of a non-patient facing MIPS eligible clinician. We believe that using a similar threshold for applying the rural and HPSA designation to an individual MIPS eligible clinician, a group, or virtual group with multiple practices under its TIN or TINs within a virtual group will add consistency for such practices across the MIPS as it pertains to groups and virtual groups obtaining such statuses. Also, we believe that establishing a 75 percent 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. Therefore, for performance periods occurring in 2018 and future years, we propose that an individual MIPS eligible clinician, a group, or a virtual with multiple practices under its TIN or TINs within a virtual group would be designated as a rural or HPSA practice if more than 75 percent 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. We solicit public comment on these proposals.

e. Non-Patient Facing MIPS Eligible Clinicians

Section 1848(q)(2)(C)(iv) of the Act requires the Secretary, in specifying measures and activities for a performance category, to give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient. To the extent feasible and appropriate, the Secretary may take those circumstances into account and apply alternative

measures or activities that fulfill the goals of the applicable performance category to such non-patient facing MIPS eligible clinicians. In carrying out these provisions, we are required to consult with non-patient facing MIPS eligible clinicians.

In addition, section 1848(q)(5)(F) of the Act allows the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician. We assume many non-patient facing MIPS eligible clinicians will not have sufficient measures and activities applicable and available to report under the performance categories under MIPS. We refer readers to section II.C.6.f.(7) of this proposed rule for the discussion regarding how we address performance category weighting for MIPS eligible clinicians for whom no measures or activities are applicable and available in a given category.

In the CY 2017 Quality Payment Program final rule (81 FR 77048 through 77049), we defined a non-patient facing MIPS eligible clinician for MIPS at §414.1305 as an individual MIPS eligible clinician that bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. In order to account for the formation of virtual groups starting in the 2018 performance year and how non-patient facing determinations would apply to virtual groups, we need to modify the definition of a non-patient facing MIPS eligible clinician. Therefore, for performance periods occurring in 2018 and future years, we propose to modify the definition of a non-patient facing MIPS eligible clinician at §414.1305 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

percent 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 non-patient facing determination period.

We considered a patient-facing encounter to be an instance in which the individual MIPS eligible clinician or group billed for items and services furnished such as general office visits, outpatient visits, and procedure codes under the PFS. We published the list of patient-facing encounter codes for performance periods occurring in 2017 at qpp.cms.gov/resources/education. We intend to publish the list of patient-facing encounter codes for performance periods occurring in 2018 at qpp.cms.gov by the end of 2017. The list of patient-facing encounter codes is used to determine the non-patient facing status of MIPS eligible clinicians.

The list of patient-facing encounter codes include two general categories of codes: Evaluation and Management (E&M) codes; and Surgical and Procedural codes. E&M codes capture clinician-patient encounters that occur in a variety of care settings, including office or other outpatient settings, hospital inpatient settings, emergency departments, and nursing facilities, in which clinicians utilize information provided by patients regarding history, present illness, and symptoms to determine the type of assessments to conduct. Assessments are conducted on the affected body area(s) or organ system(s) for clinicians to make medical decisions that establish a diagnosis or select a management option(s).

Surgical and Procedural codes capture clinician-patient encounters that involve procedures, surgeries, and other medical services conducted by clinicians to treat medical conditions. In the case of many of these services, evaluation and management work is included in the payment for the single code instead of separately reported. Patient-facing encounter codes from both of these categories describe direct services furnished by eligible clinicians with impact on patient safety, quality of care, and health outcomes.

For purposes of the non-patient facing policies under MIPS, the utilization of E&M codes and Surgical and Procedural codes allows for accurate identification of patient-facing encounters, and thus accurate eligibility determinations regarding non-patient facing status. As a result, MIPS eligible clinicians considered non-patient facing are able to prepare to meet requirements applicable to non-patient facing MIPS eligible clinicians. We propose to continue applying these policies for purposes of the 2020 MIPS payment year and future years.

As described in the CY 2017 Quality Payment Program final rule, we established the non-patient facing determination period for purposes of identifying non-patient facing MIPS eligible clinicians in advance of the performance period and during the performance period using historical and performance period claims data. This eligibility determination process allows us to begin identifying non-patient facing MIPS eligible clinicians prior to or shortly after the start of the performance period. The non-patient facing determination period is a 24-month assessment period, which includes a two-segment analysis of claims data regarding patient-facing encounters during an initial 12-month period prior to the performance period followed by another 12-month period during the performance period. The initial 12-month segment of the non-patient facing determination period 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 60-day claims run out, which allows us to inform individual MIPS eligible clinicians and groups of their non-patient facing status during the month (December) prior to the start of the performance period. The second 12-month segment of the non-patient facing determination period 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 and includes a 60-day claims run out, which will allow us to inform additional individual MIPS eligible clinicians and groups of their non-patient status during the performance period.

However, based on our analysis of data from the initial segment of the non-patient facing determination period for performance periods occurring in 2017 (that is, data spanning from September 1, 2015 to August 31, 2016), we found that it may not be necessary to include a 60-day claims run out since we could achieve a similar outcome for such eligibility determinations by utilizing a 30-day claims run out. In our comparison of data analysis results utilizing a 60-day claims run out versus a 30-day claims run out, there was a 1 percent decrease in data completeness (see Table 1 for data completeness regarding comparative analysis of a 60-day and 30-day claims run out). The small decrease in data completeness would not negatively impact individual MIPS eligible clinicians or groups regarding non-patient facing determinations. We believe that a 30-day claims run out would allow us to complete the analysis and provide such determinations in a more timely manner.

TABLE 1: Percentages of Data Completeness for 60-day and 30-day Claims Run Out

Incurred Year	30-day Claims Run Out*	60-day Claims Run Out*
2015	97.1%	98.4%

* Note: Completion rates are estimated and averaged at aggregated service categories and may not be applicable to subsets of these totals. For example, completion rates can vary by provider due to claim processing practices, service mix, and post payment review activity. Completion rates vary from subsections of a calendar year; later portions of a given calendar year will be less complete than earlier ones. Completion rates vary due to variance in loading patterns due to technical, seasonal, policy, and legislative factors. Completion rates are a function of the incurred date used to process claims, and these factors will need to be updated if claims are processed on a claim from date or other methodology.

For performance periods occurring in 2018 and future years, we propose 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.

For purposes of the 2020 MIPS payment year, we 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 that may qualify as non-patient facing during performance periods occurring in 2018, we would conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2017, to August 31, 2018.

Similarly, for future years, we would conduct an initial eligibility determination analysis based on 12 months of data (consisting of the last 4 months of the calendar year 2 years prior to the performance period and the first 8 months of the calendar year prior to the performance period) to determine the non-patient facing status of individual MIPS eligible clinicians and groups, and conduct another eligibility determination analysis based on 12 months of data (consisting of the last 4 months of the calendar year prior to the performance period and the first 8 months of the performance period) to determine the non-patient facing status of additional individual MIPS eligible clinicians and groups. We would not change the non-patient facing status of any individual MIPS eligible clinician or group identified as non-patient facing during the first eligibility determination analysis based on the second eligibility determination analysis. Thus, an individual MIPS eligible clinician or group that is identified as non-patient facing during the first eligibility determination analysis would continue to be considered non-patient facing for the duration of the performance period and MIPS payment year regardless of the results of the second eligibility determination analysis. We would conduct the second eligibility determination analysis to account for the identification of additional, previously unidentified individual MIPS eligible clinicians and groups that are considered non-patient facing.

Additionally, in the CY 2017 Quality Payment Program final rule (81 FR 77241), we established a policy regarding the re-weighting of the advancing care information performance category for non-patient facing MIPS eligible clinicians. Specifically, MIPS eligible clinicians who are considered to be non-patient facing will have their advancing care information performance category automatically reweighted to zero (81 FR 77241). For groups that are considered to be non-patient facing (that is, more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician) during the non-patient facing determination period, we are proposing in section II.C.7.b.(3) of this proposed rule to automatically reweight their advancing care information performance category to zero.

We propose to continue applying these policies for purposes of the 2020 MIPS payment year and future years. We solicit public comment on these proposals.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77049), we noted that MIPS eligible clinicians who practice in CAHs that bill under Method I (Method I CAHs), the MIPS payment adjustment would apply to payments made for items and services billed by MIPS eligible clinicians, but it would not apply to the facility payment to the CAH itself. For MIPS eligible clinicians who practice in Method II CAHs and have not assigned their billing rights to the CAH, the MIPS payment adjustment would apply in the same manner as for MIPS eligible clinicians who bill for items and services in Method I CAHs. As established in the CY 2017 Quality Payment Program final rule (81 FR 77051), 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.

We refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77049 through 77051) for our discussion of MIPS eligible clinicians who practice in Method II CAHs.

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

As established in the CY 2017 Quality Payment Program final rule (81 FR 77051 through 77053), services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments. As noted, 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.

We refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77051 through 77053) for our discussion of MIPS eligible clinicians who practice in RHCs or FQHCs.

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

Section 1848(q)(6)(E) of the Act provides that the MIPS payment adjustment is applied to the amount otherwise paid under Part B with respect to the items and services furnished by a MIPS eligible clinician during a year. Some eligible clinicians may not receive MIPS payment adjustments due to their billing methodologies. 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. Therefore, we propose that services rendered by an eligible clinician that are payable under the ASC, HHA, Hospice, or HOPD methodology would not be subject to the MIPS payments adjustments. However, 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. We note 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. We solicit public comments on this proposal.

i. MIPS Eligible Clinician Identifier

As described in the CY 2017 Quality Payment Program final rule (81 FR 77057), we established that the use of multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or collectively through a group's performance and that the same identifier be used for all four performance categories. While we have multiple identifiers for participation and performance, we established the use of a single identifier, TIN/NPI, for applying the MIPS payment adjustment, regardless of how the MIPS eligible clinician is assessed.

(1) Individual Identifiers

As established in the CY 2017 Quality Payment Program final rule (81 FR 77058), we define a MIPS eligible clinician at §414.1305 to mean the use of a combination of unique billing TIN and NPI combination as the identifier to assess performance of an individual MIPS eligible clinician. Each unique TIN/NPI combination is considered a different MIPS eligible clinician, and MIPS performance is assessed separately for each TIN under which an individual bills.

(2) Group Identifiers for Performance

As established in the CY 2017 Quality Payment Program final rule (81 FR 77059), we codified the definition of a group at §414.1305 to mean a group that consists of a single TIN with

two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN.

(3) APM Entity Group Identifier for Performance

As described in the CY 2017 Quality Payment Program final rule (81 FR 77060), we established that each eligible clinician who is a participant of an APM Entity is identified by a unique APM participant identifier. The unique APM participant identifier is a combination of four identifiers: (1) APM Identifier (established by CMS; for example, XXXXXX); (2) APM Entity identifier (established under the APM by CMS; for example, AA00001111); (3) TIN(s) (9 numeric characters; for example, XXXXXXXXX); (4) EP NPI (10 numeric characters; for example, 1111111111). We codified the definition of an APM Entity group at §414.1305 to mean 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.

2. Exclusions

a. New Medicare-Enrolled Eligible Clinician

As established in the CY 2017 Quality Payment Program final rule (81 FR 77061 through 77062), we defined a new Medicare-enrolled eligible clinician at §414.1305 as a professional who first becomes a Medicare-enrolled eligible clinician within the PECOS during the performance period for a year and had not previously submitted claims under Medicare such as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier. Additionally, we established at §414.1310(c) that these eligible clinicians will not be treated as a MIPS eligible clinician until the subsequent year and the performance period for such subsequent year. We established at §414.1310(d) that in no case would a MIPS payment adjustment apply to the items and services furnished during a year by new Medicare-enrolled eligible clinicians for the applicable performance period.

We used the term "new Medicare-enrolled eligible clinician determination period" to refer to the 12 months of a calendar year applicable to the performance period. During the new Medicare-enrolled eligible clinician determination period, we conduct eligibility determinations on a quarterly basis to the extent that is technically feasible to identify new Medicare-enrolled eligible clinicians that would be excluded from the requirement to participate in MIPS for the applicable performance period.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77062), we established at §414.1305 that a QP (as defined at §414.1305) is not a MIPS eligible clinician, and is therefore excluded from MIPS. Also, we established that a Partial QP (as defined, at §414.1305) who does not report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year is not a MIPS eligible clinician.

c. Low-Volume Threshold

Section 1848(q)(1)(C)(ii)(III) of the Act provides that the definition of a MIPS eligible clinician does not include MIPS eligible clinicians who are below the low-volume threshold selected by the Secretary under section 1848(q)(1)(C)(iv) of the Act for a given year. Section 1848(q)(1)(C)(iv) of the Act requires the Secretary to select a low-volume threshold to apply for the purposes of this exclusion which may include one or more of the following: (1) 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; (2) 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 (3) the minimum amount, as determined by the Secretary, of allowed charges billed by the MIPS eligible clinician for a particular performance period.

In the CY 2017 Quality Payment Program final rule (81 FR 77069 through 77070), we defined individual MIPS eligible clinicians or groups who do not exceed the low-volume threshold at §414.1305 as an individual MIPS eligible clinician or group who, during the low-volume threshold determination period, has Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. We established at §414.1310(b) that for a year, MIPS eligible clinicians who do not exceed the low-volume threshold (as defined at §414.1305) are excluded from MIPS for the performance period for a given calendar year.

In the CY 2017 Quality Payment Program final rule (81 FR 77069 through 77070), we defined the low-volume threshold determination period to mean a 24-month assessment period, which includes a two-segment analysis of claims data during an initial 12-month period prior to the performance period followed by another 12-month period during the performance period. The initial 12-month segment of the low-volume threshold determination period 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 60-day claims run out, which allows us to inform eligible clinicians and groups of their low-volume status during the month (December) prior to the start of the performance period. The second 12-month segment of the low-volume threshold determination period 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 and includes a 60-day claims run out, which allows us to inform additional eligible clinicians and groups of their low-volume status during the performance period.

We recognize that individual MIPS eligible clinicians and groups that are small practices or practicing in designated rural areas face unique dynamics and challenges such as fiscal limitations and workforce shortages, but serve as a critical access point for care and provide a safety net for vulnerable populations. Claims data shows that approximately 15 percent of

individual MIPS eligible clinicians (TIN/NPIs) are considered to be practicing in rural areas after applying all exclusions. Also, we have heard from stakeholders that MIPS eligible clinicians practicing in small practices and designated rural areas tend to have a patient population with a higher proportion of older adults, as well as higher rates of poor health outcomes, co-morbidities, chronic conditions, and other social risk factors, which can result in the costs of providing care and services being significantly higher compared to non-rural areas. We also have heard from many solo practitioners and small practices who still face challenges and additional resource burden in participating in the MIPS.

In the CY 2017 Quality Payment Program final rule, we did not establish an adjustment for social risk factors in assessing and scoring performance. In response to the CY 2017 Quality Payment Program final rule, we received public comments indicating that individual MIPS eligible clinicians and groups practicing in designated rural areas would be negatively impacted and at a disadvantage if assessment and scoring methodology did not adjust for social risk factors. Additionally, commenters expressed concern that such individual MIPS eligible clinicians and groups may be disproportionately more susceptible to lower performance scores across all performance categories and negative MIPS payments adjustments, and as a result, such outcomes may further strain already limited fiscal resources and workforce shortages, and negatively impact access to care (reduction and/or elimination of available services).

After the consideration of stakeholder feedback provided during informal listening sessions since the publication of the CY 2017 Quality Payment Program final rule, we are proposing to modify the low-volume threshold policy established in the CY 2017 Quality Payment Program final rule. We believe that increasing the dollar amount and beneficiary count of the low-volume threshold would further reduce the number of eligible clinicians that are required to participate in the MIPS, which would reduce the burden on individual MIPS eligible clinicians and groups practicing in small practices and designated rural areas. Based on our

analysis of claims data, we found that increasing the low-volume threshold to 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 will exclude approximately 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the low-volume threshold that was finalized in the CY 2017 Quality Payment Program final rule. Almost half of the additionally excluded clinicians are in small practices and approximately 17 percent are clinicians from practices in designated rural areas. Applying this criterion decreases the percent of the MIPS eligible clinicians that come from small practices. For example, prior to any exclusions, clinicians in small practices represent 35 percent of all clinicians billing Part B services. After applying the eligibility criteria for the CY 2017 Quality Payment Program final rule, MIPS eligible clinicians in small practices represent approximately 27 percent of the clinicians eligible for MIPS; however, with the increased low-volume threshold, approximately 22 percent of the clinicians eligible for MIPS are from small practices. In our analysis, the proposed changes to the low-volume threshold showed little impact on MIPS eligible clinicians from practices in designated rural areas. MIPS eligible clinicians from practices in designated rural areas account for15 to 16 percent of the total MIPS eligible population. We note that, due to data limitations, we assessed rural status based on the status of individual TIN/NPI and did not model any group definition for practices in designated rural areas.

We believe that increasing the number of such individual eligible clinicians and groups excluded from MIPS participation would reduce burden and mitigate, to the extent feasible, the issue surrounding confounding variables impacting performance under the MIPS. Therefore, beginning with the 2018 MIPS performance period, we are proposing to increase the low-volume threshold. Specifically, at §414.1305, we are proposing to define an individual MIPS eligible clinician or group who does not exceed the low-volume threshold as an individual MIPS eligible

clinician or group who, during the low-volume threshold determination period, has Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries. This would mean that 37 percent of individual MIPS eligible clinicians and groups would be in MIPS based on the low-volume threshold exclusion (and the other exclusions). However, 65 percent of Medicare payments would still be captured under MIPS compared to 72.2 percent of Medicare payments under the CY 2017 Quality Payment Program final rule.

We recognize that increasing the dollar amount and beneficiary count of the low-volume threshold would increase the number of individual MIPS eligible clinicians and groups excluded from MIPS. We assessed various levels of increases and found that $90,000 as the dollar amount and 200 as the beneficiary count balances the need to account for individual MIPS eligible clinicians and groups who face additional participation burden while not excluding a significant portion of the clinician population.

MIPS eligible clinicians who do not exceed the low-volume threshold (as defined at §414.1305) are excluded from MIPS for the performance period with respect to a year. 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 the MIPS requirements for the applicable performance period and not subject to a MIPS payment adjustment for the applicable year. Such an exclusion would not affect an APM Entity's QP determination if the APM Entity is an Advanced APM.

In the CY 2017 Quality Payment Program final rule, we established the low-volume threshold determination period to refer to the timeframe used to assess claims data for making eligibility determinations for the low-volume threshold exclusion (81 FR 77069 through 77070). We defined the low-volume threshold determination period to mean a 24-month assessment

period, which includes a two-segment analysis of claims data during an initial 12-month period prior to the performance period followed by another 12-month period during the performance period. Based on our analysis of data from the initial segment of the low-volume threshold determination period for performance periods occurring in 2017 (that is, data spanning from September 1, 2015 to August 31, 2016), we found that it may not be necessary to include a 60-day claims run out since we could achieve a similar outcome for such eligibility determinations by utilizing a 30-day claims run out.

In our comparison of data analysis results utilizing a 60-day claims run out versus a 30-day claims run out, there was a 1 percent decrease in data completeness. The small decrease in data completeness would not substantially impact individual MIPS eligible clinicians or groups regarding low-volume threshold determinations. We believe that a 30-day claims run out would allow us to complete the analysis and provide such determinations in a more timely manner. For performance periods occurring in 2018 and future years, we propose a modification to the low-volume threshold determination period, in which the initial 12-month segment of the low-volume threshold 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 low-volume threshold 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.

For purposes of the 2020 MIPS payment year, we 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. To account for the identification of

additional individual eligible clinicians and groups that do not exceed the low-volume threshold during performance periods occurring in 2018, we would conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2017 to August 31, 2018. We 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. Thus, an individual eligible clinician or group that is identified as not exceeding the low-volume threshold during the first eligibility determination analysis would continue to be excluded from MIPS for the duration of the performance period regardless of the results of the second eligibility determination analysis. We established our policy to include two eligibility determination analyses in order to prevent any potential confusion for an individual eligible clinician or group to know whether or not participate in MIPS; also, such policy makes it clear from the onset as to which individual eligible clinicians and groups would be required to participate in MIPS. We would conduct the second eligibility determination analysis to account for the identification of additional, previously unidentified individual eligible clinicians and groups who do not exceed the low-volume threshold. We note that low-volume threshold determinations are made at the individual and group level, and not at the virtual group level.

We note that section 1848(q)(1)(C)(iv) of the Act requires the Secretary to select a low-volume threshold to apply for the purposes of this exclusion which may include one or more of the following: (1) 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; (2) 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 (3) the minimum amount, as determined by the Secretary, of allowed charges billed by the MIPS eligible clinician for a particular performance period. We have established a low-volume

threshold that accounts for the minimum number of Part-B enrolled individuals who are treated by a MIPS eligible clinician and that accounts for the minimum amount of allowed charges billed by a MIPS eligible clinician. We have not made proposals specific to a minimum number of items and service furnished to Part-B enrolled individuals by a MIPS eligible clinician.

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, we have assessed the option of establishing a low-volume threshold for items and services furnished to Part-B enrolled individuals by a MIPS eligible clinician. We have 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. We believe that defining items and services by using the number of patient encounters or procedures is a simple and straightforward approach for stakeholders to understand. However, we are concerned that using this unit of analysis could incentivize clinicians to focus on volume of services rather than the value of services provided to patients. Defining items and services by procedure would tie a specific clinical procedure rendered to a patient to a clinician. We solicit public comment on the methods of defining items and services furnished by clinicians described above and alternate methods of defining items and services.

For the individual MIPS eligible clinicians and groups that would be excluded from MIPS participation as a result of an increased low-volume threshold, we believe that in future years it would be beneficial to provide, to the extent feasible, such individual MIPS eligible clinicians and groups with the option to opt-in to MIPS participation if they might otherwise be excluded under the low-volume threshold such as where they only meet one of the threshold determinations (including a third determination based on Part B items and services, if established). 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 or, if established, the threshold pertaining to Part B items and services, we believe the clinician should, to the extent feasible, have the opportunity to choose whether or not to participate in the MIPS and be subject to MIPS payment adjustments. We recognize 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. Because of these concerns and our desire to establish options in a way that is a low-burden and user-focused experience for all MIPS eligible clinicians, we would not be able to offer this additional flexibility until performance periods occurring in 2019. Therefore, as a means of expanding options for clinicians and offering them the ability to participate in MIPS if they otherwise would not be included, for the purposes of the 2021 MIPS payment year, we propose 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, including as defined by dollar amount, beneficiary count or, if established, items and services. We request public comment on this proposal.

We note that there may be additional considerations we should address for scenarios in which an individual eligible clinician or a group does not exceed the low-volume threshold and opts-in to participate in MIPS. We therefore seek comment on any additional considerations we should address when establishing this opt-in policy. Such as, should we establish parameters for individual clinicians or groups who elect to opt-in to participate in MIPS such as required length of participation? Additionally, we note that there is the potential with this opt-in policy for there to be an impact on our ability to create quality benchmarks that meet our 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. We therefore seek comment on how to address any potential impact on our ability to create quality benchmarks that meet our sample size requirements.

We solicit public comments on these proposals.

3. Group Reporting

a. Background

As described in the CY 2017 Quality Payment Program final rule, we established the following requirements for groups (81 FR 77072):

- Individual eligible clinicians and individual MIPS eligible clinicians will have their performance assessed as a group as part of a single TIN associated with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by a NPI, who have reassigned their Medicare billing rights to the TIN (at §414.1310(e)(1)).
- A group must meet the definition of a group at all times during the performance period for the MIPS payment year in order to have its performance assessed as a group (at §414.1310(e)(2)).
- Individual eligible clinicians and individual MIPS eligible clinicians within a group must aggregate their performance data across the TIN to have their performance assessed as a group (at §414.1310(e)(3)).
- A group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories (at §414.1310(e)(4)).

As noted in the CY 2017 Quality Payment Program final rule, we would not make 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 (81 FR 77057). In section II.C.1.d. of this proposed rule, we are proposing to modify the way in which size would be determined for small practices by establishing a process under which CMS would utilize claims data to make small practice size determinations. Also, in section II.C.4.e. of this proposed rule, we are proposing to establish a policy under which CMS would utilize claims data to determine group size for groups of 10 or fewer eligible clinicians seeking to form or join a virtual group.

As noted in the CY 2017 Quality Payment Program final rule, a group size would be determined before exclusions are applied (81 FR 77057). We note that group size determinations are based on the number of NPIs associated with a TIN, which would include clinicians (NPIs) who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.

b. Registration

As described in the CY 2017 Quality Payment Program final rule (81 FR 77072 through 77073), we established, the following policies:

- A group must adhere to an election process established and required by CMS (§414.1310(e)(5)), which includes:

++ Groups will not be required to register to have their performance assessed as a group except for groups submitting data on performance measures via participation in the CMS Web Interface or groups electing to report the CAHPS for MIPS survey for the quality performance category. For all other data submission mechanisms, groups must work with appropriate third party intermediaries as necessary to ensure the data submitted clearly indicates that the data represent a group submission rather than an individual submission.

++ In order for groups to elect participation via the CMS Web Interface or administration of the CAHPS for MIPS survey, such groups must register by June 30 of the applicable performance period (that is, June 30, 2018, for performance periods occurring in 2018). We note that groups participating in APMs that require APM Entities to report using the CMS Web Interface are not required to register for the CMS Web Interface or administer the CAHPS for MIPS survey separate from the APM.

When groups submit data utilizing third party intermediaries, such as a qualified registry, QCDR, or EHR, we are able to obtain group information from the third party intermediary and

discern whether the data submitted represents group submission or individual submission once the data are submitted.

In the CY 2017 Quality Payment Program final rule (81 FR 77072 through 77073), we discussed the implementation of a voluntary registration process if technically feasible. Since the publication of the CY 2017 Quality Payment Program final rule, we have determined that it is not technically feasible to develop and build a voluntary registration process. Until further notice, we are not implementing a voluntary registration process.

Also, in the CY 2017 Quality Payment Program final rule (81 FR 77075), we expressed our commitment to pursue the active engagement of stakeholders throughout the process of establishing and implementing virtual groups. We received public comments in response to the CY 2017 Quality Payment Program final rule and additional stakeholder feedback by hosting several virtual group listening sessions and convening user groups. Many stakeholders requested that CMS provide an option that would permit a portion of a group to participate in MIPS outside the group by reporting as a separate subgroup or forming a virtual group. Stakeholders indicated that the option would measure performance more effectively, enable groups to identify areas for improvement at a granular level that would further improve quality of care and health outcomes, and increase coordination of care.

We recognize that groups, including multi-specialty groups, have requested over the years that we make an option available to them that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed and scored accordingly based on the performance of the subgroup. In future rulemaking, we intend to explore the feasibility of establishing group-related policies that would permit participation in MIPS at a subgroup level and create such functionality through a new identifier. We solicit public comment on the ways in which participation in MIPS at the subgroup level could be established.

4. Virtual Groups

a. Background

There are generally three ways to participate in MIPS: (1) individual-level reporting; (2) group-level reporting; and (3) virtual group-level reporting. We refer readers to sections II.C.1., II.C.3., and II.C.5. of this proposed rule for a discussion of the previously established requirements for individual- and group-level participation and our proposed policies for performance periods occurring in 2018 and future years. In this rule, we are proposing to establish requirements for MIPS participation at the virtual group level.

Section 1848(q)(5)(I) of the Act provides for the use of voluntary virtual groups for certain assessment purposes, including the election of practices to be a virtual group and the requirements for the election process. 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. Section 1848(q)(5)(I)(ii) of the Act requires, in accordance with section 1848(q)(5)(I)(iii) of the Act, the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect, for a given performance period, to be a virtual group with at least one other such individual MIPS eligible clinician or group. The virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

Section 1848(q)(5)(I)(iii) of the Act provides that the virtual group election process must include the following requirements: (1) an individual MIPS eligible clinician or group electing to be in a virtual group must make their election prior to the start of the applicable performance period and cannot change their election during the performance period; (2) an individual MIPS eligible clinician or group 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; (3) a virtual group is a combination of TINs; (4) the requirements must provide for formal written agreements among individual MIPS eligible clinicians and groups electing to be a virtual group; and (5) such other requirements as the Secretary determines appropriate.

b. Definition of a Virtual Group

As noted above, section 1848(q)(5)(I)(ii) of the Act requires, in accordance with section 1848(q)(5)(I)(iii) of the Act, the establishment and implementation of a process that allows an individual MIPS eligible clinician or group consisting of not more than 10 MIPS eligible clinicians to elect, for a given performance period, to be a virtual group with at least one other such individual MIPS eligible clinician or group. Given that section 1848(q)(5)(I)(iii)(V) of the Act provides that a virtual group is a combination of TINs, we interpret the references to an "individual" MIPS eligible clinician in section 1848(q)(5)(I)(ii) of the Act to mean a solo practitioner, which, for purposes of section 1848(q)(5)(I) of the Act, we propose to define as a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN.

Also, we recognize that a group (TIN) may include not only NPIs who meet the definition of a MIPS eligible clinician, but also NPIs who do not meet the definition of a MIPS eligible clinician at §414.1305 and who are excluded from MIPS under §414.1310(b) or (c) based on one of four exclusions (new Medicare-enrolled eligible clinician; QP; Partial QP who chooses not to report on measures and activities under MIPS; and eligible clinicians that do not

exceed the low-volume threshold). Thus, we interpret the references to a group "consisting of not more than 10" MIPS eligible clinicians in section 1848(q)(5)(I)(ii) of the Act to mean that a group with 10 or fewer eligible clinicians (as defined at §414.1305) would be eligible to form or join a virtual group. For purposes of the MIPS payment adjustment, the adjustment would apply only to NPIs in the virtual group who meet the definition of a MIPS eligible clinician at §414.1305 and who are not excluded from MIPS under §414.1310(b) or (c). We note that such groups, as defined at §414.1305, would need to include at least one MIPS eligible clinician in order to be eligible to join or form a virtual group. We refer readers to section II.C.4.g. of this proposed rule for discussion regarding the assessment and scoring of groups participating in MIPS as a virtual group.

We propose to define a virtual group at §414.1305 as a combination of two or more TINs composed of a solo practitioner (a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN), or a group (as defined at §414.1305) 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.

Lastly, we note 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.

We note 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. However, we note that, as discussed in section II.C.4.h. of this proposed rule, 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.

Additionally, we recognize that there are circumstances in which a TIN may have one portion of its NPIs participating under the generally applicable MIPS scoring criteria while the remaining portion of NPIs under the TIN is participating in a MIPS APM or an Advanced APM under the MIPS APM scoring standard. In the CY 2017 Quality Payment Program final rule (81 FR 77058), we noted that except for groups containing APM participants, we are not permitting groups to "split" TINs if they choose to participate in MIPS as a group (81 FR 77058). Thus, we consider a group to mean an entire single TIN that elects to participate in MIPS at the group or virtual group level, including groups that have a portion of its NPIs participating in a MIPS APM or an Advanced APM. We note that such groups would participate in MIPS similar to other groups.

To clarify, for all groups, including groups containing participants in a MIPS APM or an Advanced APM, the group's performance assessment consists of the entire TIN regardless of whether the group participates in MIPS as part of a virtual group. Generally, for groups other than groups containing participants in a MIPS APM or an Advanced APM, each MIPS eligible clinician under the TIN (TIN/NPI) receives a MIPS adjustment based on the entire group's performance assessment (entire TIN). 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) receives a MIPS adjustment based on the entire group's performance assessment (entire TIN). 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.

We propose to apply a similar policy to groups, including groups containing participants in a MIPS APM or an Advanced APM, that are participating in MIPS as part of a virtual group.

Specifically, 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). As discussed in section II.C.4.h. of this proposed rule, we are proposing to use waiver authority to ensure that any participants in the group who are participating in a MIPS APM receive their payment adjustment based on their score under the APM scoring standard (TIN/NPI). Such participants may be exempt from MIPS if they achieve QP or Partial QP status.

We refer readers to section II.C.4.e. of this proposed rule for a discussion of the proposed virtual group election process and section II.C.4.g. of this proposed rule for discussion of our proposals regarding the assessment and scoring of virtual groups.

We recognize that virtual groups would each have unique characteristics and varying patient populations. As noted in section II.C.4.a. of this proposed rule, the statute provides the Secretary with discretion to establish appropriate classifications regarding the composition of virtual groups such as by geographic area or specialty. However, we believe it is important for virtual groups to have the flexibility to determine their own composition at this time, and, as a result, we are not proposing to establish any such classifications regarding virtual group composition. We further note that the statute does not limit the number of TINs that may form a virtual group, and we are not proposing to establish such a limit at this time. We did consider however proposing to establish such a limit, such as 50 or 100 participants. In particular, we are concerned that virtual groups of too substantial a size (for example, 10 percent of all MIPS eligible clinicians in a given specialty or sub-specialty) may make it difficult to compare

performance between and among clinicians. We believe that limiting the number of virtual group participants could eventually assist virtual groups as they aggregate their performance data across the virtual group. However, we believe that as we initially implement virtual groups, it is important for virtual groups to have the flexibility to determine their own size, and thus, a better approach is to not place such a limit on virtual group size. We will, however, monitor the ways in which solo practitioners and groups with 10 or fewer eligible 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 as necessary. We solicit public comment on these proposals, as well as our approach of not establishing appropriate classifications (such as classification by geographic area or specialty) regarding virtual group composition or a limit on the number of TINs that may form a virtual group at this time.

In the CY 2017 Quality Payment Program final rule (81 FR 77073 through 77077), we expressed our commitment to pursue the active engagement of stakeholders throughout the process of establishing and implementing virtual groups. We received public comments in response to the CY 2017 Quality Payment Program final rule and additional stakeholder feedback by hosting several virtual group listening sessions and convening user groups. Many stakeholders requested that CMS provide 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. We refer readers to section II.C.b.3. of this proposed rule for discussion regarding a potential option for addressing such issue.

c. MIPS Virtual Group Identifier for Performance

To ensure that we have accurately captured all of the MIPS eligible clinicians participating in a virtual group, we propose that each MIPS eligible clinician who is part of a virtual group would be identified by a unique virtual group participant identifier. The unique

virtual group participant identifier 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-11111111111. We solicit public comment on this proposal.

d. Application of MIPS Group Policies to Virtual Groups

In the CY 2017 Quality Payment Program final rule (81 FR 77070 through 77072), we finalized various requirements for groups under MIPS at §414.1310(e), under which groups electing to report at the group level are assessed and scored across the TIN for all four performance categories. We propose to apply our previously finalized and proposed group policies to virtual groups, unless otherwise specified. We recognize that there are instances in which we may need to clarify or modify the application of certain previously finalized or proposed group-related policies to virtual groups, such as the definition of a non-patient facing MIPS eligible clinician; small practice, rural area and HPSA designations; and groups that have a portion of its NPIs participating in a MIPS APM or an Advanced APM (see section II.C.4.b. of this proposed rule). More generally, such policies may include those that require a calculation of the number of NPIs across a TIN (given that a virtual group is a combination of TINs), the application of any virtual group participant's status or designation to the entire virtual group, and the applicability and availability of certain measures and activities to any virtual group participant and to the entire virtual group.

With regard to the applicability of the non-patient facing policies to virtual groups, in the CY 2017 Quality Payment Program final rule (81 FR 77048 through 77049), we defined the term non-patient facing MIPS eligible clinician at §414.1305 as an individual MIPS eligible clinician that bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group

provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. We are proposing to modify the definition of a non-patient facing MIPS eligible clinician to include clinicians in a virtual group provided that more than 75 percent of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. We refer readers to section II.C.4.f. of this rule for the proposed modification. We note that other policies previously established and proposed in this proposed rule for non-patient facing groups would apply to virtual groups. For example, as discussed in section II.C.1.e. of this proposed rule, virtual groups determined to be non-patient facing would have their advancing care information performance category automatically reweighted to zero.

In regard to the application of small practice status to virtual groups, we are proposing that a virtual group would be identified as having a small practice status if the virtual group does not have 16 or more members of a virtual group (NPIs). We refer readers to section II.C.4.d. of this proposed rule for discussion regarding how small practice status would apply to virtual groups for scoring under MIPS. In the CY 2017 Quality Payment Program final rule (81 FR 77188), we defined the term small practices at §414.1305 as practices consisting of 15 or fewer clinicians and solo practitioners. In section II.C.1.c. of this proposed rule, we are proposing for performance periods occurring in 2018 and future years to identify small practices by utilizing claims data. For performance periods occurring in 2018, we would identify small practices based on 12 months of data starting from September 1, 2016 to August 31, 2017.

In section II.C.1.e. of this rule, we propose to determine rural area and HPSA practice designations for groups participating in MIPS at the group level. We note that in section II.C.7.b we describe our scoring proposals for practices that are in a rural area or HPSA practice. For performance periods occurring in 2018 and future years, we are proposing that a group with 75

percent 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. We are proposing that a virtual group with 75 percent or more of the virtual group's TINs designated as rural areas or HPSA practices would be designated as a rural area or HPSA practice at the virtual group level. We note that other policies previously established and proposed in this proposed rule for rural area and HPSA groups would apply to virtual groups.

We recognize that the measures and activities available to groups would also be available to virtual groups. 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 (for example, across their TINs). We note that other previously established group-related policies and proposed policies in this proposed rule pertaining to the four performance categories would apply to virtual groups.

Therefore, we propose to apply MIPS group policies to virtual groups except as otherwise specified. We solicit public comment on this proposal. We are also interested on receiving feedback on how such group-related policies previously established and proposed in this proposed rule either would or would not apply to virtual groups. In addition, we request public comment on any other policies that may need to be clarified or modified with respect to virtual groups, such as those that require a calculation of the number of NPIs across a TIN (given that a virtual group is a combination of TINs), the application of any virtual group participant's status or designation to the entire virtual group, the application of the group reporting requirements for the individual performance categories to virtual groups, and the applicability and availability of certain measures and activities to any virtual group participant and to the entire virtual group.

e. Election Process

As noted above, section 1848(q)(5)(I)(iii)(I) and (II) of the Act provides that the virtual group election process must include certain requirements, including that: (1) an individual MIPS

eligible clinician or group electing to be in a virtual group must make their election prior to the start of the applicable performance period and cannot change their election during the performance period; and (2) an individual MIPS eligible clinician or group 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. We propose to codify at §414.1315(a) that a solo practitioner or a group of 10 or fewer eligible clinicians must make their election prior to the start of the applicable performance period and cannot change their election during the performance period. Virtual group participants may elect to be in 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. For the 2018 performance year and future years, we are proposing to establish an election period.

We propose to codify at §414.1315(b) that, beginning with performance periods occurring in 2018, a solo practitioner, or group of 10 or fewer eligible clinicians electing to be in a virtual group must make their election by December 1 of the calendar year preceding the applicable performance period. For example, a solo practitioner or group would need to make their election by December 1, 2017 to participate in MIPS as a virtual group during the 2018 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, regarding the formation of a virtual group for an applicable performance period. We intend to publish the beginning date of the virtual group election period applicable to the 2018 performance period and future years in subregulatory guidance.

In order to provide support and reduce burden, we intend to make technical assistance (TA) available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group. Clinicians can access TA infrastructure and resources that they may already be utilizing). For Quality Payment Program year 3, we intend to provide an electronic

election process if technically feasible. We propose that clinicians who do not elect to contact their designated TA representative would still have the option of contacting the Quality Payment Program Service Center.

We propose to codify at §414.1315(c) a two-stage virtual group election process, stage 1 of which is optional, for the applicable 2018 and 2019 performance periods. Stage 1 pertains to virtual group eligibility determinations. In stage 1, solo practitioners and groups with 10 or fewer eligible clinicians interested in forming or joining a virtual group would have the option to contact their designated TA representative or the Quality Payment Program Service Center in order to obtain information pertaining to virtual groups and/or determine whether or not they are eligible, as it relates to the practice size requirement of a solo practitioner or a group of 10 or fewer eligible clinicians, to participate in MIPS as a virtual group (§414.1315(a)(1)(i)). We note that activity involved in stage 1 is not required, but a resource available to solo practitioners and groups with 10 or fewer eligible clinicians; otherwise, solo practitioners or groups with 10 or fewer eligible clinicians that do not engage in any activity during stage 1, they would begin the election process at stage 2. 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 provide solo practitioners and groups with the option 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, solo practitioners and groups may have conducted all such efforts to only have their election registration be rejected with no recourse or remaining time to amend and resubmit.

During stage 1 of the virtual group election process, we would determine whether or not a TIN is eligible to form or join a virtual group. In order for a solo practitioner to be eligible to form or join a virtual group, the solo practitioner would need to be considered a MIPS eligible

clinician (defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN, and not excluded from MIPS under §414.1310(b) and (c). 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 not excluded from MIPS based on the low-volume threshold exclusion at the group level. For purposes of determining TIN size for virtual group participation eligibility, we coin the term "virtual group eligibility determination period" and define it to mean an analysis of claims data during an assessment period of up to five months that would begin on July 1 and end as late as November 30 of a calendar year prior to the performance year and includes a 30-day claims run out.

To capture a real-time representation of TIN size, we propose 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. We note that an eligibility determination regarding TIN size is based on a relative point in time within the five-month virtual group eligibility determination period, and not an eligibility determination made at the end of such five-month determination period. 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 election period and the applicable performance period. TINs could determine their status by contacting their designated TA representative or the Quality Payment Program 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 the Quality Payment Program Service Center on October 20, 2017, the claims data analysis would include the months of July through September of 2017, and if determined not to exceed 10 eligible clinicians, such TIN's size status would be identified at such time and would be retained for the duration of the election period and the 2018 performance period. If another group contacted their designated TA representative or the Quality Payment Program Service Center on November

20, 2017, the claims data analysis would include the months of July through October of 2017, and if determined not to exceed 10 eligible clinicians, such TIN's size status would be identified at such time and would be retained for the duration of the election period and the 2018 performance period.

We believe such a virtual group determination period process provides a relative representation of real-time group size for purposes of virtual group eligibility and allows groups to know their real-time size status immediately and plan accordingly for virtual group implementation. 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 Quality Payment Program Service Center and inquire about virtual group participation eligibility. We note that 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.

For groups that do not choose to participate in stage 1 of the election process (that is, the group does not request an eligibility determination), we will make an eligibility determination during stage 2 of the election process. If a group began the election process at stage 2 and if its TIN size is determined not to exceed 10 eligible clinicians and not excluded based on the low-volume threshold exclusion at the group level, the group is determined eligible to participate in MIPS as part of a virtual group, and such virtual group eligibility determination status would be retained for the duration of the election period and applicable performance period.

Stage 2 pertains to virtual group formation. For stage two, we propose the following:

- TINs comprising a virtual group must establish a written formal agreement between each member of a virtual group prior to an election (§414.1315(c)(2)(i)).

- 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. (§414.1315(c)(2)(ii)). We anticipate this election will occur via e-mail to the Quality Payment Program Service Center using the following email address: MIPS_VirtualGroups@cms.hhs.gov.

- The submission of a virtual group election must include, at a minimum, information pertaining to each TIN and NPI associated with the virtual group and contact information for the virtual group representative (§414.1315(c)(2)(iii). A virtual group representative would submit the following type of information: each TIN associated with the virtual group; each NPI associated with a TIN that is part of the virtual group; name of the virtual group representative; affiliation of the virtual group representative to the virtual group; contact information for the virtual group representative; and 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. Each member of the virtual group must retain a copy of the virtual group's written agreement. We note that the virtual group agreement is subject to the MIPS data validation and auditing requirements as described in section II.C.9.c. of this rule.

- Once an election is made, the virtual group representative must contact their designated CMS contact to update any election information that changed during an applicable performance period one time prior to the start of an applicable submission period (§414.1315(c)(2)(iv)). We anticipate that virtual groups will use the Quality Payment Program Service Center as their designated CMS contact; however, we will define this further in subregulatory guidance.

For stage 2 of the election process, we would review all submitted election information; 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 and when information is available, 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; and 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 virtual group formation criteria and identified as an official virtual group participating in MIPS for an applicable performance period, we would contact the official designated virtual group representative via e-mail notifying the virtual group of its official virtual group status and issuing a virtual group identifier for performance (as described in section II.C.4.c. of this proposed rule) that would accompany the virtual group's submission of performance data during the submission period.

In regard to virtual group determinations pertaining to the low-volume threshold, we recognize that such determinations are made at the individual and group level, but not at the virtual group level. The low-volume threshold determinations are applicable to the way in which individual eligible clinicians and groups participate in MIPS as individual MIPS eligible clinicians (solo practitioners) or groups. For example, if an individual MIPS eligible clinician is part of a practice that is participating in MIPS at the individual level (reporting at the individual level), then the low-volume threshold determination is made at the individual level. Whereas, if an individual MIPS eligible clinician is part of a practice that is participating in MIPS at the group level (reporting at the group level), then the low-volume threshold determination at the group level would be applicable to such MIPS eligible clinician regardless of the low-volume threshold determination made at the individual level because such individual MIPS eligible clinician is part of a group reporting at the group level and the low-volume threshold determinations for groups applies to the group as a whole. Similarly, if a solo practitioner or a group with 10 or fewer eligible clinicians seeks to participate in MIPS at the virtual group level

(reporting at the virtual group level), then the low-volume threshold determination at the individual or group level would be applicable to such solo practitioner or group with 10 or fewer eligible clinicians. Thus, solo practitioners (individual MIPS eligible clinicians) or groups with 10 or fewer eligible clinicians that are determined not to exceed the low-volume threshold at the individual or group level would not be eligible to participate in MIPS as an individual, group, or virtual group.

As we engaged in various discussions with stakeholders during the rulemaking process through listening sessions and user groups, stakeholders indicated that many solo practitioners and small groups have limited resources and technical capacities, which may make it difficult for the entities to form virtual groups without sufficient time and technical assistance. Depending on the resources and technical capacities of the entities, stakeholders conveyed that it may take entities 3 to 18 months to prepare to participate in MIPS as a virtual group. The majority of stakeholders indicated that virtual groups would need at least 6 to 12 months prior to the start of the 2018 performance period to form virtual groups, prepare health IT systems, and train staff to be ready for the implementation of virtual group related activities by January 1, 2018.

We recognize that for the first year of virtual group formation and implementation prior to the start of the 2018 performance period, the timeframe for virtual groups to make an election by registering would be relatively short, particularly from the date we issue the publication of a final rule toward the end of the 2017 calendar year. To provide solo practitioners and groups with 10 or fewer eligible clinicians with additional time to assemble and coordinate resources, and form a virtual group prior to the start of the 2018 performance period, we are providing virtual groups with an opportunity to make an election prior to the publication of our final rule. We intend for the virtual group election process to be available as early as mid-September of 2017; we will publicize the specific opening date via subregulatory guidance. Virtual groups would have from mid-September to December 1, 2017 to make an election for the 2018

performance year. In regard to our proposed policies pertaining to virtual group implementation (for example, definition of a virtual group and election process requirements), we intend to closely align with the statutory requirements in order to establish clear expectations for solo practitioners and small groups, and have an opportunity to begin the preparation of forming virtual groups in advance of the publication of our final rule. However, any MIPS eligible clinicians applying to be a virtual group that does not meet all finalized virtual group requirements would not be permitted to participate in MIPS as a virtual group.

As previously noted, groups participating in a virtual group would have the size of their TIN determined for eligibility purposes. The virtual group size would be determined one time for each performance period. We recognize that the size of a group may fluctuate during a performance period with eligible clinicians and/or MIPS eligible clinicians joining or leaving a group. For groups within a virtual group that are determined to have a group size of 10 eligible clinicians or less based on the one time determination per applicable performance year, any new eligible clinicians or MIPS eligible clinicians that join the group during the performance period would participate in MIPS as part of the virtual group. In such cases, we recognize that a group may exceed 10 eligible clinicians associated with its TIN during an applicable performance period, but at the time of election, such group would have been determined eligible to form or join a virtual group given that the TIN did not have more than 10 eligible clinicians associated with its TIN. As previously noted, the virtual group representative would need to contact the Quality Payment Program Service Center to update the virtual group's information that was provided during the election period if any information changed during an applicable performance period one time prior to the start of an applicable submission period (for example, include new NPIs who joined a TIN that is part of a virtual group). Virtual groups must re-register before each performance period.

The statute provides that a solo practitioner (TIN/NPI) and a group with 10 or fewer eligible clinicians may elect to be in no more than one virtual group for a performance period. We note that such a solo practitioner or a group that is part of a virtual group may not elect to be in more than one virtual group for a performance period. Also, the statute determines that a virtual group election by the group for an applicable performance period applies to all MIPS eligible clinicians in the group. In the case of a TIN within a virtual group being acquired or merged with another TIN, or no longer operating as a TIN (for example, a group practice closes) during a performance period, 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. We consider a TIN that is acquired or merged with another TIN, or no longer operating as a TIN (e.g., a group practice closes) to mean a TIN that no longer exists or operates under the auspices of such TIN during a performance year.

As outlined in section 1848(q)(5)(I)(iii) of the Act and previously noted, a virtual group is a combination of TINs, which would include at least two separate TINs associated with a solo practitioner (TIN/NPI), or a group with 10 or fewer eligible clinicians and another such solo practitioner, or group. However, given that a virtual group must be a combination of TINs, we recognize 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. For the number of TINs able to form a virtual group, we note that there is not a limit to the number of TINs able to comprise a virtual group.

f. Virtual Group Agreements

The statute provides for formal written agreements among the MIPS eligible clinicians electing to form a virtual group. We propose 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. We note that 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. During the election process and submission of a virtual group election, a designated virtual group representative would be required to confirm through acknowledgement that an agreement is in place between each member of the virtual group. An agreement would be executed for at least one performance period. If a NPI joins or leaves a TIN, or a change is made to a TIN that impacts the agreement itself, such as a legal business name change, during the applicable performance year, a virtual group would be required to update the agreement to reflect such changes and submit changes to CMS via the Quality Payment Program Service Center.

We propose, at §414.1315(c)(3), that a formal written agreement between each member of a virtual group must include the following elements:

- Expressly state the only parties to the agreement are the TINs and NPIs of the virtual group (at §414.1315(c)(3)(i)). 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, respectively at §414.1315(c)(3)(ii)).

- 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) at §414.1315(c)(3)(iii)).

- 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 at §414.1315(c)(3)(iv)).

- 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 at §414.1315(c)(3)(v)).

- 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 at §414.1315(c)(3)(vi)).

- 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 at §414.1315(c)(3)(vii)).

- Be for a term of at least one performance period as specified in the formal written agreement at §414.1315(c)(3)(viii)).

- 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 at §414.1315(c)(3)(ix)).

As part of the virtual group election ICR, we filed a 60-day notice on June 14, 2017 (82 FR 27257), which includes an agreement template that could be used by virtual groups and will be made available via subregulatory guidance. The agreement template is not required, but

serves as a model agreement that could be utilized by virtual groups. The agreement template includes all necessary elements required for such an agreement.

We solicit public comment on these proposals.

Through the formal written agreements, we want to ensure that all members of a virtual group are aware of their participation in a virtual group. As noted above, formal written agreements must include a provision that requires each TIN within a virtual group to notify all NPIs associated with the TIN regarding their participation in the MIPS as a virtual group in order to ensure that each member of a virtual group is aware of their participation in the MIPS as a virtual group. We want to implement an approach that considers a balance between the need to ensure that all members of a virtual group are aware of their participation in a virtual group and the minimization of administration burden. We solicit public comment on approaches for virtual groups to ensure that all members of a virtual group are aware of their participation in the virtual group.

g. Reporting Requirements

As we noted in this proposed rule, we believe virtual groups should generally be treated under the MIPS as groups. Therefore, for MIPS eligible clinicians participating at the virtual group level, we propose 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 at §414.1315(d)(1).

- 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 (at §414. 1315(d)(2)).

- 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 (at §414.1315(d)(3)).

- 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 (at §414.1315(d)(4)).

- Virtual groups would need to adhere to an election process established and required by CMS (at §414.1315(d)(5)).

We solicit public comment on these proposals.

h. Assessment and Scoring for the MIPS Performance Categories

As noted above, section 1848(q)(5)(I)(i) of the Act provides that eligible clinicians electing to be a virtual group will: (1) have their performance assessed for the quality and cost performance categories in a manner that applies the combined performance of all eligible clinicians in the virtual group to each MIPS eligible clinician (except for those participating in a MIPS APM or an Advanced APM under the MIPS APM scoring standard) in the virtual group for a performance period of a year; and (2) be scored based on the assessment of the combined performance described above regarding the quality and cost performance categories for a performance period. We believe it is critical for virtual groups to be assessed and scored at the virtual group level for all performance categories; it eliminates the burden of virtual group members having to report as a virtual group and separately outside of a virtual group. Additionally, we believe that the assessment and scoring at the virtual group level 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. We propose

at §414.1315 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.

In the CY 2017 Quality Payment Program final rule (81 FR 77319 through 77329), we established the MIPS final score methodology, which will apply to virtual groups. We refer readers to sections II.C.7.b. and II.C.8. of this proposed rule for scoring policies that would apply to virtual groups.

As previously noted, we propose to allow solo practitioners and groups with 10 or fewer eligible clinicians that have elected to be part of a virtual group to have their performance measured and aggregated at the virtual group level across all four performance categories; however, we would apply payment adjustments at the individual TIN/NPI level. Each TIN/NPI would receive a final score based on the virtual group performance, but the payment adjustment would still be applied at the TIN/NPI level. We would assign the virtual group score to all TIN/NPIs billing under a TIN in the virtual group during the performance period.

During the performance year, we recognize that NPIs in a TIN that has joined a virtual group may also be participants in an APM. The TIN, as part of the virtual group, 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.

For participants in MIPS APMs, we propose to use our authority under section 1115A(d)(1) for MIPS APM authorized under section 1115A of the Act, and under section 1899(f) for the Shared Savings Program, to waive the requirement under section 1848 (q)(2)(5)(I)(i)(II) of the Act that requires performance category scores from virtual group reporting must be used to generate the composite score upon which the MIPS payment adjustment is based for all TIN/NPIs in the virtual group. Instead, we would use the score assigned to the MIPS eligible clinician based on the applicable APM Entity score to determine

MIPS payment adjustments for all MIPS eligible clinicians that are part of an APM Entity participating in a MIPS APM, in accordance with §414.1370, instead of determining MIPS payment adjustments for these MIPS eligible clinicians using the composite score of their virtual group.

APMs seek to deliver better care at lower cost and to test new ways of paying for care and measuring and assessing performance. In the CY 2017 Quality Payment Program final rule, we established policies to the address concerns we have expressed in regard to the application of certain MIPS policies to MIPS eligible clinicians in MIPS APMs (81 FR 77246 through 77269). In section II.C.6.g. of this proposed rule, we reiterate those concerns and propose additional policies for the APM scoring standard. We believe it is important to consistently apply the APM scoring standard under MIPS for eligible clinicians participating in MIPS APMs in order to avoid potential misalignments between the evaluation of performance under the terms of the MIPS APM and evaluation of performance on measures and activities under MIPS, and to preserve the integrity of the initiatives we are testing. Therefore, we believe it is necessary to waive the requirement to only use the virtual group scores under section 1848 (q)(5)(I)(i)(II) of the Act, and instead to apply the score under the APM scoring standard for eligible clinicians in virtual groups who are also in an APM Entity participating in an APM.

We note that MIPS eligible clinicians who are participants in both a virtual group and a MIPS APM would be assessed under MIPS as part of the virtual group and under the APM scoring standard as part of an APM Entity group, but would receive their payment adjustment based only on the APM Entity score. 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. We refer readers to section II.C.6.g.(2) of this proposed rule for further discussion regarding the waiver and the CY 2017 Quality Payment

Program final rule (81 FR 77013) for discussion regarding the timeframe used for determining QP status.

5. MIPS Performance Period

In the CY 2017 Quality Payment Program final rule (81 FR 77085), we finalized at §414.1320(b)(1) that for purposes of the MIPS payment year 2020, the performance period for the quality and cost performance categories is CY 2018 (January 1, 2018 through December 31, 2018). For the improvement activities and advancing care information performance categories, we finalized at §414.1320(b)(2) that for purposes of the MIPS payment year 2020, the performance period for the improvement activities and advancing care information performance categories is a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018 (January 1, 2018, through December 31, 2018). We are not proposing any changes to these policies.

We also finalized at §414.1325(f)(2) to use claims with dates of service during the performance period that must be processed no later than 60 days following the close of the performance period for purposes of assessing performance and computing the MIPS payment adjustment. Lastly, we finalized that individual MIPS eligible clinicians or groups who report less than 12 months of data (due to family leave, etc.) would be required to report all performance data available from the applicable performance period (for example, CY 2018 or a minimum of a continuous 90-day period within CY 2018).

We are proposing at §414.1320(c) and (c)(1) that for purposes of the MIPS payment year 2021 and future years, for the quality and cost performance categories, the performance period under MIPS would be the full calendar year (January 1 through December 31) that occurs 2 years prior to the applicable payment year. For example, for the MIPS payment year 2021, the performance period would be CY 2019 (January 1, 2019 through December 31, 2019), and for the MIPS payment year 2022 the performance period would be CY 2020 (January 1, 2020 through December 31, 2020).

We are proposing at §414.1320(d) and (d)(1) that for purposes of the MIPS payment year 2021, the performance period for the improvement activities and advancing care information performance categories would be a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable payment year, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

We request comments on our proposals for the performance period for MIPS payment year 2021 and future years.

6. MIPS Performance Category Measures and Activities

a. Performance Category Measures and Reporting

(1) Submission Mechanisms

We finalized in the CY 2017 Quality Payment Program final rule (81 FR 77094) at §414.1325(a) that individual MIPS eligible clinicians and groups must submit measures and activities, as applicable, for the quality, improvement activities, and advancing care information performance categories. For the cost performance category, we finalized that each individual MIPS eligible clinician's and group's cost performance would be calculated using administrative claims data. As a result, individual MIPS eligible clinicians and groups are not required to submit any additional information for the cost performance category. For individual eligible clinicians and groups that are not MIPS eligible clinicians, such as physical therapists, but elect to report to MIPS, we will calculate administrative claims-based cost measures and quality measures, if data are available. We finalized in the CY 2017 Quality Payment Program final rule (81 FR 77094 through 77095) multiple data submission mechanisms for MIPS, which provide individual MIPS eligible clinicians and groups with the flexibility to submit their MIPS measures and activities in a manner that best accommodates the characteristics of their practice, as indicated in Tables 2 and 3. Table 2 summarizes the data submission mechanisms for individual MIPS eligible clinicians that we finalized at §414.1325(b) and (e). Table 3 summarizes the data submission mechanisms for groups that are not reporting through an APM that we finalized at §414.1325(c) and (e).

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

Performance Category/Submission Combinations Accepted	Individual Reporting Data submission Mechanisms
Quality	Claims QCDR Qualified registry EHR
Cost	Administrative claims[1]
Advancing Care Information	Attestation QCDR Qualified registry EHR
Improvement Activities	Attestation QCDR Qualified registry EHR

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

Performance Category/Submission Combinations Accepted	Group Reporting Data Submission Mechanisms
Quality	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) and Administrative claims (for all-cause hospital readmission measure; no submission required)
Cost	Administrative claims[1]
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)

We finalized at §414.1325(d) that individual MIPS eligible clinicians and groups may elect to submit information via multiple mechanisms; however, they must use the same identifier

[1] Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare Part B claims. NOTE: Claims differ from administrative claims as they require MIPS eligible clinicians to append certain billing codes to denominator eligible claims to indicate the required quality action or exclusion occurred.

for all performance categories, and they may only use one submission mechanism per performance category. In response to the CY 2017 Quality Payment Program final rule (81 FR 77089), we received comments supportive of the use of multiple submission mechanisms for a single performance category due to the flexibility it would provide clinicians. Another commenter supported such an approach because they believed that the scoring of only one submission mechanism per performance category may influence which quality measures a MIPS eligible clinician chooses to report given that the commenter believed only a limited number of measures relevant to one's practice might be available through a particular submission mechanism. The commenter also believed that such flexibility would encourage continued participation in MIPS.

We are proposing to revise §414.1325(d) for purposes of the 2020 MIPS payment year and future years, beginning with performance periods occurring in 2018, 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 (specifically, the quality, improvement activities, or advancing care information performance category). Under this proposal, 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. We 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 we believe that such an approach would limit flexibility.

If an individual MIPS eligible clinician or group submits the same measure through two different mechanisms, each submission would be calculated and scored separately. We do not have the ability to aggregate data on the same measure across submission mechanisms. We would only count the submission that gives the clinician the higher score, thereby avoiding the double count. We refer readers to section II.C.7. of this proposed rule, which further outlines how we propose to score measures and activities regardless of submission mechanism.

We believe that this flexible approach would help individual MIPS eligible clinicians and groups with reporting, as it provides more options for the submission of data for the applicable performance categories. 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. This would enable the MIPS eligible clinician to receive the maximum number of points available under the quality performance category. We believe that by providing this flexibility, we would be allowing MIPS eligible clinicians the flexibility to choose the measures and activities that are most meaningful to them, regardless of the submission mechanism. We are aware 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. We would like to clarify that the requirements for the performance categories remain the same, regardless of the number of submission mechanisms used. It is also important to note for the improvement activities and advancing care information performance categories, that using multiple data submission mechanisms (for example, attestation and the

qualified registry) may limit our ability to provide real-time feedback. While we strive to provide flexibility to individual MIPS eligible clinicians and groups, we would like to note that our goal within the MIPS program is to minimize complexity and administrative burden to individual MIPS eligible clinicians and groups. We request comments on this proposal.

As discussed in section II.C.4. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups. With respect to data submission mechanisms, we are proposing that virtual groups 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.

For those MIPS eligible clinicians participating in a MIPS APM, who are on an APM Participant List on at least one of the three snapshot dates as finalized in the CY 2017 Quality Payment Program Final Rule (81 FR 77444 through 77445), or for MIPS eligible clinicians participating in a full TIN MIPS APM, who are on an APM Participant List on at least one of the four snapshot dates as discussed in section II.C.6.g.(2) of this proposed rule, the APM scoring standard applies. We refer readers to §414.1370 and the CY 2017 Quality Payment Program final rule (81 FR 77246), which describes how MIPS eligible clinicians participating in APM entities submit data to MIPS in the form and manner required, including separate approaches to the quality and cost performance categories applicable to MIPS APMs. We are not proposing any changes to how APM entities in MIPS APMs and their participating MIPS eligible clinicians submit data to MIPS.

(2) Submission Deadlines

In the CY 2017 Quality Payment Program final rule (81 FR 77097), we finalized

submission deadlines by which all associated data for all performance categories must be submitted for the submission mechanisms described in this rule.

As specified at §414.1325(f)(1), the data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms is March 31 following the close of the performance period. The submission period will begin prior to January 2 following the close of the performance period, if technically feasible. For example, for performance periods occurring in 2018, the data submission period will occur prior to January 2, 2019, if technically feasible, through March 31, 2019. If it is not technically feasible to allow the submission period to begin prior to January 2 following the close of the performance period, the submission period will occur from January 2 through March 31 following the close of the performance period. In any case, the final deadline will remain March 31, 2019.

At §414.1325(f)(2), we specified that for the Medicare Part B claims submission mechanism, 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. Lastly, for the CMS Web Interface submission mechanism, at §414.1325(f)(3), we 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. For example, the CMS Web Interface submission period could span an 8-week timeframe beginning January 16 and ending March 13. The specific deadline during this timeframe will be published on the CMS website. We are not proposing any changes to the submission deadlines in this proposed rule.

b. Quality Performance Criteria

(1) Background

Sections 1848(q)(1)(A)(i) and (ii) of the Act require the Secretary to develop a methodology for assessing the total performance of each MIPS eligible clinician according to performance standards and, using that methodology, to provide for a final score for each MIPS eligible clinician. Section 1848(q)(2)(A)(i) of the Act requires us to use the quality performance category in determining each MIPS eligible clinician's final score, and section 1848(q)(2)(B)(i) of the Act describes the measures and activities that must be specified under the quality performance category.

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.

Sections 1848(q)(1)(E) of the Act requires the Secretary to encourage the use of QCDRs, and section 1848(q)(5)(B)(ii)(I) of the Act requires the Secretary to encourage the use of CEHRT and QCDRs for reporting measures under the quality performance category under the final score methodology, but the statute does not limit the Secretary's discretion to establish other reporting mechanisms.

Section 1848(q)(2)(C)(iv) of the Act generally requires the Secretary to give consideration to the circumstances of non-patient facing MIPS eligible clinicians and allows the Secretary, to the extent feasible and appropriate, to apply alternative measures or activities to such clinicians.

As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77098 through 77099), we finalized MIPS quality criteria that focus on measures that are important to beneficiaries and maintain some of the flexibility from PQRS, while addressing several of the

comments we received in response to the CY 2017 Quality Payment Program proposed rule and the MIPS and APMs RFI.

- To encourage meaningful measurement, we finalized allowing individual MIPS eligible clinicians and groups the flexibility to determine the most meaningful measures and data submission mechanisms for their practice.

- To simplify the reporting criteria, we aligned the submission criteria for several of the data submission mechanisms.

- To reduce administrative burden and focus on measures that matter, we lowered the required number of the measures for several of the data submission mechanisms, yet still required that certain types of measures, particularly outcome measures, be reported.

- To create alignment with other payers and reduce burden on MIPS eligible clinicians, we incorporated measures that align with other national payers.

- To create a more comprehensive picture of a practice's performance, we also finalized the use of all-payer data where possible.

As beneficiary health is always our top priority, we finalized criteria to continue encouraging the reporting of certain measures such as outcome, appropriate use, patient safety, efficiency, care coordination, or patient experience measures. However, as discussed in the CY 2017 Quality Payment Program final rule (81 FR 77098), we removed the requirement for measures to span across multiple domains of the NQS. We continue to believe the NQS domains are extremely important, and we encourage MIPS eligible clinicians to continue to strive to provide care that focuses on: effective clinical care, communication and care coordination, efficiency and cost reduction, person and caregiver-centered experience and outcomes, community and population health, and patient safety. While we do not require that MIPS eligible clinicians select measures across multiple domains, we encourage them to do so. In addition, we believe the MIPS program overall, with the focus on the quality, cost, improvement

activities, and advancing care information performance categories, will naturally cover many elements in the NQS.

(2) Contribution to Final Score

For MIPS payment year 2019, the quality performance category will account for 60 percent of the final score, subject to the Secretary's authority to assign different scoring weights under section 1848(q)(5)(F) of the Act. Section 1848(q)(2)(E)(i)(I)(aa) of the Act states that the quality performance category will account for 30 percent of the final score for MIPS. However, section 1848(q)(2)(E)(i)(I)(bb) of the Act stipulates that for the first and second years for which MIPS applies to payments, the percentage of the final score applicable for the quality performance category will be increased so that the total percentage points of the increase equals the total number of percentage points by which the percentage applied for the cost performance category is less than 30 percent. Section 1848(q)(2)(E)(i)(II)(bb) of the Act requires that, for the transition year for which MIPS applies to payments, not more than 10 percent of the final score shall be based on the cost performance category. Furthermore, section 1848(q)(2)(E)(i)(II)(bb) of the Act states that, for the second year for which MIPS applies to payments, not more than 15 percent of the final score shall be based on the cost performance category.

In the CY 2017 Quality Payment Program final rule (81 FR 77100), we finalized at §414.1330(b) that, for MIPS payment years 2019 and 2020, 60 percent and 50 percent, respectively, of the MIPS final score will be based on the quality performance category. For the third and future years, 30 percent of the MIPS final score will be based on the quality performance category.

As discussed in section II.C.6.d. of this proposed rule, we are proposing to weight the cost performance category at zero percent for the second MIPS payment year (2020). In accordance with section 1848(q)(5)(E)(i)(I)(bb) of the Act, for the first 2 years, the percentage of the MIPS final score that would otherwise be based on the quality performance category (that is,

30 percent) must be increased by the same number of percentage points by which the percentage based on the cost performance category is less than 30 percent. Therefore, if our proposal to reweight the cost performance category for MIPS payment year 2020 is finalized, we would need to inversely reweight the quality performance category for the same year. Accordingly, we are proposing to modify §414.1330(b)(2) to reweight the percentage of the MIPS final score based on the quality performance category for MIPS payment year 2020 as may be necessary to account for any reweighting of the cost performance category, if finalized. For example, if our proposal to reweight the cost performance category to zero percent for MIPS payment year 2020 is finalized, then we would modify §414.1330(b)(2) to provide that performance in the quality performance category will comprise 60 percent of a MIPS eligible clinician's final score for MIPS payment year 2020. We refer readers to section II.C.6.d. for more information on the cost performance category.

As also discussed in section II.C.6.d. of this proposed rule, we note that by reweighting the cost performance category to zero percent in performance period 2018, there will be a sharp increase in the cost performance category to a 30 percent weight in performance period 2019. In order to assist MIPS eligible clinicians and groups in obtaining additional comfort with measurement based on the cost performance category, we considered maintaining our previously-finalized cost performance category weight of 10 percent for the 2018 performance period. However, in our discussions with some MIPS eligible clinicians and clinician societies, eligible clinicians expressed their desire to down-weight the cost performance category to zero percent for an additional year with full knowledge that the cost performance category weight is set at 30 percent under the statute for the 2021 MIPS payment year. The clinicians we spoke with preferred our proposed approach and noted that they are actively preparing for full cost performance category implementation and would be prepared for the 30 percent statutory weight for the cost performance category for the 2021 MIPS payment year.

We intend to provide an initial opportunity for clinicians to review their performance based on the new episode-based measures at some point in the fall of 2017, as the measures are developed and as the information is available. We note that this feedback will be specific to the new episode-based measures that are developed under the process described above and may be presented in a different format than MIPS eligible clinicians' performance feedback as described in section II.C.9.a. of this proposed rule. However, our intention is to align the feedback as much as possible to ensure clinicians receive opportunities to review their performance on potential new episode-based measures for the cost performance category prior to the proposed 2019 MIPS performance period. We are unable to offer a list of new episode-based measures on which we will provide feedback because that will be determined in our ongoing development work described above. We are concerned that continuing to provide feedback on the older episode-based measures along with feedback on new episode-based measures will be confusing and a poor use of resources. Because we are focusing on development of new episode-based measures, our feedback on episode-based measures that were previously developed will discontinue after 2017 as these measures would no longer be maintained or reflect changes in diagnostic and procedural coding. As described in section II.C.9.a. of this proposed rule, we intend to provide feedback on these new measures as they become available in a new format around summer 2018, in addition to the fall 2017 feedback discussed previously. We note that the feedback provided in the summer of 2018 will go to those MIPS eligible clinicians for whom we are able to calculate the episode-based measures, which means it would be possible that a clinical may not receive feedback on episode-based measures in both the fall of 2017 and the summer of 2018. We believe that receiving feedback on the new episode-based measures, along with the previously-finalized total per capita cost and MSPB measures, will support clinicians in their readiness for the proposed 2019 MIPS performance period.

Section 1848(q)(5)(B)(i) of the Act requires the Secretary to treat any MIPS eligible clinician who fails to report on a required measure or activity as achieving the lowest potential score applicable to the measure or activity. Specifically, under our finalized scoring policies, an individual MIPS eligible clinician or group that reports on all required measures and activities could potentially obtain the highest score possible within the performance category, assuming they perform well on the measures and activities they report. An individual MIPS eligible clinician or group who does not submit data on a required measure or activity would receive a zero score for the unreported items in the performance category (in accordance with section 1848(q)(5)(B)(i) of the Act). The individual MIPS eligible clinician or group could still obtain a relatively good score by performing very well on the remaining items, but a zero score would prevent the individual MIPS eligible clinician or group from obtaining the highest possible score within the performance category.

(3) Quality Data Submission Criteria

(a) Submission Criteria

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

In the CY 2017 Quality Payment Program final rule (81 FR 77114), we finalized at §414.1335(a)(1) that individual MIPS eligible clinicians submitting data via claims and individual MIPS eligible clinicians and groups submitting data via all mechanisms (excluding the CMS Web Interface and the CAHPS for MIPS survey) are required to meet the following submission criteria. For the applicable period during the performance period, the individual MIPS eligible clinician or group will report at least six measures, including at least one outcome measure. If an applicable outcome measure is not available, the individual MIPS eligible clinician or group will be required to report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an

outcome measure. If fewer than six measures apply to the individual MIPS eligible clinician or group, then the individual MIPS eligible clinician or group would be required to report on each measure that is applicable. We defined "applicable" to mean measures relevant to a particular MIPS eligible clinician's services or care rendered. As discussed in section II.C.7.a.(2)(e)., we will only make determinations as to whether a sufficient number of measures are applicable for claims-based and registry submission mechanisms; we will not make this determination for EHR and QCDR submission mechanisms, for example.

Alternatively, the individual MIPS eligible clinician or group will report one specialty measure set, or the measure set defined at the subspecialty level, if applicable. If the measure set contains fewer than six measures, MIPS eligible clinicians will be required to report all available measures within the set. If the measure set contains six or more measures, MIPS eligible clinicians will be required to report at least six measures within the set. Regardless of the number of measures that are contained in the measure set, MIPS eligible clinicians reporting on a measure set will be required to report at least one outcome measure or, if no outcome measures are available in the measure set, the MIPS eligible clinician will report another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) within the measure set in lieu of an outcome measure. MIPS eligible clinicians may choose to report measures in addition to those contained in the specialty measure set and will not be penalized for doing so, provided that such MIPS eligible clinicians follow all requirements discussed here.

In accordance with §414.1335(a)(1)(ii), individual MIPS eligible clinicians and groups will select their measures from either the set of all MIPS measures listed or referenced in Table A of the Appendix in this proposed rule or one of the specialty measure sets listed in Table B of the Appendix in this proposed rule. We note that some specialty measure sets include measures grouped by subspecialty; in these cases, the measure set is defined at the subspecialty level.

Previously finalized quality measures may be found in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77816).

We also finalized the definition of a high priority measure at §414.1305 to mean an outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measure. Except as discussed in section II.C.6.b.(3)(a) of this proposed rule with regard to the CMS Web Interface and the CAHPS for MIPS survey, we are not proposing any changes to the submission criteria or definitions established for measures in this proposed rule.

In the CY 2017 Quality Payment Program final rule (81 FR 77114), we solicited comments regarding adding a requirement to our finalized policy that patient-facing MIPS eligible clinicians would be required to report at least one cross-cutting measure in addition to the high priority measure requirement for further consideration for the Quality Payment Program Year 2 and future years. For clarification, we consider a cross-cutting measure to be any measure that is broadly applicable across multiple clinical settings and individual MIPS eligible clinicians or groups within a variety of specialties. We specifically requested feedback on how we could construct a cross-cutting measure requirement that would be most meaningful to MIPS eligible clinicians from different specialties and that would have the greatest impact on improving the health of populations. We received conflicting feedback on adding a future requirement for MIPS eligible clinicians to report at least one cross-cutting measure in the Quality Payment Program Year 2 and future years.

Many commenters agreed that cross-cutting measures are applicable across multiple clinical settings and that MIPS eligible clinicians within a variety of specialties should report at least one cross-cutting measure. Some stated that cross-cutting measures promote shared accountability and improve the health of populations. Others recommended we continue to work with stakeholders and specialists, including solo and small practices, to develop cross-cutting measures for all settings, whether they be patient-facing or non-patient facing practices that are

patient-centric (that is, following the patient and not the site of care) and recommended the term "patient-centered measures" rather than "cross-cutting measures." In addition, some commenters stated we should consider measures that are multidisciplinary, foster cross-collaboration within virtual groups, improve patient outcomes, target high-cost areas, target areas with gaps in care, and include individual patient preferences in shared decision-making. A few commenters provided specific measures that they recommended utilizing as cross-cutting measures, such as: Screening for Hepatitis C; Controlling High Blood Pressure; Tobacco Use Cessation Counseling and Treatment; Advance Care Planning; or Medication Reconciliation. One commenter recommended we utilize shared accountability measures around surgical goals of care, shared decision making relying on some form of risk estimation such as a risk calculator, medication reconciliation, and a shared plan of care across clinicians. Another commenter suggested that instead of having a cross-cutting measure requirement, we could use health IT as a cross-cutting requirement. Specifically, the commenter noted we could require that at least one measure using end-to-end electronic reporting, or that at least one measure be tied to an improvement activity the clinician is performing. Other commenters suggested that we provide bonus points to practices that elect to submit data on cross-cutting measures and hold harmless from any future cross-cutting measure requirements MIPS eligible clinicians who have less than 15 instances in the measure denominator during the performance period, allow MIPS eligible clinicians to use high-priority measures in the place of a cross-cutting measure if necessary, and apply the guiding principles listed in NQF's "Attribution: Principles and Approaches" final report which may be found at http://www.qualityforum.org/ProjectDescription.aspx?projectID=80808.

Other commenters appreciated our decision not to finalize the requirement to report a cross-cutting measure in the transition year and requested that we not require cross-cutting measures in the future, as they believed it is administratively burdensome for clinicians and QCDRs and removes focus and resources from quality measures that are more relevant to MIPS

eligible clinicians' scope of practice and important to their patients' treatment and outcomes. They stated that PQRS demonstrated the challenge of identifying cross-cutting measures that are truly meaningful across different specialties and that truly have an impact on improving the health of populations. Some stated we should focus on high-priority measures over cross-cutting measures. A few commenters did not agree that cross-cutting measures were relevant and stated they should not be a requirement in MIPS until all MIPS eligible clinicians can successfully meet the current requirements. Others did not agree that QCDRs should be required to submit cross-cutting measures because they believed that Congress did not intend for QCDRs to submit clinical process measures, that implementation may be complicated by practices that upgrade their health IT, and vendors have indicated it would take 12 to 18 months to implement system changes to support capture of cross-cutting measures. They also questioned the value of investing additional time and resources in this effort, especially if these cross-cutting measures are ultimately found to be topped out or removed. Others believed we should delay implementation until the Quality Payment Program Year 3 in order to allow MIPS eligible clinicians to focus on implementing new CEHRT requirements and modifying their processes to address lessons learned from reporting in the first 2 years.

Except as discussed in section II.C.6.b.(3)(a)(iii). of this proposed rule with regard to the CAHPS for MIPS survey, we are not proposing any changes to the submission criteria for quality measures in this proposed rule. We thank the commenters for their feedback and will take the comments into consideration in future rulemaking. We welcome additional feedback on meaningful ways to incorporate cross-cutting measurement into MIPS and the Quality Payment Program generally.

(ii) Submission Criteria for Quality Measures for Groups Reporting via the CMS Web Interface

In the CY 2017 Quality Payment Program final rule (81 FR 77116), we finalized at §414.1335(a)(2) the following criteria for the submission of data on quality measures by

registered groups of 25 or more eligible clinicians who want to report via the CMS Web Interface. For the applicable 12-month performance period, the group would be required to report on all measures included in the CMS Web Interface completely, accurately, and timely by populating data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module or measure. If the sample of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries. A group would be required to report on at least one measure for which there is Medicare patient data. Groups reporting via the CMS Web Interface are required to report on all of the measures in the set. Any measures not reported would be considered zero performance for that measure in our scoring algorithm. In addition, we are proposing to clarify that these criteria apply to groups of 25 or more eligible clinicians. Specifically, we propose to revise §414.1335(a)(2)(i) to provide criteria applicable to groups of 25 or more eligible clinicians, report on all measures included in the CMS Web Interface. The group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module.

In the CY 2017 Quality Payment Program final rule (81 FR 77116), we finalized to continue to align the 2019 CMS Web Interface beneficiary assignment methodology with the attribution methodology for two of the measures that were formerly in the VM: The population quality measure discussed in the CY 2017 Quality Payment Program proposed rule (81 FR 28188) and total per capita cost for all attributed beneficiaries discussed in the CY 2017 Quality Payment Program proposed rule (81 FR 28196). When establishing MIPS, we also finalized a modified attribution process to update the definition of primary care services and to adapt the attribution to different identifiers used in MIPS. These changes are discussed in the CY 2017 Quality Payment Program proposed rule (81 FR 28196). We note that groups reporting via the CMS Web Interface may also report the CAHPS for MIPS survey and receive bonus points for

submitting that measure. We are not proposing any changes to the submission criteria for quality measures for groups reporting via the CMS Web Interface in this proposed rule.

(iii) Performance Criteria for Quality Measures for Groups Electing to Report Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

In the CY 2017 Quality Payment Program final rule (81 FR 77100), we finalized at §414.1335(a)(3) the following criteria for the submission of data on the CAHPS for MIPS survey by registered groups via CMS-approved survey vendor: For the applicable 12-month performance period, a group that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measure must use a survey vendor that is approved by CMS for a particular performance period to transmit survey measures data to CMS. The CAHPS for MIPS survey counts for one measure towards the MIPS quality performance category and, as a patient experience measure, also fulfills the requirement to report at least one high priority measure in the absence of an applicable outcome measure. In addition, groups that elect this data submission mechanism must select an additional group data submission mechanism (that is, qualified registries, QCDRs, EHR, etc.) in order to meet the data submission criteria for the MIPS quality performance category. The CAHPS for MIPS survey will count as one patient experience measure, and the group will be required to submit at least five other measures through one other data submission mechanism. A group may report any five measures within MIPS plus the CAHPS for MIPS survey to achieve the six measures threshold. We are not proposing any changes to the performance criteria for quality measures for groups electing to report the CAHPS for MIPS survey in this proposed rule.

In the CY 2017 Quality Payment Program final rule (see 81 FR 77120), we finalized retaining the CAHPS for MIPS survey administration period that was utilized for PQRS of November to February. However, this survey administration period has become operationally problematic for the administration of MIPS. In order to compute scoring, we must have the

CAHPS for MIPS survey data earlier than the current survey administration period deadline allows. Therefore, we are proposing for the Quality Payment Program Year 2 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. In addition, we propose to further specify the start and end timeframes of the survey administration period through our normal communication channels.

In addition, as discussed in the CY 2017 Quality Payment Program final rule (81 FR 77116), we anticipated exploring the possibility of updating the CAHPS for MIPS survey under MIPS, specifically not finalizing all of the proposed Summary Survey Measures (SSMs). The CAHPS for MIPS survey currently consists of the core CAHPS Clinician & Group (CG-CAHPS) Survey developed by the Agency for Healthcare Research and Quality (AHRQ), plus additional survey questions to meet CMS's program needs. We are proposing for the Quality Payment Program Year 2 and future years to remove two SSMs, specifically, "Helping You to Take Medication as Directed" and "Between Visit Communication" from the CAHPS for MIPS survey. We are proposing to remove the SSM entitled "Helping You to Take Medication as Directed" due to low reliability. In 2014 and 2015, the majority of groups had very low reliability on this SSM. Furthermore, based on analyses conducted of SSMs in an attempt to improve their reliability, removing questions from this SSM did not result in any improvements in reliability. The SSM, "Helping You to Take Medication as Directed," has also never been a scored measure with the Medicare Shared Savings Program CAHPS for Accountable Care Organizations (ACOs) Survey. We refer readers to the CY 2014 Physician Fee Schedule final rule for a discussion on the CAHPS for ACO survey scoring (79 FR 67909 through 67910) and measure tables (79 FR 67916 through 67917). The SSM entitled "Between Visit Communication" currently contains only one question. This question could also be considered related to other SSMs entitled: "Care Coordination" or "Courteous and Helpful Office Staff," but

does not directly overlap with any of the questions under that SSM. However, we are proposing to remove this SSM in order to maintain consistency with the Medicare Shared Savings Program which, utilizes the CAHPS for Accountable Care Organizations (ACOs) Survey. The SSM entitled "Between Visit Communication" has never been a scored measure with the Medicare Shared Savings Program CAHPS for ACOs Survey.

In addition to public comments we receive, we will also take into consideration analysis we will be conducting before finalizing this proposal. Specifically, we will review the findings of the CAHPS for ACO survey pilot, which was administered from November 2016 through February 2017. The CAHPS for ACO survey pilot utilized a survey instrument which did not contain the two SSMs we are proposing for removal from the CAHPS for MIPS survey. For more information on the other SSMs within the CAHPS for MIPS survey, please see the explanation of the CAHPS for PQRS survey in the CY 2016 PFS final rule with comment period (80 FR 71142 through 71143).

TABLE 4: Proposed Summary Survey Measures (SSMs) included in the CAHPS for MIPS Survey

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

We are seeking comment on expanding the patient experience data available for the CAHPS for MIPS survey. Currently, the CAHPS for MIPS survey is available for groups to report under the MIPS. The patient experience survey data that is available on Physician Compare is highly valued by patients and their caregivers as they evaluate their health care options. However, in user testing with patients and caregivers in regard to the Physician

Compare website, the users regularly ask for more information from patients like them in their own words. Patients regularly request that we include narrative reviews of individual clinicians and groups on the website. AHRQ is fielding a beta version of the CAHPS Patient Narrative Elicitation Protocol (https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html). This includes five open-ended questions designed to be added to the CG CAHPS survey, after which the CAHPS for MIPS survey is modeled. These five questions have been developed and tested in order to 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. More scientifically rigorous patient narrative data would not only greatly benefit patients in their decision for healthcare, but it would also greatly aid individual MIPS eligible clinicians and groups as they assess how their patients experience care. We are seeking comment on adding these five open-ended questions to the CAHPS for MIPS survey in future rulemaking. Beta testing is an ongoing process, and we anticipate reviewing the results of that testing in collaboration with AHRQ before proposing changes to the CAHPS for MIPS survey.

We are requiring, where possible, all-payer data for all reporting mechanisms, yet certain reporting mechanisms are limited to Medicare Part B data. Specifically, the CAHPS for MIPS survey currently relies on sampling protocols based on Medicare Part B billing; therefore, only Medicare Part B beneficiaries are sampled through that methodology. In the CY 2017 Quality Payment Program proposed rule (81 FR 28189), we requested comments on ways to modify the methodology to assign and sample patients for these mechanisms using data from other payers. We received mixed feedback on the use of all-payer data overall. The full discussion of the comments and the responses can be found in the CY 2017 Quality Payment Program final rule (81 FR 77123 through 77125). We are requesting additional comments on ways to modify the methodology to assign and sample patients using data from other payers for reporting

mechanisms that are currently limited to Medicare Part B data. In particular, we are seeking comment on the ability of groups to provide information on the patients to whom they provide care during a calendar year, whether it would be possible to identify a list of patients seen by individual clinicians in the group, and what type of patient contact information groups would be able to provide. Further, we would like to seek 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. We are also seeking comment on EHR vendors' ability to provide information on the patients who receive care from their client groups.

(b) Data Completeness Criteria

In the CY 2017 Quality Payment Program final rule (81 FR 77125), we finalized data completeness criteria for the transition year and MIPS payment year 2020. We finalized at §414.1340 the data completeness criteria below for performance periods occurring in 2017.

- Individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR must report on at least 50 percent of the individual MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the performance period. In other words, for these submission mechanisms, we expect to receive quality data for both Medicare and non-Medicare patients. For the transition year, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent would receive 3 points for submitting the measure.

- Individual MIPS eligible clinicians submitting data on quality measures data using Medicare Part B claims, would report on at least 50 percent of the Medicare Part B patients seen during the performance period to which the measure applies. For the transition year, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent would receive 3 points for submitting the measure.

- Groups submitting quality measures data using the CMS Web Interface or a CMS-approved survey vendor to report the CAHPS for MIPS survey must meet the data submission requirements on the sample of the Medicare Part B patients CMS provides.

In addition, we finalized an increased data completeness threshold of 60 percent for MIPS for performance periods occurring in 2018 for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims. We noted that these thresholds for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims would increase for performance periods occurring in 2019 and onward.

We are proposing to modify the previously established data completeness criteria for MIPS payment year 2020. Specifically, we would like to provide an additional year for individual MIPS eligible clinicians and groups to gain experience with MIPS before increasing the data completeness thresholds for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims. We are concerned about the unintended consequences of accelerating the data completeness threshold so quickly, which may jeopardize MIPS eligible clinicians' ability to participate and perform well under the MIPS, particularly those clinicians who are least experienced with MIPS quality measure data submission. We want to ensure that an appropriate yet achievable level of data completeness is applied to all MIPS eligible clinicians. We continue to believe it is important to incorporate higher data completeness thresholds in future years to ensure a more accurate assessment of a MIPS eligible clinician's performance on quality measures and to avoid any selection bias. Therefore, we propose, below, a 60 percent data completeness threshold for MIPS payment year 2021. We strongly encourage all MIPS eligible clinicians to perform the quality actions associated with the quality measures on their patients. The data submitted for each measure is expected to be representative of the individual MIPS eligible clinician's or group's overall performance for that measure. The data completeness threshold of less than 100 percent is intended to reduce burden

and accommodate operational issues that may arise during data collection during the initial years of the program. We are providing this notice to MIPS eligible clinicians so that they can take the necessary steps to prepare for higher data completeness thresholds in future years.

Therefore, we propose to revise the data completeness criteria for the quality performance category at §414.1340(a)(2) to provide that MIPS eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, or EHR submission mechanism must submit data on at least 50 percent of the individual MIPS eligible clinician's or group's patients that meet the measure's denominator criteria, regardless of payer, for MIPS payment year 2020. We also propose to revise the data completeness criteria for the quality performance category at §414.1340(b)(2) to provide that MIPS eligible clinicians and groups submitting quality measures data using Medicare Part B claims, must submit data on at least 50 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2020. We further propose at §414.1340(a)(3), that MIPS eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, or EHR submission mechanism must submit data on at least 60 percent of the individual MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment year 2021. We also propose at §414.1340(b)(3), that MIPS eligible clinicians and groups submitting quality measures data using Medicare Part B claims, must submit data on at least 60 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2021. We would like to note that we anticipate for future MIPS payment years we will propose to increase the data completeness threshold for data submitted using QCDRs, qualified registries, EHR submission mechanisms, or Medicare Part B claims. As MIPS eligible clinicians gain experience with the MIPS, we would propose to steadily increase these thresholds for future

years through rulemaking. In addition, we are seeking comment on what data completeness threshold should be established for future years.

In the CY 2017 Quality Payment Program final rule (81 FR 77125 through 77126), we finalized our approach of including all-payer data for the QCDR, qualified registry, and EHR submission mechanisms because we believed this approach provides a more complete picture of each MIPS eligible clinician's scope of practice and provides more access to data about specialties and subspecialties not currently captured in PQRS. In addition, 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. We are not proposing any changes to these policies in this proposed rule. As noted in the CY 2017 Quality Payment Program final rule, those MIPS eligible clinicians who fall below the data completeness thresholds will receive 3 points for the specific measures that fall below the data completeness threshold in the transition year of MIPS only. For the Quality Payment Program Year 2, we are proposing that MIPS eligible clinicians would receive 1 point for measures that fall below the data completeness threshold, with an exception for small practices of 15 or fewer who would still receive 3 points for measures that fail data completeness. We refer readers to section II.C.6.b.(3)(b) of this proposed rule for our proposed policies on instances when MIPS eligible clinicians' measures fall below the data completeness threshold.

(c) Summary of Data Submission Criteria

Table 5 reflects our proposed quality data submission criteria for MIPS payment year 2020 via Medicare Part B claims, QCDR, qualified registry, EHR, CMS Web Interface, and the CAHPS for MIPS survey. It is important to note that while we finalized at §414.1325(d) in the CY 2017 Quality Payment Program final rule that individual MIPS eligible clinicians and groups may only use one submission mechanism per performance category, in section II.C.6.a.(1) of this rule, we are proposing 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 advancing care information performance categories. We refer readers to section II.C.6.a.(1) of this proposed rule for further discussion of this proposal.

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 percent 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 percent 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 groups	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 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 percent of assigned beneficiaries.	Sampling requirements for 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.

As discussed in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77127), we finalized at §414.1335 that non-patient facing MIPS eligible clinicians would be required to meet the applicable submission criteria that apply for all MIPS eligible clinicians for the quality

performance category. We are not proposing any changes to this policy in this proposed rule.

(5) Application of Facility-Based Measures

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 used 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. We refer readers to section II.C.7.a.(4) of this proposed rule for a full discussion of our proposals regarding the application of facility-based measures.

(6) Global and Population-Based Measures

In the CY 2017 Quality Payment Program final rule (81 FR 77136), we did not finalize all of our proposals on global and population-based measures as part of the quality score. Specifically, we did not finalize our proposal to use the acute and chronic composite measures of the AHRQ Prevention Quality Indicators (PQIs). We agreed with commenters that additional enhancements, including the addition of risk adjustment, needed to be made to these measures prior to inclusion in MIPS. We did, however, calculate these measures at the TIN level, through the QRURs released in September 2016, and this data can be used by MIPS eligible clinicians for informational purposes.

We did finalize the all-cause hospital readmissions (ACR) measure from the VM Program as part of the quality measure domain for the MIPS total performance score. We finalized this measure with the following modifications. We did not apply the ACR measure to solo practices or small groups (groups of 15 or less). We did apply the ACR measure to groups of 16 or more who meet the case volume of 200 cases. A group was scored on the ACR measure even if it did not submit any quality measures, if it submitted in other

performance categories. Otherwise, the group was not scored on the readmission measure if it did not submit data in any of the performance categories. In our transition year policies, the readmission measure alone would not produce a neutral to positive MIPS payment adjustment since in order to achieve a neutral to positive MIPS payment adjustment, an individual MIPS eligible clinician or group must submit information on one of the three performance categories as discussed in the CY 2017 Quality Payment Program final rule (81 FR 77329). In addition, the ACR measure in the MIPS transition year CY 2017 was based on the performance period (January 1, 2017 through December 31, 2017). However, for MIPS eligible clinicians who did not meet the minimum case requirements, the ACR measure was not applicable. We are not proposing any changes for the global and population-based measures in this proposed rule. As discussed in section II.C.4.d. of this rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups.

c. Selection of MIPS Quality Measures for Individual MIPS Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment

(1) Background and Policies for the Call for Measures and Measure Selection Process

Under section 1848(q)(2)(D)(i) of the Act, the Secretary, through notice and comment rulemaking, must establish an annual list of MIPS quality measures from which MIPS eligible clinicians may choose for purposes of assessment for a performance period. The annual list of MIPS quality measures must be published in the **Federal Register** no later than November 1 of the year prior to the first day of a performance period. Updates to the annual list of MIPS quality measures must be published in the **Federal Register** no later than November 1 of the year prior to the first day of each subsequent performance period. Updates may include the addition of new MIPS quality measures, substantive changes to MIPS quality measures, and removal of MIPS quality measures. MIPS eligible clinicians reporting on the quality performance category are required to use the most recent version of the clinical quality measure (CQM) electronic specifications as indicated in the CY 2017 Quality Payment Program final rule (81 FR 77291). For purposes of the 2018 MIPS performance period, the spring 2017 version of the eCQM annual update to the measure specifications and any applicable addenda are available on the electronic clinical quality improvement (eCQI) Resource Center website at https://ecqi.healthit.gov. The CMS Quality Measure Development Plan (MDP) serves as a strategic framework for the future of the clinician quality measure development to support MIPS and APMs. The MDP is available on the CMS website and highlights known measurement gaps and recommends approaches to close those gaps through development, use, and refinement of quality measures that address significant variation in performance gaps. We encourage stakeholders to develop additional quality measures for MIPS that would address the gaps.

Under section 1848(q)(2)(D)(ii) of the Act, the Secretary must solicit a "Call for Quality Measures" each year. Specifically, the Secretary must request that eligible clinician

organizations and other relevant stakeholders identify and submit quality measures to be considered for selection in the annual list of MIPS quality measures, as well as updates to the measures. Under section 1848(q)(2)(D)(ii) of the Act, eligible clinician organizations are professional organizations as defined by nationally recognized specialty boards of certification or equivalent certification boards. However, we do not believe there needs to be any special restrictions on the type or make-up of the organizations that submit measures for consideration through the call for measures. Any such restriction would limit the type of quality measures and the scope and utility of the quality measures that may be considered for inclusion under the MIPS.

As we described previously in the CY 2017 Quality Payment Program final rule (81 FR 77137), we will accept quality measures submissions at any time, but only measures submitted during the timeframe provided by us through the pre-rulemaking process of each year will be considered for inclusion in the annual list of MIPS quality measures for the performance period beginning 2 years after the measure is submitted. This process is consistent with the pre-rulemaking process and the annual call for measures, which are further described at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html).

Submission of potential quality measures, regardless of whether they were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a) of the Act, which is currently the National Quality Forum, is encouraged. The annual Call for Measures process allows eligible clinician organizations and other relevant stakeholder organizations to identify and submit quality measures for consideration. Presumably, stakeholders would not submit measures for consideration unless they believe that the measure is applicable to clinicians and can be reliably and validly measured at the individual clinician level. The NQF-convened Measure Application Partnership (MAP) provides an additional opportunity

for stakeholders to provide input on whether or not they believe the measures are applicable to clinicians as well as feasible, scientifically acceptable, and reliable and valid at the clinician level. Furthermore, we must go through notice and comment rulemaking to establish the annual list of quality measures, which gives stakeholders an additional opportunity to review the measures and provide input on whether or not they believe the measures are applicable to clinicians, as well as feasible, scientifically acceptable, and reliable and valid at the clinician level. Additionally, we are required by statute to submit new measures to an applicable specialty- appropriate, peer-reviewed journal.

As previously noted, we encourage the submission of potential quality measures regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a) of the Act. However, we propose to request 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.

We will apply these considerations when considering quality measures for possible inclusion in MIPS.

In addition, we note that we are likely to reject measures that do not provide substantial evidence of variation in performance; for example, if a measure developer submits data showing a small variation in performance among a group already composed of high performers, such evidence would not be substantial enough to assure us that sufficient variation in performance exists. We also note that we are 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.

We also note that retired measures that were in one of CMS's previous quality programs, such as the Physician Quality Reporting System (PQRS) program, will likely be rejected if proposed for inclusion. This includes measures that were retired due to being topped out, as defined below. For example, measures may be retired due to attaining topped out status because of high performance, or measures that are retired due to a change in the evidence supporting their use.

In the CY 2017 Quality Payment Program final rule (81 FR 77153), we established that we will categorize measures into the six NQS domains (patient safety, person- and caregiver-centered experience and outcomes, communication and care coordination, effective clinical care, community/population health, and efficiency and cost reduction). We intend to submit future MIPS quality measures to the NQF-convened Measure Application Partnership's (MAP), as appropriate, and we intend to consider the MAP's recommendations as part of the comprehensive assessment of each measure considered for inclusion under MIPS.

In the CY 2017 Quality Payment Program final rule (81 FR 77155), we established that

we use the Call for Quality Measures process as a forum to gather the information necessary to draft the journal articles for submission from measure developers, measure owners and measure stewards since we do not always develop measures for the quality programs. The submission of this information does not preclude us from conducting our own research using Medicare claims data, Medicare survey results, and other data sources that we possess. We submit new measures for publication in applicable specialty-appropriate, peer-reviewed journals before including such measures in the final annual list of quality measures.

In the CY 2017 Quality Payment Program final rule (81 FR 77158), we established at §414.1330(a)(2) that for purposes of assessing performance of MIPS eligible clinicians on the quality performance category, we use quality measures developed by QCDRs. In the circumstances where a QCDR wants to use a QCDR measure for inclusion in the MIPS program for reporting, those measures go through a CMS approval process during the QCDR self-nomination period. We also established that we post the quality measures for use by QCDRs by no later than January 1 for performance periods occurring in 2018 and future years.

Previously finalized MIPS quality measures can be found in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675). Updates may include the proposal to add new MIPS quality measures, including measures selected 2 years ago during the Call for Measures process. The new MIPS quality measures proposed for inclusion in MIPS for the 2018 performance period and future years are found in Table A. The proposed new and modified MIPS specialty sets for the 2018 performance period and future years are listed in Table B, and include existing measures that are proposed with modifications, new measures, and measures finalized in the CY 2017 Quality Payment Program final rule. We note that the modifications made to the specialty sets may include the removal of certain quality measures that were previously finalized. The specialty measure sets should be used as a guide for eligible clinicians to choose measures applicable to their specialty. To clarify, some of the MIPS

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. MIPS eligible clinicians are not required to report on the specialty measure sets, but they are suggested measures for specific specialties. Throughout measure utilization, measure maintenance should be a continuous process done by the measure owners, to include environmental scans of scientific literature about the measure. New information gathered during this ongoing review may trigger an ad hoc review. The specialty measure sets in Table B of the Appendix, include existing measures that are proposed with modifications, new measures, and measures that were previously finalized in the CY 2017 Quality Payment Program final rule. Please note that these specialty specific measure sets are not all inclusive of every specialty or subspecialty. On January 25, 2017, we announced that we would be accepting recommendations for potential new specialty measure sets for year 2 of MIPS under the Quality Payment Program. These recommendations were based on the MIPS quality measures finalized in the CY 2017 Quality Payment Program final rule, and include recommendations to add or remove the current MIPS quality measures from the specialty measure sets. The current specialty measure sets can be found on the Quality Payment Program website at https://qpp.cms.gov/measures/quality. All specialty measure sets submitted for consideration were assessed to ensure that they met the needs of the Quality Payment Program.

As a result, we propose to add new quality measures to MIPS (Table A), revise the specialty measure sets in MIPS (Table B), remove specific MIPS quality measures only from specialty sets (Table C.1), and propose to remove specific MIPS quality measures from the MIPS program for the 2018 performance period (Table C.2). The aforementioned measure tables can be found in the Appendix of this proposed rule. In addition, we are proposing to also remove cross cutting measures from most of the specialty sets. Specialty groups and societies

reported that cross cutting measures may or may not be relevant to their practices, contingent on the eligible clinicians or groups. CMS chose to retain the cross cutting measures in Family Practice, Internal Medicine and Pediatrics specialty sets because they are frequently used in these practices. The proposed 2017 cross cutting measures, (81 FR 28447 through 28449), were compiled and placed in a separate table for eligible clinicians to elect to use or not, for reporting. To clarify, the cross-cutting measures are intended to provide clinicians with a list of measures that are broadly applicable to all clinicians regardless of the clinician's specialty. Even though it is not required to report on cross-cutting measures, it is provided as a reference to clinicians who are looking for additional measures to report outside their specialty. We continue to consider cross-cutting measures to be an important part of our quality measure programs, and seek comment on ways to incorporate cross-cutting measures into MIPS in the future. The proposed Table of Cross-Cutting Measures can be found in Table D of the Appendix.

For MIPS quality measures that are undergoing substantive changes, we propose to identify measures including, but not limited to measures that have had measure specification, measure title, and domain changes. MIPS quality measures with proposed substantive changes can be found at Table E of the Appendix.

The measures that would be used for the APM scoring standard and our authority for waiving certain measure requirements are described in section II.C.6.g.(3)(b)(ii) and the measures that would be used to calculate a quality score for the APM scoring standard are proposed in Tables 14, 15, and 16.

We also seek comment for this rule, on whether there are any MIPS quality measures that commenters believe should be classified in a different NQS domain than what is being proposed, or that should be classified as a different measure type (for example, process vs. outcome) than what is being proposed in this rule.

(2) Topped Out Measures

As defined in the CY 2017 Quality Payment Program final rule at (81 FR 77136), a measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Topped out measures could have a disproportionate impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians. We refer readers to section II.C.7.a.(2)(c) of this proposed rule for additional information regarding the scoring of topped out measures.

We noted in the CY 2017 Quality Payment Program final rule that we anticipate removing topped out measures over time and sought comment on what point in time we should remove topped out measures from MIPS (81 FR 77286). We received the following comments.

Many commenters recommended that we retain topped out quality measures for 2 or more years because commenters believed they serve to motivate continued high-quality care; more clinicians may participate in MIPS compared to prior programs such as PQRS, and thus there may be more performance variation in MIPS showing that the measure is not actually topped out; declines in performance will not be captured if a measure is eliminated; it will help provide stability and encourage reporting in the early years of the MIPS program; removing topped out measures could further limit the number of measures available to specialists; and providing eligible clinicians and the public with information about high performance is as important as informing them about deficits.

A few commenters recommended that we publish information about topped out and potentially topped out measures prior to the performance period to allow clinicians time to adjust their reporting strategies, with one commenter noting that improvement may be rewarded in addition to achievement. One commenter recommended pushing back the baseline performance period for the purpose of identifying topped out measures to 2018 because in the transition year

it is unclear how many eligible clinicians will be reporting at different times and for what time period they will report.

Finally, a few commenters recommended that we consider specialty, case mix, and rural location before determining that a measure is topped out, specifically whether there is still room for improvement among certain specialist groups and to ensure that rural provider improvement is recognized. One commenter recommended that we determine topped out measures based on reporting in the Quality Payment Program rather than PQRS or value modifier reporting because the commenter believed using historical performance disadvantages small groups. A few commenters requested that the process for identifying and determining the removal of topped out measures be transparent, evidence-based, patient-centered, and include feedback from all appropriate stakeholders, including the medical community and measures owner. A few commenters specifically recommended that determining whether to remove a topped out measure be part of a rulemaking process while another commenter suggested that we seek out stakeholder input from the Measure Applications Partnership (MAP) on whether a measure should be removed, awarded lower points, or remain with benchmarks as a flat percentage.

We propose 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, we may propose to remove the measure through comment and rulemaking for the 4th year. Therefore, 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 provides a path toward removing topped out measures over time, and will apply to the MIPS quality measures. QCDR measures that consistently are identified as topped out according to the same timeline as proposed below, would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the comment and rulemaking process described below.

We propose to phase in this policy starting with a select set of six highly topped out measures identified in section II.C.7.a.(2)(c) of this proposed rule. In section II.C.7.a.(2)(c) of this proposed rule, we are also proposing 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 the 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 measures identified in section II.C.7.a.(2)(c), is as follows:

- 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 Quality Payment Program website: https://qpp.cms.gov/resources/education.

- Year 2: Measures are identified as topped out in the benchmarks published for the 2018 MIPS performance period. We refer readers to section II.C.7.a.(2)(c) of this proposed rule for additional information regarding the scoring of topped out measures.

- 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.

We seek comment 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 we should remove topped out measures once they reach that point. For example, should we automatically remove topped out measures after they are identified for the proposed number of years or should we review measures identified for removal and consider certain criteria before removing the measure? If so what criteria should be considered? We would like to note that if for some reason a measure benchmark is topped out for only one submission mechanism benchmark, then we would remove that measure from the submission mechanism, but not remove the measure from other submission mechanisms available for submitting that measure.

We also seek comment on whether topped out Summary Survey Measures (SSMs), if topped out, should be considered for removal from the Consumer Assessment of Healthcare Providers and Systems (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 within the CAHPS for MIPS Clinician or Group Survey measure.

In the CY 2017 Quality Payment Program final rule, we state that we do not believe it would be appropriate to remove topped out measures from the CMS Web Interface for the

Quality Payment Program because the CMS Web Interface measures are used in MIPS and in APMs, such as the Shared Savings Program. Removing topped out measures from the CMS Web Interface would not be appropriate because we have aligned policies where possible, with the Shared Savings Program, such as using the Shared Savings Program benchmarks for the CMS Web Interface measures (81 FR 77285). In the CY 2017 Quality Payment Program final rule, we also finalized that MIPS eligible clinicians reporting via the CMS Web Interface must report all measures included in the CMS Web Interface (81 FR 77116). Thus, if a CMS Web Interface measure is topped out, the CMS Web Interface reporter cannot select other measures. We refer readers to section II.C.7.a.(2) of this proposed rule for information on scoring policies with regards to topped out measures from the CMS Web Interface for the Quality Payment Program. We are not proposing to include CMS Web Interface measures in our proposal on removing topped out measures.

(3) Non-Outcome Measures

In the CY 2017 Quality Payment Program final rule, we sought comment on whether we should remove non-outcomes measures for which performance cannot reliably be scored against a benchmark (for example, measures that do not have 20 reporters with 20 cases that meet the data completeness standard) for 3 years in a row (81 FR 77288).

A few commenters recommended that measures that cannot be scored against a benchmark should be removed from the MIPS score. One commenter recommended that non-outcome measures that are unscorable should be given a weight of zero or re-weighted in the performance category. One commenter supported removing non-outcomes measures for which performance cannot reliably be scored against a benchmark for 3 years in a row. One commenter believed it would also be appropriate to remove outcomes measures under a separate more protracted timeline because the commenter believed the reporting of outcome measures is

more difficult and expected to increase at a slower pace, while maintaining outcome measures would encourage the testing and availability of such measures.

Based on the need for CMS to further assess this issue, we are not proposing to remove non-outcome measures in this proposed rule. However, we seek 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. We intend to revisit this issue and make proposals in future rulemaking.

(4) Quality Measures Determined to be Outcome Measures

Under the MIPS, individual MIPS eligible clinicians are generally required to submit at least one outcome measure, or, if no outcome measure is available, one high priority measure. As such, our determinations as to whether a measure is an outcome measure is of importance to stakeholders. We utilize 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, we will utilize 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 this is not clear, we will consider the following step.

- Utilization of the CMS Blueprint definitions for outcome measures: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf . 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.

We also note that patient-reported outcome measures are considered outcome measures, as they measure the health of the patient directly resulting from the health care provided.

Efficiency measures are not considered outcome measures, as they are measuring the cost of care associated with a specific level of care, but we do note that efficiency is considered a high priority measure.

After a MIPS quality measure is established in the program, it is generally only reviewed again if there are significant changes to a measure for the next program year that might warrant a change to the designation of outcome or not. In most cases, these updates are significant enough that they are usually presented as a new measure from the measure owner. New measures to the program will follow the criteria outlined above. QCDR measures however, are reviewed on a yearly basis (during the fall) regardless if there is a significant change or not. We refer readers to section II.C.10.a. for additional information on the QCDR self-nomination and measures review and approval process.

We seek comment on the criteria and process outlined above on how we designate outcome measures. Specifically are there additional criteria we should take into consideration when we determine if a measure meets the criteria of an outcome measure? Should we use different criteria for MIPS measures versus QCDR measures?

d. Cost Performance Category

(1) Background

(a) General Overview

Measuring cost is an integral part of measuring value as part of MIPS. In implementing the cost performance category for the transition year (2017 MIPS performance period/2019 MIPS payment year), we started with measures that had been used in previous programs but noted our intent to move towards episode-based measurement as soon as possible, consistent with the statute and the feedback from the clinician community. Specifically, we adopted 2 measures that had been used in the VM: the total per capita costs for all attributed beneficiaries measure (referred to as the total per capita cost measure) and the MSPB measure (81 FR 77166 through 77168). We also adopted 10 episode-based measures that had previously been included in the Supplemental Quality and Resource Use Reports (sQRURs) (81 FR 77171 through 77174).

At §414.1325(e), we finalized that all measures used under the cost performance category would be derived from Medicare administrative claims data and, thus, participation would not require additional data submission. We finalized a reliability threshold of 0.4 for measures in the cost performance category (81 FR 77170). We also finalized a case minimum of 35 for the MSPB measure (81 FR 77171) and 20 for the total per capita cost measure (81 FR 77170) and each of the 10 episode-based measures (81 FR 77175) in the cost performance category to ensure the reliability threshold is met.

For the transition year, we finalized a policy to weight the cost performance category at zero percent in the final score in order to give clinicians more opportunity to understand the attribution and the scoring methodology and gain more familiarity with the measures through performance feedback (81 FR 77165 through 77166) so that clinicians may be able to act to improve their performance. In the CY 2017 Quality Payment Program final rule, we finalized a

cost performance category weight of 10 percent for the 2020 MIPS payment year (81 FR 77165). For the 2021 MIPS payment year and beyond, the cost performance category will have a weight of 30 percent of the final score as required by section 1848(q)(5)(E)(i)(II)(aa) of the Act.

For descriptions of the statutory basis and our existing policies for the cost performance category, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77162 through 77177).

As finalized at §414.1370(g)(2), the cost performance category is weighted at zero percent for MIPS eligible clinicians scored under the MIPS APM scoring standard because many MIPS APM models incorporate cost measurement in other ways. For more on the APM scoring standard, see II.C.6.E. of this proposed rule.

(2) Weighting in the Final Score

We are proposing at §414.1350(b)(2) to change the weight of the cost performance category from 10 percent to zero percent for the 2020 MIPS payment year. We continue to have concerns about the level of familiarity and understanding of cost measures among clinicians. We will use this additional year in which the score in the cost performance category does not count towards the final score for outreach to increase understanding of the measures so that clinicians will be more comfortable with their role in reducing costs for their patients. In addition, we will use this additional year to develop more episode-based measures, which are cost measures that are focused on a clinical conditions or procedures. We intend to propose in future rulemaking to adopt episode-based measures currently in development.

Although we believe reducing this weight is appropriate given the level of understanding of the measures and the scoring standards, we note that section 1848(q)(5)(E)(i)(II)(aa) of the Act requires the cost performance category be assigned a weight of 30 percent of the MIPS final score beginning in the 2021 MIPS payment year. We recognize that assigning a zero percent weight to the cost performance category for the 2020 MIPS payment year may not provide a

smooth enough transition for integrating cost measures into MIPS and may not provide enough encouragement to clinicians to review their performance on cost measures. This policy could reduce understanding of the measures when we reach the 2021 MIPS payment year and the cost performance category will be used to determine 30 percent of the final score for MIPS eligible clinicians, when in the two previous years it was weighted at zero. Therefore, we also seek comment on keeping the weight of the cost performance category at 10 percent for the 2020 MIPS payment year.

In our discussions with clinicians and clinician societies, clinicians expressed their desire to down-weight the cost performance category to zero percent for an additional year with full knowledge that the cost performance category weight is set at 30 percent under the statute for the 2021 MIPS payment year. The clinicians we spoke with preferred a low weighting and noted that they are actively preparing for cost performance category implementation and would be prepared for the 30 percent statutory weight for the cost performance category for the 2021 MIPS payment year. We intend to continue to provide education to clinicians to help them prepare for the upcoming 30 percent weight.

We invite public comments on this proposal of a zero percent weighting for the cost performance category and the alternative option of 10 percent weighting for the cost performance category for the 2020 MIPS payment year.

(3) Cost Criteria

(a) Measures Proposed for the MIPS Cost Performance Category

(i) Background

Under §414.1350(a), we specify cost measures for a performance period to assess the performance of MIPS eligible clinicians on the cost performance category. For the 2017 MIPS performance period, we will utilize 12 cost measures that are derived from Medicare administrative claims data. Two of these measures, the MSPB measure and total per capita cost

measure, have been used in the VM (81 FR 77166 through 77168), and the remaining 10 are episode-based measures that were included in the sQRURs in 2014 and 2015 (81 FR 77171 through 77174).

Section 1848(r) of the Act specifies a series of steps and activities for the Secretary to undertake to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for cost measurement, including for purposes of MIPS. Section 1848(r)(2) of the Act requires the development of care episode and patient condition groups, and classification codes for such groups, and provides for care episode and patient condition groups to account for a target of an estimated one-half of expenditures under Parts A and B (with this target increasing over time as appropriate). Section 1848(r) of the Act requires us to consider several factors when establishing these groups. For care episode groups, we must consider the patient's clinical problems at the time items and services are furnished during an episode of care, such as clinical conditions or diagnoses, whether inpatient hospitalization occurs, the principal procedures or services furnished, and other factors determined appropriate by the Secretary. For patient condition groups, we must consider the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period), and other factors determined appropriate.

Section 1848(r)(2) of the Act requires us to post on the CMS website a draft list of care episode and patient condition groups and codes for solicitation of input from stakeholders, and subsequently, post on the CMS website an operational list of such groups and codes. In December 2016, we published the Episode-Based Cost Measure Development for the Quality Program (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Episode-Based-Cost-Measure-Development-for-the-Quality-Payment-Program.pdf) and requested input on a draft list of care

episode and patient condition groups and codes as required by section 1848(r)(2)(E) and (F) of the Act. We additionally requested feedback on our overall approach to cost measure development, including several pages of specific questions on the proposed approach for clinicians and stakeholders to provide feedback on. This feedback will be used to modify our cost measure development and ensure that our approach is continually informed by stakeholder feedback. We are currently reviewing the feedback that was recently received on that posting and will share plans to work with clinicians and others on the further developments of these episodes in the future.

We will be posting the operational list of care episode and patient condition groups in December 2017, as required by section 1848(r)(2)(G) of the Act. 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.

(ii) Total Per Capita Cost and MSPB Measures

For the 2018 MIPS performance period and future performance periods, we are proposing 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. We refer readers to the description of these measures in the CY 2017 Quality Payment Program final rule (81 FR 77164 through 77171). We are proposing to include the total per capita cost measure because it is a global measure of all Medicare Part A and Part B costs during the performance period. MIPS eligible clinicians are familiar with the total per capita cost measure because the measure has been used in the VM since the 2015 payment adjustment period and performance feedback has been provided through the annual QRUR since 2013 (for a subset of groups that had 20 or more eligible professionals, based on 2014 performance) and to all groups in the annual QRUR since 2014 (based on 2013 performance) and mid-year QRUR since 2015. We are proposing to use

the MSPB measure because many MIPS eligible clinicians will be familiar with the measure from the VM, where it has been included since the 2016 payment adjustment period and in annual QRUR since 2014 (based on 2013 performance) and the mid-year QRUR since 2015, or its hospital-specified version, which has been a part of the Hospital VBP Program since 2015, based on 2013 performance. In addition to familiarity, these two measures cover a large number of patients and provide an important measurement of clinician contribution to the overall population that a clinician encounters.

We are not proposing any changes to the methodologies for payment standardization, risk adjustment, and specialty adjustment for these measures and refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77164 through 77171) for more information about these methodologies.

We will continue to evaluate cost measures that are included in MIPS on a regular basis and anticipate that measures could be added or removed, subject to rulemaking under applicable law, as measure development continues. We will also maintain the measures that are used in the cost performance category by updating specifications, risk adjustment, and attribution as appropriate. We anticipate including a list of cost measures for a given performance period in annual rulemaking.

We invite public comments on these proposals.

(iii) Episode-Based Measures

Episode-based measures differ from the total per capita cost measure and MSPB measure because their specifications only include services that are related to the episode of care for a clinical condition or procedure (as defined by procedure and diagnosis codes), as opposed to including all services that are provided to a patient over a given period of time. For the 2018 MIPS performance period, we are not proposing to include in the cost performance category the 10 episode-based measures that we adopted for the 2017 MIPS performance period in the CY

2017 Quality Payment Program final rule (81 FR 77171 through 77174). We instead will work to develop new episode-based measures, with significant clinician input, for future performance periods.

We received extensive comments on our proposal to include 41 of these episode-based measures for the 2017 MIPS performance period, which we responded to in the CY 2017 Quality Payment Program final rule (81 FR 77171 through 77174). We also received additional comments after publication of that final rule with comment period about the decision to include 10 episode-based measures for the 2017 MIPS performance period. Although comments were generally in favor of the inclusion of episode-based measures in the future, there was also overwhelming stakeholder interest in more clinician involvement in the development of these episode-based measures as required by section 1848(r)(2) of the Act. Although there was an opportunity for 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 we are currently using to develop episode-based measures. We believe that the new episode-based measures, which we intend to propose in future rulemaking to include in the cost performance category for the 2019 MIPS performance period, will be substantially improved by more extensive stakeholder feedback and involvement in the process.

Thus far, stakeholder feedback has been sought in several ways. First, stakeholder feedback has been sought through various public postings. In October 2015 and April 2016, pursuant to section 1848(r)(2)(B) and (C) of the Act, we gathered input from stakeholders on the episode groups previously developed under section 1848(n)(9)(A) of the Act that has been used to inform the process of constructing the new episode-based cost measures. This feedback emphasized several key aspects of cost measure development such as attribution, risk adjustment, and alignment with quality measurement and patient outcomes. Stakeholders have also emphasized that feedback related to cost measures should be actionable and timely. In

addition, a draft list of care episode and patient condition groups, along with trigger codes, was posted for comment in December 2016 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Episode-Based-Cost-Measure-Development-for-the-Quality-Payment-Program.pdf) as required by section 1848(r)(2)(E) of the Act and comments were accepted as required by section 1848(r)(2)(F) of the Act.

This draft list of care episode and patient condition groups and trigger codes was informed by engagement with clinicians from over 50 clinician specialty societies through a Clinical Committee formed to participate in cost measure development. The Clinical Committee work has provided input from a diverse array of clinicians on identifying conditions and procedures for episode groups. Moving forward, the Clinical Committee will recommend which services or claims would be counted in episode costs. This will ensure that cost measures in development are directly informed by a substantial number of clinicians and members of specialty societies.

In addition, a technical expert panel has met 3 times to provide oversight and guidance for our development of episode-based cost measures. The technical expert panel has offered recommendations for defining an episode group, assigning costs to the group, and attributing episode groups to clinicians. This expert feedback has been built into the current cost measure development process.

As this process continues, we are continuing to seek input from clinicians. Earlier this year, we opened an opportunity to submit the names of clinicians to participate in this process. This process remains open to additional individuals. We believe that episode-based measures will benefit from this comprehensive approach to development. In addition, because it is possible that the new episode-based measures under development could address similar conditions as those in the episode-based measures finalized for the 2017 MIPS performance

period, we believe that it would be better to focus attention on the new episode-based measures, so that clinicians would not receive feedback or scores from two measures for the same patient condition or procedure. Recognizing that under section 1848(q)(5)(E)(i)(II)(aa) of the Act, we must assign a weight of 30 percent to the cost performance category for the 2021 MIPS payment year, we will endeavor to have as many episode-based measures available as possible for the proposed 2019 MIPS performance period.

We plan to include episode-based measures in the cost performance category in future years as they are developed and would propose new measures in future rulemaking.

Although we are not proposing to include any episode-based measures in calculating the cost performance category score for the 2020 MIPS payment year, we do plan to continue to provide confidential performance feedback to clinicians on their performance on episode-based measures developed under the processes required by section 1848(r)(2) of the Act 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 determining the cost performance category score in the future. Because these measures will be generated based on claims data like other cost measures, we will not collect any additional data from clinicians. As we develop new episode-based measures, we believe it is likely that they would cover similar clinical topics to those that are in the previously developed episode-based measures because of our intent to address common clinical conditions with episode-based measures. We aim to provide an initial opportunity for clinicians to review their performance based on the new episode-based measures at some point in the fall of 2017, as the measures are developed and as the information is available. We note that this feedback will be specific to the new episode-based measures that are developed under the process described above and may be presented in a different format than MIPS eligible clinicians' performance feedback as described in section II.C.9.a. of this proposed rule. However, our intention is to align the feedback as much as possible to ensure clinicians

receive opportunities to review their performance on potential new episode-based measures for the cost performance category prior to the proposed 2019 MIPS performance period. We are unable to offer a list of new episode-based measures on which we will provide feedback because that will be determined in our ongoing development work described above. We are concerned that continuing to provide feedback on the older episode-based measures along with feedback on new episode-based measures will be confusing and a poor use of resources. Because we are focusing on development of new episode-based measures, our feedback on episode-based measures that were previously developed will discontinue after 2017 as these measures would no longer be maintained or reflect changes in diagnostic and procedural coding. As described in section II.C.9.a. of this proposed rule, we intend to provide feedback on these new measures as they become available in a new format around summer 2018. We note that the feedback provided in the summer of 2018 will go to those MIPS eligible clinicians for whom we are able to calculate the episode-based measures, which means it would be possible a clinician may not receive feedback on episode-based measures in both the fall of 2017 and the summer of 2018. We believe that receiving feedback on the new episode-based measures, along with the previously-finalized total per capita cost and MSPB measures, will support clinicians in their readiness for the proposed 2019 MIPS performance period.

As previously finalized in the in the CY 2017 Quality Payment Program final rule (81 FR 77173), the episode-based measures that we are not proposing for the 2018 MIPS performance period will be used for determining the cost performance category score for the 2019 MIPS payment year, although the cost performance category score will be weighted at zero percent in that year.

We invite public comments on this proposal.

(iv) Attribution

In the CY 2017 Quality Payment Program final rule, we 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 CY 2017 Physician Fee Schedule final rule, we 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 we added to the list of primary care services beginning with the 2017 performance period. We therefore propose 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.

We are not proposing any changes to the attribution methods for the MSPB measure and refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77168 through 77169) for more information.

We invite public comment on our proposals.

(v) Reliability

In the CY 2017 Quality Payment Program final rule (81 FR 77169 through 77170), we finalized a reliability threshold of 0.4 for measures in the cost performance category. Reliability is an important evaluation for cost measures to ensure that differences in performance are not the result of random variation. Statistically, reliability depends on performance variation for a measure across clinicians ("signal"), the random variation in performance for a measure within a clinician's attributed beneficiaries ("noise"), and the number of beneficiaries attributed to the clinician. High reliability for a measure suggests that comparisons of relative performance among clinicians are likely to be stable over different performance periods and that the

performance of one clinician on the measure can be confidently distinguished from another. As an example of the statistical concept of reliability, a test in which the same individual received very different scores depending on how the included questions are framed would not be reliable. Potential reliability values range from 0.00 to 1.00, where 1.00 (highest possible reliability) signifies that all variation in the measure's rates is the result of variation in differences in performance across clinicians, whereas 0.0 (lowest possible reliability) signifies that all variation could be a result of measurement error. The 0.4 reliability threshold that we adopted for the cost performance category measures in MIPS means that the majority of MIPS eligible clinicians and groups who meet the case minimum required for scoring under a measure have measure reliability scores that exceed 0.4. We generally consider reliability levels between 0.4 and 0.7 to indicate "moderate" reliability and levels above 0.7 to indicate "high" reliability.

We addressed comments we received on the CY 2017 Quality Payment Program proposed rule (81 FR 77169 through 77171), that expressed concern that our 0.4 reliability threshold was too low. Many commenters recommended that cost measures be included only when they could meet the standard of "high" reliability (0.7 or above). Many commenters on the CY 2017 Quality Payment Program final rule made similar comments. Commenters emphasized the importance of reliability; however, we have also seen commenters incorrectly refer to measures as being 40 percent reliable. Reliability is not a percentage but is instead a coefficient so a measure with 0.4 reliability does not reflect that it is only correct for 40 percent of those measured. We encourage a review of our analysis of reliability for the total per capita cost measure (80 FR 71282) and MSPB (81 FR 77169 through 77171).

Reliability is an important evaluation tool for an individual measure, but it is only one element of evaluation. Reliability generally increases as we increase the case size but a high reliability may also reflect low variation. A measure in which all clinicians perform at nearly the same rate would be reliable but not valuable in a program that attempts to recognize and reward

differential performance. A measure in which there is very little variation provides little value in a program like MIPS given the devotion of resources to developing and maintaining that measure over other potential measures. Reliability must also be considered in the context of a measurement system like MIPS which incorporates other elements of measurement. We understand and appreciate the concerns that have been expressed about reliability of measures. Medicine, however, always has a certain amount of variability which may affect the reliability score. We want strong reliability, but not at the expense of losing valuable information about clinicians. We are 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. Therefore, we are not proposing any adjustments to our reliability policies, but we will continue to evaluate reliability as we develop new measures and to ensure that our measures meet an appropriate standard.

(b) Attribution for Individuals and Groups

We are not proposing any changes for how we attribute cost measures to individual and group reporters. We refer readers to the CY 2017 Quality Payment Program final rule for more information (81 FR 77175 through 77176).

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

Both measures proposed for inclusion in the cost performance category for the 2018 MIPS performance period are risk adjusted at the measure level. Although the risk adjustment of the 2 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. We recognize 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 our plans for attempting to address them are discussed in length in section II.C.7.b.(1)(a) of this rule.

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

In section II.C.7.a.(1)(c) of this proposed rule, we discuss our proposal to assess performance on any measures impacted by ICD-10 updates based only on the first 9 months of the 12-month performance period. Because the total per capita cost and MSPB measures include costs from all Medicare Part A and B services, regardless of the specific ICD-10 codes that are used on claims, and do not assign patients based on ICD-10, we do 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, as we continue our plans to expand cost measures to incorporate episode-based measures, ICD-10 changes could become important. Episode-based measures may be opened (triggered) by and may assign services based on ICD-10 codes. Therefore, a change to ICD-10 coding could have a significant effect on an episode-based measure. Changes to ICD-10 codes will be incorporated into the measure specifications on a regular basis through the measure maintenance process.

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

We are not proposing changes to the policy we finalized in the CY 2017 Quality Payment Program final rule (81 FR 77176) that we will attribute cost measures to non-patient facing MIPS eligible clinicians who have sufficient case volume, in accordance with the attribution methodology.

Section 1848(q)(2)(C)(iv) of the Act requires the Secretary to consider the circumstances of professional types who typically furnish services without patient facing interaction (non-patient facing) when determining the application of measures and activities. In addition, this section allows the Secretary to apply alternative measures or activities to non-patient facing MIPS eligible clinicians that fulfill the goals of a performance category. Section 1848(q)(5)(F)

of the Act allows the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician involved.

We believe that non-patient facing clinicians are an integral part of the care team and that their services do contributed to the overall costs but at this time we believe it better to focus on the development of a comprehensive system of episode-based measures which focus on the role of patient-facing clinicians. Accordingly, for the 2018 MIPS performance period, we are not proposing alternative cost measures for non-patient facing MIPS eligible clinicians or groups. This means that non-patient facing MIPS eligible clinicians or groups are unlikely to be attributed any cost measures that are generally attributed to clinicians who have patient-facing encounters with patients. Therefore, we anticipate that, similar to MIPS eligible clinicians or groups that do not meet the required case minimums for any cost measures, 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. We continue to consider opportunities to develop alternative cost measures for non-patient facing clinicians and solicit comment on this topic to inform our future rulemaking.

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

In section II.C.7.a.(4) of this proposed rule, we discuss our proposal to implement section 1848(q)(2)(C)(ii) of the Act by assessing clinicians who meet certain requirements and elect participation based on the performance of their associated hospital in the Hospital VBP Program. We refer readers to that section for full details on our proposals related to facility-based measurement, including the measures and how the measures are scored, for the cost performance category.

e. Improvement Activity Criteria

(1) Background

Section 1848(q)(2)(C)(v)(III) of the Act defines an improvement activity as an activity that relevant eligible clinician 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. Section 1848(q)(2)(B)(iii) of the Act requires the Secretary to specify improvement activities under subcategories for the performance period, which must include at least the subcategories specified in section 1848(q)(2)(B)(iii)(I) through (VI) of the Act, and in doing so to give consideration to the circumstances of small practices, and practices located in rural areas and geographic health professional shortage areas (HPSAs).

Section 1848(q)(2)(C)(iv) of the Act generally requires the Secretary to give consideration to the circumstances of non-patient facing individual MIPS eligible clinicians or groups and allows the Secretary, to the extent feasible and appropriate, to apply alternative measures and activities to such individual MIPS eligible clinicians and groups.

Section 1848(q)(2)(C)(v) of the Act required the Secretary to use a request for information (RFI) to solicit recommendations from stakeholders to identify improvement activities and specify criteria for such improvement activities, and provides that the Secretary may contract with entities to assist in identifying activities, specifying criteria for the activities, and determining whether individual MIPS eligible clinicians or groups meet the criteria set. For a detailed discussion of the feedback received from the MIPS and APMs RFI, see the CY 2017 Quality Payment Program 2017 final rule (81 FR 77177).

We 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.

In the CY 2017 Quality Payment Program final rule (81 FR 77199), we solicited comments on activities that would advance the usage of health IT to support improvement activities. We received several comments in support of the concept to include emerging certified health IT capabilities as part of the activities in the Improvement Activities Inventory and several commenters supported our assessment that using CEHRT can aid in improving clinical practices and help healthcare organizations achieve success on numerous improvement activities, as well as the continued integration of improvement activities and advancing clinical information. However, several commenters expressed concern about health IT-associated burdens and costs and recommended that we also continue to offer diverse activities that do not rely on emerging capabilities of certified health IT, as they are not universally available or may only be offered as high cost add-on capabilities. Some commenters also requested that we be less prescriptive in our requirements for the use of health IT.

In response to the comments, we will continue to focus on incentivizing the use of health IT, telehealth, and connection of patients to community-based services. The use of health IT is an important aspect of care delivery processes described in many of the proposed new improvement activities in Table F in the Appendix of this proposed rule, and in Table H: Finalized Improvement Activities Inventory that we finalized in the CY 2017 Quality Payment Program final rule (81 FR 77817 through 77831). In that same final rule, we also finalized a policy to allow MIPS eligible clinicians to achieve a bonus in the advancing care information performance category when they use functions included in CEHRT to complete eligible activities from the Improvement Activities Inventory. Please refer to section II.C.6.f.(2)(d) of this proposed rule for details on how improvement activities using CEHRT relate to the objectives and measures of the advancing care information and improvement activities performance categories. We are not proposing any changes to these policies for incentivizing the use of health IT in this proposed rule; however, we will continue to consider including emerging

certified health IT capabilities as part of activities within the Improvement Activities Inventory in future years.

In addition, as noted previously, we believe a key goal of the Quality Payment Program is to establish a program that allows for close alignment of the four performance categories. Although we are not proposing any specific new policies, we seek comment on how we might provide flexibility for MIPS eligible clinicians to effectively demonstrate improvement through health IT usage while also measuring such improvement. We welcome public comment on these considerations.

(2) Contribution to the Final Score

In the CY 2017 Quality Payment Program final rule (81 FR 77179 through 77180), we finalized at §414.1355 that the improvement activities performance category would account for 15 percent of the final score. We also finalized at §414.1380(b)(3)(iv) criteria for recognition as a certified-patient centered medical home or comparable specialty practice. We are proposing to clarify the term "certified" patient-centered medical home finalized at §414.1380(b)(3)(iv). It has come to our attention that the common terminology utilized in the general medical community for "certified" patient-centered medical home is "recognized" patient-centered medical home. Therefore, in order to provide clarity we are proposing that the term "recognized" be accepted as equivalent to the term "certified" when referring to the requirements for a patient-centered medical home to receive full credit for the improvement activities performance category for MIPS. Specifically, we propose to revise §414.1380(b)(3)(iv) to provide that a MIPS eligible clinician or group in a practice that is certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, receives full credit for performance on the improvement activities performance category. For purposes of §414.1380 (b)(3)(iv), "full credit" means that the MIPS eligible clinician or group has met the highest potential category score of 40 points. A practice is certified or recognized as

a patient-centered medical home if it meets any of the criteria specified under §414.1380(b)(3)(iv).

In the CY 2017 Quality Payment Program final rule (81 FR 77198), we requested commenters' specific suggestions for additional activities or activities that may merit additional points beyond the "high" level. Several commenters urged us to increase the overall number of high-weighted activities in this performance category. Some commenters recommended additional criteria for designating high-weighted activities, such as an improvement activity's impact on population health, medication adherence, and shared decision-making tools, and encouraged us to be more transparent in our weighting decisions. Several commenters recommended that we weight registry-related activities as high, and suggested that we award individual MIPS eligible clinicians and groups in APMs full credit in this performance category. The commenters also offered many recommendations for changing current medium-weighted activities to high and offered many specific suggestions for new high-weighted improvement activities.

In response to the comments, we are proposing new, high-weighted activities in Table F in the Appendix of this proposed rule. As explained in the CY 2017 Quality Payment Program final rule (81 FR 77194), we 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. We are not proposing changes to this approach in this proposed rule; however, we will take these suggested additional criteria into consideration for designating high-weighted activities in future rulemaking. For MIPS eligible clinicians participating in MIPS APMs, we finalized a policy to reduce reporting burden through the APM scoring standard for this category to recognize improvement activities work performed through participation in MIPS APMs. This policy is codified at §414.1370(g)(3), and we refer readers to the CY 2017 Quality Payment

Program final rule for further details on reporting and scoring this category under the APM Scoring Standard (81 FR 77259 through 77260).

(3) Improvement Activities Data Submission Criteria

(a) Submission Mechanisms

In the CY 2017 Quality Payment Program final rule (81 FR 77180), we discussed that for the transition year of MIPS we would allow 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. Specifically, we finalized a policy that 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. In addition, we 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. We would like to maintain stability in the Quality Payment Program and continue this policy into future years. Therefore, we are proposing at §414.1360 that for purposes of the transition year of MIPS and future years 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 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. In addition, as discussed in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups.

We would like to note that while we finalized at §414.1325(d) in the CY 2017 Quality Payment Program final rule that individual MIPS eligible clinicians and groups may only use one submission mechanism per performance category, in section II.C.6.a.(1) of this proposed rule, we are proposing 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 advancing care information performance categories. We refer readers to section II.C.6.a.(1) of this proposed rule for further discussion of this proposal.

We also included a designation column in the Improvement Activities Inventory at Table H in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77817) that indicated which activities qualified for the advancing care information bonus finalized at §414.1380. In future updates to the Improvement Activities Inventory we intend to continue to indicate which activities qualify for the advancing care information performance category bonus.

In the CY 2017 Quality Payment Program final rule (81 FR 77181), we 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, we 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 in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups. We are not proposing any changes to this policy in this

proposed rule. However, we are requesting comment on whether we should establish a minimum threshold (for example, 50 percent) 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, we are requesting comments on recommended minimum threshold percentages and whether we should establish different thresholds based on the size of the group. For example, in considering different thresholds we could attribute recognition as a certified or recognized patient-centered medical home or comparable specialty practice at the individual TIN/NPI level, and attribute this designation to the group under which they bill if they are participating in MIPS as a group or as part of a virtual group. A group or virtual group consisting of 100 NPIs could have a reporting threshold of 50 percent while a group consisting of 10 NPIs could have a lower reporting threshold of 10 percent. We are concerned that while establishing any specific threshold for the percentage of NPIs in a TIN that must participate in an improvement activity for credit will incentivize some groups to move closer to the threshold, it may have the unintended consequence of incentivizing groups who are exceeding the threshold to gravitate back toward the threshold. Therefore, we are requesting comments on how to set this threshold while maintaining the goal of promoting greater participation in an improvement activity.

Additionally, we noted in the CY 2017 Quality Payment Program final rule (81 FR 77197) that we intended, in future years, to score the improvement activities performance category based on performance and improvement, rather than simple attestation. We seek comment on how we could measure performance and improvement; we are 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.

(b) Submission Criteria

In the CY 2017 Quality Payment Program final rule (81 FR 77185), we 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 in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups.

We 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. To develop the improvement activities score assigned to each MIPS APM, we compare the requirements of the specific MIPS APM with the list of activities in the Improvement Activities Inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians. If by our assessment 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 we identify as participating in APMs that are not MIPS APMs will need to select additional improvement activities to achieve the improvement activities highest score. We refer readers to section II.C.6.g. of this proposed rule for further discussion of the APM scoring standard.

We also provided full credit for the improvement activities performance category, as required by law, 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.

We also noted in the CY 2017 Quality Payment Program final rule that practices may receive this designation at a practice level and that TINs may be comprised of both undesignated practices and designated practices (81 FR 77178). We 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. We also indicated that we would continue to have more stringent requirements in future years, and would lay the groundwork for expansion towards continuous improvement over time (81 FR 77189). We received many comments on the CY 2017 Quality Payment Program final rule regarding our transition year policy that only one practice site within a TIN needs to be certified as a patient-centered medical home for the entire TIN to receive full credit in the improvement activities performance category. While several commenters supported our transition year policy, others disagreed and suggested to move to a more stringent requirement in future years while still offering some flexibility. Accordingly, we propose 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 percent of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice. This is an increase to the requirement that only one practice site within a TIN needs to be certified as a patient-centered medical home, but does not require every site be certified, which could be overly restrictive given that some sites within a TIN may be in the process of being certified as patient-centered medical homes. In addition, we believe a 50 percent threshold is achievable which is supported by a study of physician-owned primary care groups in a recent Annals of Family Medicine article (Casalino, et al., 2016) http://www.annfammed.org/content/14/1/16.full. For nearly all groups in this study (sampled with variation in size and geographic area) at least 50 percent of the practice sites within the group had a medical home designation. If the group is unable to meet the 50 percent 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 in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups. Further, we welcome 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.

We have 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. The CPC+ model meets the criteria to be an Advanced APM. CPC+ eligibility criteria for practices include, but are not limited to, the use of CEHRT and care delivery activities such as: assigning patients to clinician panels; providing

24/7 clinician access; and supporting quality improvement activities. Control groups in CPC+ are required to meet the same eligibility criteria as those selected to be active participants in the model. For Round 2 of CPC+, CMS is randomly assigning accepted practices into the intervention group or a control group. Practices accepted into CPC+ and randomized into the control group have satisfied the requirements for participation in CPC+, a medical home model, and we believe that the MIPS eligible clinicians in the control group should therefore receive full credit for the improvement activities performance category. In addition, the practices randomized to the CPC+ control group must sign a Participation Agreement with us; the agreement will require practices in a control group to maintain a Practitioner Roster of all MIPS eligible clinicians in the practice.

Accordingly, we are proposing 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. The inclusion of MIPS eligible clinicians in practices that have been randomized into the CPC+ control group recognizes that they have met the requirements to receive full credit for performance in the improvement activities performance category as a medical home model, and will help ensure more equitable treatment of the CPC+ control group by allowing clinicians in the control group that have met the criteria for participation in the CPC+ APM to receive the same recognition as those actively participating in the CPC+ intervention group.

We request comments on these proposals.

(c) Required Period of Time for Performing an Activity

In the CY 2017 Quality Payment Program final rule (81 FR 77186), we 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 in section II.C.4.d. of this proposed rule, we are proposing to generally apply our previously finalized and proposed group policies to virtual groups. We are not proposing any changes to the required period of time for performing an activity for the improvement activities performance category in this proposed rule.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77187), we 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. We are not proposing 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.

(5) Special Consideration for Small, Rural, or Health Professional Shortage Areas Practices

In the CY 2017 Quality Payment Program final rule (81 FR 77188), we 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, we 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, we 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. We are not proposing 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.

(6) Improvement Activities Subcategories

In the CY 2017 Quality Payment Program final rule (81 FR 77190), we 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, we finalized at §414.1365 the following additional subcategories: Achieving Health Equity; Integrated Behavioral and Mental Health; and Emergency Preparedness and Response. We are not proposing any changes to the improvement activities subcategories for the improvement activities performance category in this proposed rule.

(7) Improvement Activities Inventory

(a) Proposed Approach on the Annual Call for Activities Process for Adding New Activities

In Table H in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77817), we finalized the Improvement Activities Inventory for MIPS. In addition, through subregulatory guidance we provided an informal process for submitting new improvement activities for potential inclusion in the comprehensive Improvement Activities Inventory for the Quality Payment Program Year 2. During this transition period we received input from various MIPS eligible clinicians and organizations suggesting possible new activities via a nomination form that was posted on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-

Patient-Assessment-Instruments/MMS/CallForMeasures.html. We are proposing new activities and changes to the Improvement Activities Inventory in Tables F and G of the Appendix of this proposed rule.

For the Quality Payment Program Year 3 and future years, we are proposing to formalize an Annual Call for Activities process for adding possible new activities to the Improvement Activities Inventory. We believe this is a way to engage eligible clinician organizations and other relevant stakeholders, including beneficiaries, in the identification and submission of improvement activities for consideration. We propose 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 Quality Payment Program website at www.qpp.cms.gov. As part of the process, individual MIPS eligible clinicians, groups, and other relevant stakeholders would be able to nominate additional improvement activities that we may consider adding to the Improvement Activities Inventory. 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 the criteria we have identified in section II.C.6.e.(7)(b) of this proposed rule. The 2018 proposed new improvement activities and the 2018 proposed improvement activities with changes can be found in Tables F and G of the Appendix of this proposed rule and will be available on the CMS website.

We request comments on this proposed annual Call for Activities process.

(b) Criteria for Nominating New Improvement Activities for the Annual Call for Activities

We propose for the Quality Payment Program 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 advancing care information bonus;
- Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care);
- Feasible to implement, recognizing importance in minimizing burden, 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.

We note that in future rulemaking, activities that overlap with other performance categories may be included if such activities support the key goals of the program.

We request comments on this proposal.

(c) Submission Timeline for Nominating New Improvement Activities for the Annual Call for Activities

It is our intention that the nomination and acceptance process will, to the best extent possible, parallel the Annual Call for Measures process already conducted for MIPS quality measures. Aligned with this approach, we propose 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 us 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, we propose 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. This proposal is slightly different than the Call for Measures timeline. The Annual Call for Measures requires a 2-year implementation timeline because the measures being considered for inclusion in MIPS undergo the pre-rulemaking process with review by the Measures Application Partnership (MAP). We are not proposing that improvement activities undergo MAP review. Therefore, our intention is to close the Annual Call for Activities submissions by March 1 before the applicable performance period, which will enable us to propose the new improvement activities for adoption in the same year's rulemaking cycle for implementation in the following year. For example, an improvement activity submitted prior to March 1, 2018, would be considered for performance periods occurring in 2019. In addition, we propose that we will add new improvement activities to the inventory through notice-and-comment rulemaking. In future years we anticipate developing a process and establishing criteria for identifying activities for removal from the Improvement Activities Inventory through the Annual Call for Activities process. We are requesting comments on what criteria should be used to identify improvement activities for removal from the Improvement Activities Inventory.

(8) Approach for Adding New Subcategories

In the CY 2017 Quality Payment Program final rule (81 FR 77197), we 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.

We are not proposing any changes to the approach for adding new subcategories for the improvement activities performance category in this proposed rule. However, we are proposing that in future years of the Quality Payment Program we will add new improvement activities subcategories through notice-and-comment rulemaking. In addition, we are seeking comments on new improvement activities subcategories.

A number of 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. Such a health IT subcategory could include only improvement activities that are specifically related to the advancing care information performance category measures and allow MIPS eligible clinicians to earn credit in the improvement activities performance category, while receiving a bonus in the advancing care information performance category as well. We are seeking 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 advancing care information performance category be enhanced? Are there additional policies that should be explored in future rulemaking? We welcome public comment on this potential health IT subcategory.

(9) CMS Study on Burdens Associated with Reporting Quality Measures

In the CY 2017 Quality Payment Program final rule (81 FR 77195), we finalized specifics regarding the CMS Study on Improvement Activities and Measurement including the study purpose, study participation credit and requirements, and the study procedure. We are modifying the name of the study in this proposed rule to the "CMS study on burdens associated with reporting quality measures" to more accurately reflect the purpose of the study. The study assesses clinician burden and data submission errors associated with the collection and submission of clinician quality measures for MIPS, enrolling groups of different sizes and individuals in both rural and non-rural settings and also different specialties. We also noted that study participants would receive full credit in the improvement activities performance category after successfully electing, participating, and submitting data to the study coordinators at CMS for the full calendar year (81 FR 77196). We requested comment on the study, and received generally supportive feedback for the study.

We are not proposing any changes to the study purpose. We are proposing 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. In addition to performing descriptive statistics to compare the trends in errors and burden between study years 2017 and 2018, we would like to perform a more rigorous statistical analysis with the 2018 data, which will require a larger sample size. We propose 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, we are 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.

We are proposing 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, we are proposing changes to the study procedures. In the transition year of MIPS, study participants were required to attend a monthly focus group to share lessons learned in submitting quality data along with providing survey feedback to monitor effectiveness. However, an individual MIPS eligible clinician or group who chooses to report all 6 measures within a period of 90 days may not need to be a part of all of the focus groups and survey sessions after their first focus group and survey following the measurement data submission. This is because they may have nothing new to contribute in terms of discussion of errors or clinician burdens. This also applies to MIPS eligible clinicians that submit only three MIPS measures within the performance period, if they submitted all three measures within the 90-day period or at one submission. 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, we would make further engagement optional. Therefore, we are proposing that for Quality Payment Program 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.

Further, the CY 2017 study requires study measurement data to be collected at baseline and at every 3 months (quarterly basis) afterwards for the duration of the calendar year. It also

calls for a minimum requirement of three MIPS quality measures four times within the year. We believe this is inconsistent with clinicians reporting a full year's data as we believe some study participants may choose to submit data for all measures at one time, or alternatively, may choose to submit data up to six times during the 1-year period. We are proposing for the Quality Payment Program 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.

It must be noted that although the aforementioned activities constitute an information collection request as defined in the implementing regulations of the Paperwork Reduction Act of 1995 (5 CFR 1320), the associated burden is exempt from application of the Paperwork Reduction Act. Specifically, section 1848(s)(7) of the Act, as added by section 102 of the MACRA (Pub. L. 114-10) states that Chapter 35 of title 44, United States Code, shall not apply to the collection of information for the development of quality measures. Our goals for new measures are to develop new high quality, low cost measures that are meaningful, easily understandable and operable, and also, reliably and validly measure what they purport. This study shall inform us (and our contractors) on the root causes of clinicians' performance measure data collection and data submission burdens and challenges that hinders accurate and timely quality measurement activities. In addition, this study will inform us on the characteristic attributes that our new measures must possess to be able to accurately capture and measure the priorities and gaps MACRA aims for, as described in the Quality Measures Development Plan.[2] This study, therefore, serves as the initial stage of developing new measures and also adapting existing measures. We believe that understanding clinician's challenges and skepticisms, and especially, understanding the factors that undermine the optimal functioning and effectiveness of

[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf (assessed: 06/02/2017)

quality measures are requisites of developing measures that are not only measuring what it purports but also that are user friendly and understandable for frontline clinicians – our main stakeholders in measure development. This will lead to the creation of practice-derived, tested measures that reduces burden and create a culture of continuous improvement in measure development.

We request comments on our 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.

f. Advancing Care Information Performance Category

(1) Background

Section 1848(q)(2)(A) of the Act includes the meaningful use of CEHRT as a performance category under the MIPS. We refer to this performance category as the advancing care information performance category, and it is reported by MIPS eligible clinicians as part of the overall MIPS program. As required by sections 1848(q)(2) and (5) of the Act, the four performance categories of the MIPS shall be used in determining the MIPS final score for each MIPS eligible clinician. In general, MIPS eligible clinicians will be evaluated under all four of the MIPS performance categories, including the advancing care information performance category.

(2) Scoring

Section 1848(q)(5)(E)(i)(IV) of the Act states that 25 percent of the MIPS final score shall be based on performance for the advancing care information performance category. We established at §414.1380(b)(4) that the score for the advancing care information performance category would be comprised of a base score, performance score, and potential bonus points for reporting on certain measures and activities. For further explanation of our scoring policies for the advancing care information performance category, we refer readers to 81 FR 77216-77227.

(a) Base Score

For the CY 2018 performance period, we are not proposing any changes to the base score methodology as established in the CY 2017 Quality Payment Program final rule (81 FR 77217-77223). We established the policy that MIPS eligible clinicians must report a numerator of at least one for the numerator/denominator measures, or a "yes" response for the yes/no measure in order to earn the 50 percentage points in the base score. In addition, if the base score requirements are not met, a MIPS eligible clinician would receive a score of zero for the ACI performance category.

(b) Performance Score

In the CY 2017 Quality Payment Program final rule (81 FR 77223 through 77226), we finalized that MIPS eligible clinicians can earn 10 percentage points in the performance score for meeting the Immunization Registry Reporting Measure. We believe we should modify this policy because we have learned that there are areas of the country where immunization registries are not available, and we did not intend to disadvantage MIPS eligible clinicians practicing in those areas. Thus, we are proposing to modify the scoring of the Public Health and Clinical Data Registry Reporting objective beginning with the performance period in CY 2018. We propose 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, we are proposing 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. 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.

We further propose similar flexibility for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. (In section II.C.6.f.(6)(b) of this proposed rule, we are proposing to allow MIPS eligible clinicians to report using the 2018 Advancing Care Information Transition Objectives and Measures in 2018.) We propose 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, we are proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or specialized registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Specialized Registry Reporting. A MIPS eligible clinician who chooses to report to more than one specialized registry or public health agency to submit syndromic surveillance data may earn 5 percentage points in the performance score for reporting to each one, up to a maximum of 10 percentage points.

By proposing to expand the options for fulfilling the Public Health and Clinical Data Registry Reporting and the Public Health Reporting objectives, we believe that we are adding flexibility so that additional MIPS eligible clinicians can successfully fulfill this objective and earn 10 percentage points in the performance score. We are not proposing to change the maximum performance score that a MIPS eligible clinician can earn; it remains at 90 percent.

We are inviting public comment on these proposals.

(c) Bonus Score

In the CY 2017 Quality Payment Program final rule (81 FR 77220 through 77226), for the Public Health and Clinical Data Registry Reporting objective and the Public Health Reporting objective, we 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 advancing care information performance category. (In section II.C.6.f.(6)(b) of this proposed rule, we are proposing to allow MIPS eligible clinicians to report using the 2018 Advancing Care Information Transition Objectives and Measures in 2018.) Based on our proposals above to allow MIPS eligible clinicians who cannot fulfill the Immunization Registry Reporting Measure to earn additional points in the

performance score, we believe we should modify this policy so that MIPS eligible clinicians cannot earn points in both the performance score and bonus score for reporting to the same public health agency or clinical data registry. We are proposing to modify our policy beginning with the performance period in CY 2018. We are proposing 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. For example, if a MIPS eligible clinician reports to a public health agency and a clinical data registry for the performance score, they could earn the bonus score of 5 percentage points by reporting to a different agency or registry that the clinician did not identify for purposes of the performance score. A MIPS eligible clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry.

We are proposing that for the Advancing Care Information 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. We are proposing that for the 2018 Advancing Care Information Transition Objectives and Measures, a bonus of 5 percent would be awarded if the MIPS eligible clinician reports "yes" for any one of the following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting or Specialized Registry Reporting. We are proposing 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.

We are inviting public comment on this proposal.

(d) Improvement Activities Bonus Score under the Advancing Care Information Performance Category

In the CY 2017 Quality Payment Program final rule (81 FR 77202), we discussed our approach to the measurement of the use of health IT to allow MIPS eligible clinicians and groups the flexibility to implement health IT in a way that supports their clinical needs. In addition, we discussed the need to move toward measurement of health IT use with respect to its contribution to effective care coordination and improving outcomes for patients. We stated that this approach would allow us to more directly link health IT adoption and use to patient outcomes, moving MIPS beyond the measurement of EHR adoption and process measurement and into a more patient-focused health IT program. Toward that end, we adopted a policy to award a bonus score to MIPS eligible clinicians who use CEHRT to complete certain activities in the improvement activities performance category based on our belief that the use of CEHRT in carrying out these activities could further the outcomes of clinical practice improvement.

We adopted a final policy to award a 10 percent bonus for the advancing care information performance category if a MIPS eligible clinician attests to completing at least one of the improvement activities we have specified using CEHRT (81 FR 77209). We refer readers to Table 8 in the CY 2017 Quality Payment Program final rule (81 FR 77202-77209) for a list of the improvement activities eligible for the advancing care information performance category bonus. In this proposed rule, we are proposing to expand this policy beginning with the CY 2018 performance period by identifying additional improvement activities in Table 6 that would be eligible for the advancing care information 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 last year's final rule. We refer readers to the Improvement Activities section of this proposed rule (section II.C.6.e. of this proposed

rule) for a discussion of the proposed new improvement activities and proposed changes to the improvement activities for 2018.

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 we have identified as eligible for the bonus. This bonus is intended to support progression toward holistic health IT use and measurement; attesting to even one improvement activity demonstrates that the MIPS eligible clinician is working toward this holistic approach to the use of their CEHRT. The weight of the improvement activity for the improvement activities performance category has no effect on the bonus awarded in the advancing care information performance category.

We invite comment on this proposal

TABLE 6: Proposed New Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus Beginning with the 2018 Performance Period

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician transmits information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	Medium	Secure Messaging Send A Summary of Care Request/Accept Summary of Care
Patient Safety and Practice Assessment	Consulting AUC using clinical decision support when ordering advanced diagnostic imaging	A MIPS eligible clinician would attest that they are consulting specified applicable appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. This activity is for clinicians that are early adopters of the Medicare AUC program (e.g., 2018 performance year) and for clinicians that begin the program in future years as will be required by CFR §414.94 (authorized by the Protecting Access to Medicare Act of 2014). Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.	High	Clinical Decision Support (CEHRT function only)
Population Management	Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 75 percent of medical records with documentation of screening patients for abnormal blood glucose according to current U.S. Preventive Services Task Force (USPSTF) and/or Americans Diabetes Association (ADA) guidelines.	Medium	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings
Population Management	Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 75 percent of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	Medium	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.	Medium	Provide Patient Access Patient-Specific Education Patient-Generated Health Data
Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	Medium	Patient-Generated Health Data Patient Specific Education
Achieving Health Equity	Promote use of patient-reported outcome tools	Promote use of patient-reported outcome tools Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments) such as patient reported Wound Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	High	Public Health Registry Reporting Clinical Data Registry Reporting Patient-Generated Health Data
Care Coordination	Practice Improvements that Engage Community Resources to Support Patient Health Goals	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; • Including through the use of tools that facilitate electronic communication between settings; • Screen patients for health-harming legal needs; and/or Provide a guide to available community resources.	Medium	Send a Summary of Care Request/Accept Summary of Care Patient-Generated Health Data

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	Send a Summary of Care Request/Accept Summary of Care
Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.	Medium	Send a Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Health Information Exchange

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)*
Beneficiary Engagement	Engage Patients and Families to Guide Improvement in the System of Care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient. Includes patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.	High	Patient-Generated Health Data Provide Patient Access View, Download, or Transmit

(3) Performance Periods for the Advancing Care Information Performance Category

In the CY 2017 Quality Payment Program final rule (81 FR 77210 through 77211), we established a performance period for the advancing care information 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. We believe this will lower reporting burden, focus clinician quality improvement efforts and align administrative actions so that MIPS eligible clinicians can use common systems and reporting pathways. We

stated for the first and second performance periods of MIPS (CYs 2017 and 2018), we will accept a minimum of 90 consecutive days of data and encourage MIPS eligible clinicians to report data for the full year performance period. We are maintaining this policy as finalized for the performance period in CY 2018, and will accept a minimum of 90 consecutive days of data in CY 2018. We are proposing the same policy for the advancing care information performance category for the performance period in CY 2019, Quality Payment Program Year 3, and would accept a minimum of 90 consecutive days of data in CY 2019. We refer readers to section II.C.5. in this proposed rule for additional information on the MIPS performance period.

(4) Certification Requirements

In the CY 2017 Quality Payment Program final rule (81 FR 77211 through 77213), we outlined the requirements for MIPS eligible clinicians using CEHRT during the CY 2017 performance period for the advancing care information performance category as it relates to the objectives and measures they select to report, and also outlined requirements for the CY 2018 performance period. We additionally adopted a definition of CEHRT at §414.1305 for MIPS eligible clinicians that is based on the definition that applies in the EHR Incentive Programs under §495.4.

For the CY 2017 performance period, we adopted a policy by which 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 CY 2018 performance period, we previously stated that MIPS eligible clinicians must use EHR technology certified to the 2015 Edition to meet the objectives and measures specified for the advancing care information performance category.

We received significant comments and feedback from stakeholders requesting that we extend the use of 2014 Edition CEHRT beyond CY 2017 into CY 2018 and even CY 2019. Many commenters noted the lack of products certified to the 2015 Edition. Others stated that switching from the 2014 Edition to the 2015 Edition requires a large amount of time and

planning and if it is rushed there is a potential risk to patient health. Some commenters noted the significant burden of combining outputs from multiple CEHRTs. A few mentioned that the cost to switch to the 2015 Edition is prohibitive for smaller practices.

Our experience with the transition from EHR technology certified to the 2011 Edition to EHR technology certified to the 2014 Edition did make us aware of the many issues associated with the adoption of EHR technology certified to a new Edition. These include the time that will be necessary to effectively deploy EHR technology certified to the 2015 Edition standards and certification criteria and to make the necessary patient safety, staff training, and workflow investments to be prepared to report for the advancing care information performance category for 2018. We understand and appreciate these concerns, and are working in collaboration with our federal partners at the Office of the National Coordinator for Health Information Technology (ONC) to monitor progress on the 2015 Edition upgrade.

As noted in the FY 2018 Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System proposed rule (referred to as the FY 2018 IPPS/LTCH PPS proposed rule) (82 FR 20136), ONC is working with health IT developers to analyze and monitor the status of developer readiness for 2015 Edition technology. As part of these analyses, ONC also reviewed health IT being certified to 2015 Edition by health IT developers who have products that were certified for the 2014 Edition and were used by EHR Incentive Program participants to attest. This analysis compared the pace of 2014 Edition certification with the pace of 2015 Edition certification to date. As of the beginning of the second quarter of CY 2017, ONC confirmed that at least 53 percent of eligible clinicians and 80 percent of eligible hospitals have 2015 Edition certified EHR technology available based on previous EHR Incentive Programs attestation data. Based on these data, and as compared to the transition from 2011 Edition to 2014 Edition, it appears that the transition from the 2014 Edition to the 2015 Edition is on schedule for the CY 2018 performance period.

However, the analysis also considered market trends such as consolidation and the number of large and small developers covering various groups of participants and the potential impact on readiness. The eligible hospital market is fairly concentrated, with nearly 98 percent of eligible hospital EHR Incentive Program participants using health IT from the top ten developers (ranked by market share) with a significant majority of that coverage by the top five developers. For hospitals, some developers representing a smaller market share also have certified health IT already available and are not expected to have a release schedule much different from their larger competitors. Considering market factors and using previous EHR Incentive Programs attestation data, ONC estimates that at least 85 percent of eligible hospitals would have EHR technology certified to the 2015 Edition available for use by the end of CY 2017 for program participation in 2018. In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20136), we proposed to shorten the EHR reporting period to a minimum of any continuous 90-day period within CY 2018 for eligible hospitals and CAHs, as well as EPs who attest for a state's Medicaid EHR Incentive Program, to allow additional time for successful implementation of EHR technology certified to the 2015 Edition in CY 2018.

For MIPS eligible clinicians, the concern of potential impact on participation readiness when reviewing these market factors may be more significant. As noted in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20136), historical data indicates eligible professionals were more likely to use a wider range of certified health IT, including those which individually make up a smaller segment of the overall market. Therefore, when market factors are taken into account, there exists a larger proportion of readiness that is unknown due to the wider range of certified health IT which may be used by MIPS eligible clinicians. This necessitated a more conservative approach for MIPS eligible clinician readiness. That estimate is that 74 percent of MIPS eligible clinicians will be ready to participate in MIPS using 2015 Edition certified EHR technologies by January 1, 2018.

However, subsequent to the preliminary analysis, ONC has continued to monitor readiness and to receive feedback from stakeholders on factors influencing variations in the development and implementation timelines for developers supporting different segments of the market, as well as the relationship between the developer readiness timeline and participant readiness. This continuing analysis supports a potential need for a longer implementation timeline for MIPS eligible clinicians. Stakeholder feedback suggests that while the estimate for known readiness remains the same, readiness among the remaining MIPS eligible clinicians may not be on the same timeline. About one quarter of eligible professional EHR Incentive Program participants in prior years used certified health IT from small developers that each has an historical market share of 1 percent or less. Therefore, MIPS eligible clinicians will need a significant number of smaller developers to reach the same readiness on the same timeline as larger companies in order to support program participants seeking to upgrade to the 2015 Edition. However, small developers generally offer a limited number or type of products, and may have more limited resources to dedicate to upgrade development, testing and certification, and implementation, which may affect availability and timing. In addition, the same factors may impact the capacity of some developers to support participants during the process and therefore the timeline for participant readiness would also potentially be longer. This is supported by historical analysis as a smaller percentage of eligible professionals used 2014 Edition certified EHR technology for participation in the EHR Incentive Programs during the 2014 calendar year than eligible hospitals and CAHs for the same year. For this reason, we believe additional flexibility for MIPS eligible clinicians is essential to support successful participation in the advancing care information performance category.

We continue to believe that there are many benefits for switching to EHR technology certified to the 2015 Edition. As noted in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20136), the 2015 Edition health IT certification criteria enables health information exchange

through new and enhanced certification criteria standards, and through implementation specifications for interoperability. The 2015 Edition also incorporates changes that are designed to spur innovation and provide more choices to health care providers and patients for the exchange of electronic health information, including new Application Programming Interface (API) certification criteria. APIs are required for patient engagement measures within the advancing care information category; however, they may also be enabled by a health care provider or organization for their own use of third party applications with their CEHRT, such as for quality improvement. An API can also be enabled by a health care provider to give patients access to their health information through a third-party application with more flexibility than is often found in many current patient portals. From the MIPS eligible clinician perspective, an API could complement a patient portal or could also potentially make one unnecessary if patients are able to use software applications designed to interact with an API that could support their ability to view, download, and transmit their health information to a third party. In addition, the 2015 Edition health IT transitions of care certification criterion rigorously assesses a product's ability to create and receive a Consolidated-Clinical Document Architecture (C-CDA) formatted documents. The ONC also adopted certification criteria that both support interoperability in other settings and use cases, such as the Common Clinical Data Set summary record, data segmentation for privacy, and care plan certification criteria (80 FR 62603).

However, in light of the conservative readiness estimates for MIPS eligible clinicians, and in line with our commitment to supporting small practices, solo practitioners and specialties which may be more likely to use certified health IT offered by small developers, we are proposing 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 CY 2018 performance period. We propose to amend §414.1305 to reflect this change. We further note, that to encourage new participants to adopt certified health IT and to incentivize participants to upgrade

their technology to 2015 Edition products which better support interoperability across the care continuum, we are proposing to offer a bonus of 10 percentage points under the advancing care information performance category for MIPS eligible clinicians who report the Advancing Care Information Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT. We are proposing to amend §414.1380(b)(4)C)(3) to reflect this change. We are proposing this one-time bonus for CY 2018 to support and recognize MIPS eligible clinicians and groups that invest in implementing certified EHR technology in their practice. Specifically, we intend this bonus to support new participants that may be adopting health IT for the first time in CY 2018 and do not have 2014 Edition technology available to use or that may have no prior experience with meaningful use objectives and measures. We believe this bonus will help recognize their investment to adopt health IT and support their participation in the advancing care information performance category in MIPS. In addition, we believe this bonus will help to incentivize participants to continue the process of upgrading from 2014 Edition to 2015 Edition, especially small practices where the investment in updated workflows and implementation may present unique challenges. We intend this bonus to support and recognize their efforts to engage with the advancing care information measures using technology certified to the 2015 Edition, which include more robust measures using updated standards and functions which support interoperability. We seek comment on this proposed bonus. Specifically, we seek comment on 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. We note that with the addition of the 2015 Edition CEHRT bonus of 10 percentage points, MIPS eligible clinicians would be able to earn a bonus score of up to 25 percentage points in CY 2018 under the advancing care information performance category, an increase from the 15 percentage point bonus score available in CY 2017.

To facilitate readers in identifying the requirements of CEHRT for the Advancing Care Information Objectives and Measures, we are including Table 8 in section II.C.6.f.(6)(a) which lists the 2015 Edition and 2014 Edition certification criteria required to meet the objectives and measures.

We invite comments on these proposals.

(5) Scoring Methodology Considerations

Section 1848(q)(5)(E)(i)(IV) of the Act states that 25 percent of the MIPS final score shall be based on performance for the advancing care information performance category. Further, section 1848(q)(5)(E)(ii) of the Act, 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 Act) who are meaningful EHR users (as determined under section 1848(o)(2) of the Act) is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the MIPS final score, but not below 15 percent, 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. We note that section 1848(o)(5) of the Act defines an eligible professional as a physician, as defined in section 1861(r) of the Act.

In CY 2017 Quality Payment Program final rule (81 FR 77226-77227), we established a final policy, for purposes of applying section 1848(q)(5)(E)(ii) of the Act, to estimate the proportion of physicians as defined in section 1861(r) of the Act who are meaningful EHR users as those physician MIPS eligible clinicians who earn an advancing care information performance category score of at least 75 percent for a performance period. We established that we will base this estimation on data from the relevant performance period, if we have sufficient data available from that period. For example, if feasible, we would consider whether to reduce the applicable percentage weight of the advancing care information performance category in the MIPS final

score for the 2019 MIPS payment year based on an estimation using the data from the 2017 performance period. We stated that we will not include in the estimation physicians for whom the advancing care information performance category is weighted at zero percent under section 1848(q)(5)(F) of the Act, which we relied on in the CY 2017 Quality Payment Program final rule (81 FR 77226 through 77227) to establish policies under which we would weigh the advancing care information performance category at zero percent of the final score. In addition, we are proposing not to include in the estimation physicians for whom the advancing care information performance category would be weighted at zero percent under our proposal in section II.C.6.f.(7) of this proposed rule to implement certain provisions of the 21st Century Cures Act (that is, physicians who are determined hospital-based or ambulatory surgical center-based, or who are granted an exception based on significant hardship or decertified EHR technology.

We are considering modifications to the policy we established in last year's rulemaking to base our estimation of physicians who are meaningful EHR users for a MIPS payment year (for example, 2019) on data from the relevant performance period (for example, 2017). We are concerned that if in future rulemaking we decide to propose to change the weight of the advancing care information performance category based on our estimation, such a change may cause confusion to MIPS eligible clinicians who are adjusting to the MIPS program and believe this performance category will make up 25 percent of the final score for the 2019 MIPS payment year. The earliest we would be able to make our estimation based on 2017 data and propose in future rulemaking to change the weight of the advancing care information performance category for the 2019 MIPS payment year would be in mid-2018, as the deadline for data submission is March 31, 2018. We are requesting public comments on whether this timeframe is sufficient, or whether a more extended timeframe would be preferable. We are proposing to modify our existing policy such that we would base our 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. For example, we would use data from the 2017 performance period to estimate the proportion of physicians who are meaningful EHR users for purposes of reweighting the advancing care information performance category for the 2021 MIPS payment year.

We invite comments on this proposal.

(6) Objectives and Measures

(a) Advancing Care Information Objectives and Measures Specifications

We are proposing to maintain for the CY 2018 performance period the Advancing Care Information Objectives and Measures as finalized in the CY 2017 Quality Payment Program final rule (81 FR 77227 through 77229) with the modifications proposed below. As we noted (81 FR 77227), these objectives and measures were adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs final rule (80 FR 62829 through 62871), however, we did not maintain the previously established thresholds for MIPS. For a more detailed discussion of the Stage 3 objectives and measures, including explanatory material and defined terms, we refer readers to the 2015 EHR Incentive Programs final rule (80 FR 62829 through 62871).

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

2018 Advancing Care Information Objective	2018 Advancing Care Information Measure*	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Numerator/ Denominator
Patient Electronic	Provide Patient Access	Required	Up to 10%	Numerator/

2018 Advancing Care Information Objective	2018 Advancing Care Information Measure*	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Access				Denominator
	Patient-Specific Education	Not Required	Up to 10%	Numerator/ Denominator
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/ Denominator
	Secure Messaging	Not Required	Up to 10%	Numerator/ Denominator
	Patient-Generated Health Data	Not Required	Up to 10%	Numerator/ Denominator
Health Information Exchange	Send a Summary of Care	Required	Up to 10%	Numerator/ Denominator
	Request/Accept Summary of Care	Required	Up to 10%	Numerator/ Denominator
	Clinical Information Reconciliation	Not Required	Up to 10%	Numerator/ Denominator
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	0 or 5%*	Yes/No Statement
	Electronic Case Reporting	Not Required	0 or 5%*	Yes/No Statement
	Public Health Registry Reporting	Not Required	0 or 5%*	Yes/No Statement
	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 performance score		5% bonus		Yes/No Statement
Report improvement activities using CEHRT		10% bonus		Yes/No Statement
Report using only 2015 Edition CEHRT		10% bonus		Based upon measures submitted

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

Objective: Protect Patient Health Information

Objective: 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 Measure: 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.

Objective: Electronic Prescribing

Objective: Generate and transmit permissible prescriptions electronically.

E-Prescribing Measure: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

- Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period.

- Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Objective: Patient Electronic Access

Objective: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Provide Patient Access Measure: For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programing Interface (API) in the MIPS eligible clinician's CEHRT.

● Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period.

● Numerator: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.

Definition of timely - Beginning with the 2018 performance period, we are proposing to define "timely" as within 4 business days of the information being available to the MIPS eligible clinician. This definition of timely is the same as we adopted under the EHR Incentive Programs (80 FR 62815).

Patient-Specific Education Measure: The MIPS eligible clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician.

● Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period.

●Numerator: The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the performance period.

Objective: Coordination of Care Through Patient Engagement

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care.

View, Download, Transmit (VDT) Measure: 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).

Proposed change to the View, Download, Transmit (VDT) Measure: During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician by either (1) viewing, downloading or transmitting to a third party their health information; or (2) accessing their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's CEHRT; or (3) a combination of (1) and (2). We are proposing this change because we 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. We propose this change would apply beginning with the performance period in 2017.

- Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.

Secure Messaging Measure: For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic

messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).

- Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the performance period.

Patient-Generated Health Data Measure: Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the MIPS eligible clinician during the performance period.

- Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the performance period.

Objective: Health Information Exchange

Objective: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinician into their EHR using the functions of CEHRT.

Proposed change to the Objective: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first

patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.

We inadvertently used the term "health care clinician" and are proposing to replace it with the more appropriate term "health care provider". We are proposing this change would apply beginning with the performance period in 2017.

Send a Summary of Care Measure: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

Proposed Change to the Send a Summary of Care Measure: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

We inadvertently used the term "health care clinician" and are proposing to replace it with the more appropriate term "health care provider". We are proposing this change would apply beginning with the 2017 performance period.

- Denominator: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.

- Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Request/Accept Summary of Care Measure: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document.

- Denominator: Number of patient encounters during the performance period for which

a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

- Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the CEHRT.

Clinical Information Reconciliation Measure: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The MIPS eligible clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy. Review of the patient's known medication allergies; (3) Current Problem list. Review of the patient's current and active diagnoses.

- Denominator: Number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient.

- Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list; medication allergy list; and current problem list.

Objective: Public Health and Clinical Data Registry Reporting.

Objective: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

Immunization Registry Reporting Measure: 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).

We note that the functionality to be bi-directional is part of EHR technology certified to the 2015 Edition (80 FR 62554). 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.

Syndromic Surveillance Reporting Measure: 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.

Proposed change to the Syndromic Surveillance Reporting Measure: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data. We are proposing this change because we inadvertently finalized the measure description that we had proposed for Stage 3 of the EHR Incentive Program (80 FR 82866) and not the measure description that we finalized (80 FR 82970). The proposed change aligns with the measure description finalized for Stage 3.

Electronic Case Reporting Measure: The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.

Public Health Registry Reporting Measure: The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.

Clinical Data Registry Reporting Measure: The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

We note that we have split the Specialized Registry Reporting Measure that we 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. . We want to continue to encourage those MIPS eligible

clinicians who have already started down the path of reporting to a specialized registry to continue to engage in public health and clinical data registry reporting. Therefore, we propose to allow MIPS eligible clinicians and groups to continue to count active engagement in electronic public health reporting with specialized registries. We propose 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 (80 FR 62862 through 62865), meaning the clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

As noted previously, to facilitate readers in identifying the requirements of CEHRT for the Advancing Care Information Objectives and Measures, we are including the following Table 8, which includes the 2015 Edition and 2014 Edition certification criteria required to meet the objectives and measures.

TABLE 8: Advancing Care Information Objectives and Measures and Certification Criteria for 2014 and 2015 Editions

Objective	Measure	2015 Edition	2014 Edition
Protect Patient Health Information	Security Risk Analysis	The requirements are a part of CEHRT specific to each certification criterion	The requirements are included in the Base EHR Definition
Electronic Prescribing	e-Prescribing	§170.315(b)(3) (Electronic Prescribing). §170.315(a)(10) (Drug-Formulary and Preferred Drug List checks	§170.314(b)(3) (Electronic Prescribing). §170.314(a)(10) (Drug-Formulary and Preferred Drug List checks
Patient Electronic Access	Provide Patient Access	§170.315(e)(1) (View, Download, and Transmit to 3rd Party). §170.315(g)(7) (Application Access—Patient Selection) . §170.315(g)(8) (Application Access—Data Category Request) . §170.315(g)(9) (Application Access—All	§170.314(e)(1) (View, Download, and Transmit to 3rd Party).

Objective	Measure	2015 Edition	2014 Edition
		Data Request) The three criteria combined are the ''API'' certification criteria.	
Patient Electronic Access	Patient Specific Education	§170.315(a)(13) (Patient-specific Education Resources)	§170.314(a)(13) (Patient-specific Education Resources)
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	§170.315(e)(1) (View, Download, and Transmit to 3rd Party). §170.315(g)(7) (Application Access—Patient Selection) . §170.315(g)(8) (Application Access—Data Category Request) . §170.315(g)(9) (Application Access—All Data Request) The three criteria combined are the ''API'' certification criteria.	§170.314(e)(1) (View, Download, and Transmit to 3rd Party).
Coordination of Care Through Patient Engagement	Secure Messaging	§170.315(e)(2) (Secure Messaging).	§170.314(e)(3) (Secure Messaging).
Coordination of Care Through Patient Engagement	Patient-Generated Health Data	§170.315(e)(3) (Patient Health Information Capture) Supports meeting the measure, but is NOT required to be used to meet the measure. The certification criterion is part of the CEHRT definition beginning in 2018.	N/A
Health Information Exchange	Send a Summary of Care	§170.315(b)(1) (Transitions of Care).	§170.314(b)(2) (Transitions of Care-Create and Transmit Transition of Care/Referral Summaries or §170.314(b)(8) (Optional -Transitions of Care).
Health Information Exchange	Request/Accept Summary of Care	§170.315(b)(1) (Transitions of Care).	§170.314(b)(1) (Transitions of Care-Receive, Display and Incorporate Transition of Care/Referral Summaries or §170.314(b)(8) (Optional -Transitions of Care).
Health Information Exchange	Clinical Information Reconciliation	§170.315(b)(2) (Clinical Information Reconciliation and Incorporation).	§170.314(b)(4) (Clinical Information Reconciliation or §170.314(b)(9) (Optional – Clinical Information Reconciliation and Incorporation).

Objective	Measure	2015 Edition	2014 Edition
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	§170.315(f)(1) (Transmission to Immunization Registries)	N/A
Public Health and Clinical Data Registry Reporting	Syndromic Surveillance Reporting	§170.315(f)(2) (Transmission to Public Health Agencies—Syndromic Surveillance) Urgent Care Setting Only	§170.314(f)(3) (Transmission to Public Health Agencies—Syndromic Surveillance) or §170.314(f)(7) (Optional-Ambulatory Setting Only-Transmission to Public Health Agencies—Syndromic Surveillance)
Public Health and Clinical Data Registry Reporting	Electronic Case Reporting	§170.315(f)(5) (Transmission to Public Health Agencies—Electronic Case Reporting)	N/A
Public Health and Clinical Data Registry Reporting	Public Health Registry Reporting	EPs may choose one or more of the following: §170.315(f)(4) (Transmission to Cancer Registries). §170.315(f)(7) (Transmission to Public Health Agencies—Health Care Surveys).	§170.314(f)(5) (Optional – Ambulatory Setting Only – Cancer Case Information and §170.314(f)(6) (Optional – Ambulatory Setting Only – Transmission to Cancer Registries)
Public Health and Clinical Data Registry Reporting	Clinical Data Registry Reporting	No 2015 Edition health IT certification criteria at this time	N/A

We are inviting public comment on these proposals.

(b) 2017 and 2018 Advancing Care Information Transition Objectives and Measures Specifications

TABLE 9: Advancing Care Information Performance Category Scoring Methodology for 2018 Advancing Care Information Transition Objectives and Measures

2018 Advancing Care Information Transition Objective	2018 Advancing Care Information Transition Measure	Required/ Not Required for Base Score (50%)	Performance Score (Up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	E-Prescribing	Required	0	Numerator/ Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Numerator/ Denominator
	View, Download, or	Not Required	Up to 10%	Numerator/

2018 Advancing Care Information Transition Objective	2018 Advancing Care Information Transition Measure	Required/ Not Required for Base Score (50%)	Performance Score (Up to 90%)	Reporting Requirement
	Transmit (VDT)			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.

In the CY 2017 Quality Payment Program final rule (81 FR 77229 through 77237), we finalized the 2017 Advancing Care Information Transition Objectives and Measures for MIPS eligible clinicians using EHR technology certified to the 2014 Edition. We noted (81 FR 77229 that these objectives and measures have been adapted from the Modified Stage 2 objectives and measures finalized in the 2015 EHR Incentive Programs final rule (80 FR 62793 through 62825); however, we did not maintain the previously established thresholds for MIPS. For a more detailed discussion of the Modified Stage 2 Objectives and Measures, including explanatory material and defined terms, we refer readers to the 2015 EHR Incentive Programs final rule (80 FR 62793 through 62825). We are proposing to make several modifications identified and described below to the 2017 Advancing Care Information Transition Objectives and Measures for the advancing care information performance category of MIPS for the 2017 and 2018

performance periods. These modifications would not require changes to EHR technology that has been certified to the 2014 Edition.

We finalized the 2017 Advancing Care Information Transition Objectives and Measures only for the 2017 performance period because these objectives and measures are for MIPS eligible clinicians using EHR technology certified to the 2014 Edition. Because we are proposing in section II.C.6.f.(4) to continue to allow the use of EHR technology certified to the 2014 Edition in the 2018 performance period, we are also proposing to allow MIPS eligible clinicians to report the Advancing Care Information Transition Objectives and Measures in 2018.

Objective: Protect Patient Health Information

Objective: 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 Measure: 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.

Objective: Electronic Prescribing

Objective: MIPS eligible clinicians must generate and transmit permissible prescriptions electronically.

E-Prescribing Measure: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

- Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of

prescriptions written for drugs requiring a prescription to be dispensed during the performance period.

- Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Objective: Patient Electronic Access

Objective: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Proposed Modification to the Objective

We are proposing to modify this objective beginning with the 2017 performance period by removing the word "electronic" from the description of timely access as it was erroneously included in the final rule (81 FR 77228). It was our 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 (80 FR 62809 and 80 FR 62815), 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).

Provide Patient Access Measure: At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician's discretion to withhold certain information.

- Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download,

and transmit to a third party.

View, Download, Transmit (VDT) Measure: At least one patient seen by the MIPS eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period.

- Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period.

Objective: Patient-Specific Education

Objective: The MIPS eligible clinician provides patients (or patient authorized representative) with timely electronic access to their health information and patient-specific education.

Proposed Change to the Objective: The MIPS eligible clinician uses clinically relevant information from CEHRT to identify patient-specific educational resources and provide those resources to the patient. We inadvertently finalized the description of the Patient Electronic Access objective for the Patient-Specific Education Objective, so that the Patient-Specific Education Objective had the wrong description. We are proposing to correct this error by adopting the description of the Patient-Specific Education Objective adopted under modified Stage 2 in the 2015 EHR Incentive Programs final rule (80 FR 62809 and 80 FR 62815). We are proposing this change would apply beginning with the performance period in 2017.

Patient-Specific Education Measure: The MIPS eligible clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS eligible clinician.

- Denominator: The number of unique patients seen by the MIPS eligible clinician

during the performance period.

- Numerator: The number of patients in the denominator who were provided access to patient-specific educational resources using clinically relevant information identified from CEHRT during the performance period.

Objective: Secure Messaging

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Secure Messaging Measure: For at least one patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the performance period.

- Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period.

- Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the performance period.

Objective: Health Information Exchange

Objective: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinicians into their EHR using the functions of CEHRT.

Proposed change to the Objective: The MIPS eligible clinician provides a summary of

care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.

We inadvertently used the term "health care clinician" and are proposing to replace it with the more appropriate term "health care provider". We are proposing this change would apply beginning with the performance period in 2017.

Health Information Exchange Measure: 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.

Proposed change to the measure: The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral.

This change reflects the change proposed to the Health Information Exchange objective replacing "health care clinician" with "health care provider". We are proposing this change would apply beginning with the performance period in 2017.

- Denominator: Number of transitions of care and referrals during the performance period for which the EP was the transferring or referring health care clinician.

Proposed Change to the denominator: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring health care provider. This change reflects the change proposed to the Health Information Exchange Measure replacing "health care clinician" with "health care provider". We also inadvertently referred to the EP in the description and are replacing "EP" with "MIPS eligible

clinician". We are proposing this change would apply beginning with the performance period in 2017.

- Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Medication Reconciliation

Objective: Medication Reconciliation

Proposed Objective

We are proposing to add a description of the Medication Reconciliation Objective beginning with the CY 2017 performance period, which we inadvertently omitted from the CY 2017 Quality Payment Program proposed and final rules, as follows:

Proposed Objective: The MIPS eligible clinician who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation. This description aligns with the objective adopted for Modified Stage 2 at 80 FR 62811.

Medication Reconciliation Measure: The MIPS eligible clinician performs medication reconciliation for at least one transition of care in which the patient is transitioned into the care of the MIPS eligible clinician.

- Denominator: Number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient.

- Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

Proposed Modification to the Numerator

Proposed Numerator: The number of transitions of care or referrals in the denominator

where medication reconciliation was performed.

We are proposing to modify the numerator by removing medication list, medication allergy list, and current problem list. These three criteria were adopted for Stage 3 (80 FR 62862) but not for Modified Stage 2 (80 FR 62811). We are proposing this change would apply beginning with the performance period in 2017.

Objective: Public Health Reporting

Objective: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

Immunization Registry Reporting Measure: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data.

Syndromic Surveillance Reporting Measure: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.

Specialized Registry Reporting Measure: The MIPS eligible clinician is in active engagement to submit data to a specialized registry.

We invite public comments on these proposals.

(c) Exclusions

We are proposing to add exclusions to the measures associated with the Health Information Exchange and Electronic Prescribing objectives required for the base score. We propose these exclusions would apply beginning with the CY 2017 performance period. In the CY 2017 Quality Payment Program final rule (81 FR 77237 through 77238), we did not finalize any exclusions for the measures specified for the advancing care information performance category as we believe that the MIPS exclusion criteria and that the advancing care information performance category scoring methodology together accomplish the same end as the previously established exclusions for the majority of the advancing care information performance category

measures. We further noted that it was not necessary to finalize the proposed exclusion for the Immunization Registry Reporting Measure because MIPS eligible clinicians have the flexibility to choose whether to report the measure because it is part of the performance score of the advancing care information performance category. However, we understand that many MIPS eligible clinicians may not achieve a base score because they cannot fulfill the measures associated with the Health Information Exchange objective in the base score because they seldom refer or transition patients, and we believe that the implementation burden of the objective is too high to require of those with only a small number of referrals or transitions. Similarly, we understand that many MIPS eligible clinicians do not often write prescriptions in their practice or lack prescribing authority, and thus could not meet the E-prescribing Measure and would also fail to earn a base score. As this was not our intention, we are proposing to establish exclusions for these measures, as described below.

Proposed Exclusion for the E-Prescribing Objective and Measure

In the CY 2017 Quality Payment Program final rule (81 FR 28237 through 28238), we established a policy that MIPS eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. This policy has confused MIPS eligible clinicians as a null value would appear to indicate a MIPS eligible clinician has failed the measure and thus not would not achieve a base score. We are proposing to change this policy beginning with the CY 2017 performance period and propose to establish an exclusion for the e-Prescribing Measure. MIPS eligible clinicians who wish to claim this 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. If a MIPS eligible clinician does not claim the exclusion, they would fail the measure and not earn a base score or any score in the advancing care information performance category.

Advancing Care Information Objective and Measure

Objective: Electronic Prescribing

Objective: Generate and transmit permissible prescriptions electronically.

E-Prescribing Measure: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

- Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period.

- Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Proposed Exclusion: Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

2017 and 2018 Advancing Care Information Transition Objective and Measure

Objective: Electronic Prescribing

Objective: MIPS eligible clinicians must generate and transmit permissible prescriptions electronically.

E-Prescribing Measure: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

- Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period.

- Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Proposed Exclusion: Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

Proposed Exclusion for the Health Information Exchange Objective and Measures

We are proposing to add exclusions for the measures associated with the Health Information Exchange Objective. Stakeholders have expressed concern through public comments on the CY 2017 Quality Payment Program proposed rule and other inquiries to us that some MIPS eligible clinicians are unable to meet the measures associated with the Health Information Exchange Objective, which are required for the base score, because they do not regularly refer or transition patients in the normal course of their practice. As we did not intend to disadvantage those MIPS eligible clinicians and prevent them from earning a base score, we are proposing the exclusions.

Advancing Care Information Objective and Measures

Objective: Health Information Exchange

Objective: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinician into their EHR using the functions of CEHRT.

We note that we proposed above to replace "health care clinician" with "health care provider".

Send a Summary of Care Measure: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health

care clinician (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

We note that we proposed above to replace "health care clinician" with "health care provider".

- Denominator: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.
- Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Proposed Exclusion: Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Request/Accept Summary of Care Measure: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document.

- Denominator: Number of patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
- Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the CEHRT.

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

2017 and 2018 Advancing Care Information Transition Objective and Measures

Objective: Health Information Exchange

Objective: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinicians into their EHR using the functions of CEHRT.

We note that we are proposing above to replace "health care clinician" with "health care provider".

Health Information Exchange Measure: 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.

We note that we are proposing above to replace "health care clinician" with "health care provider".

- Denominator: Number of transitions of care and referrals during the performance period for which the EP was the transferring or referring health care clinician.

We note that we are proposing above to replace "health care clinician" with "health care provider".

- Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Proposed Exclusion: Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

We are inviting public comment on these proposals.

(7) Additional Considerations

(a) 21st Century Cures Act

As we noted in the CY 2017 Quality Payment Program final rule (81 FR 77238), section 101(b)(1)(A) of the MACRA amended section 1848(a)(7)(A) of the Act to sunset the meaningful use payment adjustment at the end of CY 2018. Section 1848(a)(7) of the Act includes certain statutory exceptions to the meaningful use payment adjustment under section 1848(a)(7)(A) of the Act. Specifically, section 1848(a)(7)(D) of the Act exempts hospital-based EPs from the application of the payment adjustment under section 1848(a)(7)(A) of the Act. In addition, section 1848(a)(7)(B) of the Act provides that the Secretary may, on a case-by-case basis, exempt an EP from the application of the payment adjustment under section 1848(a)(7)(A) of the Act if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an EP who practices in a rural area without sufficient internet access. The last sentence of section 1848(a)(7)(B) of the Act also provides that in no case may an exemption be granted under subparagraph (B) for more than 5 years. The MACRA did not maintain these statutory exceptions for the advancing care information performance category of the MIPS. Thus, we had previously stated that the provisions under sections 1848(a)(7)(B) and (D) of the Act are limited to the meaningful use payment adjustment under section 1848(a)(7)(A) of the Act and do not apply in the context of the MIPS.

Following the publication of the CY 2017 Quality Payment Program final rule, the 21st Century Cures Act (Pub. L. 114-255) was enacted on December 13, 2016. Section 4002(b)(1)(B) of the 21st Century Cures Act 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 advancing care information 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. As a result of this legislative change, we believe that the general exceptions described under sections 1848(a)(7)(B) and (D) of the Act are applicable under the MIPS program. We include below proposals to implement these provisions as applied to assessments of MIPS eligible clinicians under section 1848(q) of the Act with respect to the advancing care information performance category.

(i) MIPS Eligible Clinicians Facing a Significant Hardship

In the CY 2017 Quality Payment Program final rule (81 FR 77240 through 77243), we recognized that there may not be sufficient measures applicable and available under the advancing care information performance category to 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. We relied on section 1848(q)(5)(F) of the Act to establish a final policy to assign a zero percent weighting to the advancing care information performance category in the final score if there are not sufficient measures and activities applicable and available to MIPS eligible clinicians within the categories of significant hardship noted above (81 FR 77243). Additionally, under the final policy (81 FR 77243), we did not impose a limitation on the total number of MIPS payment years for which the advancing care information performance category could be weighted at zero percent, in contrast with the 5-year limitation on significant hardship exceptions under the Medicare EHR Incentive Program as required by section 1848(a)(7)(B) of the Act.

We are not proposing substantive changes to this policy; however, as a result of the changes in the law made by the 21st Century Cures Act discussed above, we will not rely on section 1848(q)(5)(F) of the Act and instead are proposing to use the authority in the last sentence of section 1848(o)(2)(D) of the Act for significant hardship exceptions under the advancing care information performance category under MIPS. Section 1848(o)(2)(D) of the

Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, states in part that the provisions of section 1848(a)(7)(B) of the Act shall apply to assessments of MIPS eligible clinicians with respect to the advancing care information performance category in an appropriate manner which may be similar to the manner in which such provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act. We would assign a zero percent weighting to the advancing care information performance category in the MIPS final score for a MIPS payment year for MIPS eligible clinicians who successfully demonstrate a significant hardship through the application process. We would use the same categories of significant hardship and application process as established in the CY 2017 Quality Payment Program final rule (81 FR 77240-77243). We would automatically reweight the advancing care information performance category to zero percent 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. 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 advancing care information performance category, they would be scored on the advancing care information 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.

We believe this policy would be an appropriate application of the provisions of section 1848(a)(7)(B) of the Act to MIPS eligible clinicians and is similar to the manner in which those provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act. Under the Medicare EHR Incentive Program an approved hardship exception exempted an EP from the payment adjustment. We believe that weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category.

As required under section 1848(a)(7)(B) of the Act, eligible professionals were not granted significant hardship exceptions for the payment adjustments under the Medicare EHR Incentive Program for more than 5 years. We propose not to apply the 5-year limitation under section 1848(a)(7)(B) of the Act to significant hardship exceptions for the advancing care information performance category under MIPS. We believe this proposal is an appropriate application of the provisions of section 1848(a)(7)(B) of the Act to MIPS eligible clinicians due to our desire to reduce clinician burden, promote the greatest level of participation in the MIPS program, and maintain consistency with the policies established in last year's final rule (81 FR 77243). In the Medicare EHR Incentive Program, we received many applications for significant hardship exceptions and approved most of them, which we believe indicates many eligible professionals were unable to or would have struggled to satisfy the requirements of meaningful use. We believe that there will be a continued need for significant hardship exceptions in order to provide clinicians with the necessary flexibility to participate in the MIPS program that best matches their available resources and circumstances, which may not change during a 5-year time period. For example, a clinician in an area without internet connectivity may continue to lack connectivity for more than 5 years. In addition, in the CY 2017 Quality Payment Program final rule (81 FR 77242 through 77243), we noted that we had received comments expressing appreciation that CMS moved away from the 5-year limitation to significant hardship exceptions.

We solicit 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.

(ii) Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices

Section 1848(q)(2)(B)(iii) of the Act requires the Secretary to give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and geographic HPSAs in establishing improvement activities under MIPS. In the

CY 2017 Quality Payment Program final rule (81 FR 77187 through 77188), we finalized that for MIPS eligible clinicians and groups that are in small practices or located in rural areas, or geographic health professional shortage areas (HPSAs), to achieve full credit under the improvement activities category, one high-weighted or two medium-weighted improvement activities are required.

While there is no corresponding statutory provision for the advancing care information performance category, we believe that special consideration should also be available for MIPS eligible clinicians located in small practices. Through comments received on the CY 2017 Quality Payment Program proposed rule (81 FR 28161-28586), we heard many concerns about the impact of MIPS on eligible clinicians in small practices. Some commenters stated that there was not a meaningful exclusion for small practices that cannot afford the upfront investments (including investments in EHR technology) (81 FR 77066). Many noted there are still many small practices that have not adopted EHRs due to the administrative and financial burden. Some expressed concern that small group and solo practices would be driven out of business because of the potential negative payment adjustments under MIPS (81 FR 77055). A few commenters were concerned about the impact of MACRA on small practices and asked CMS to remain sensitive to this concern and offer special opportunities for MIPS eligible clinicians in areas threatened by access problems (81 FR 77055).

Based on these concerns, we are proposing a significant hardship exception for the advancing care information performance category for MIPS eligible clinicians who are in small practices, under the authority in section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act (see discussion of the statutory authority for significant hardship exceptions in section II.C.6.f.(7)(ii). We are proposing that this hardship exception would be available to MIPS eligible clinicians in small practices as defined under §414.1305 (15 or fewer clinicians and solo practitioners). We are proposing in section II.C.1.e.

of this proposed rule, that CMS would make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years. We are proposing to reweight the advancing care information performance category to zero percent of the MIPS final score for MIPS eligible clinicians who qualify for this hardship exception. We are proposing this exception would be available beginning with the 2018 performance period and 2020 MIPS payment year. We are proposing a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by us by December 31st of the performance period or a later date specified by us. We are also proposing 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 advancing care information performance category. In accordance with section 1848(a)(7)(B) of the Act, the exception would be subject to annual renewal. Under our proposal in section II.C.6.f.(7)(a), the 5-year limitation under section 1848(a)(7)(B) of the Act would not apply to this significant hardship exception for MIPS eligible clinicians in small practices.

We believe that applying the significant hardship exception in this way would be appropriate given the challenges small practices face as described by the commenters. In addition, we believe this application would be similar to the manner in which the exception applies with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act because weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category.

While we would be making this significant hardship exception available to small practices in particular, we are considering whether other categories or types of clinicians might similarly require an exception. We solicit comment on what those categories or types are, why such an exception is required, and any data available to support the necessity of the exception.

We note that supporting data would be particularly helpful to our consideration of whether any additional exceptions would be appropriate.

We are seeking comments on these proposals.

(iii) Hospital-Based MIPS Eligible Clinicians

In the CY 2017 Quality Payment Program final rule (81 FR 77238 through 77240), we defined a hospital-based MIPS eligible clinician under §414.1305 as a MIPS eligible clinician who furnishes 75 percent 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. We intend 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, we will use a 12-month period as close as practicable to this time period. We discussed our assumption that MIPS eligible clinicians who are determined hospital-based do not have sufficient advancing care information measures applicable to them, and we established a policy to reweight the advancing care information performance category to zero percent of the MIPS final score for the MIPS payment year in accordance with section 1848(q)(5)(F) of the Act (81 FR 77240).

We are not proposing substantive changes to this policy; however, as a result of the changes in the law made by the 21st Century Cures Act discussed above, we will not rely on section 1848(q)(5)(F) of the Act and instead are proposing to use the authority in the last sentence of section 1848(o)(2)(D) of the Act for exceptions for hospital-based MIPS eligible clinicians under the advancing care information performance category. Section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, states in part that

the provisions of section 1848(a)(7)(D) of the Act shall apply to assessments of MIPS eligible clinicians with respect to the advancing care information performance category in an appropriate manner which may be similar to the manner in which such provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act. We would assign a zero percent weighting to the advancing care information 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 advancing care information 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 hospital-based chooses to report on the advancing care information measures, they would be scored on the advancing care information 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.

We believe this policy would be an appropriate application of the provisions of section 1848(a)(7)(D) of the Act to MIPS eligible clinicians and is similar to the manner in which those provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act. Under the Medicare EHR Incentive Program an approved hardship exception exempted an EP from the payment adjustment. We believe that weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category.

We propose to amend §414.1380(c)(1) and (2) of the regulation text to reflect this proposal.

We request 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 hospital-based MIPS eligible clinicians.

(iv) Ambulatory Surgical Center (ASC) –Based MIPS Eligible Clinicians

Section 16003 of the 21st Century Cures Act amended section 1848(a)(7)(D) of the Act to provide that no payment adjustment may be made under section 1848(a)(7)(A) of the Act for 2017 and 2018 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.

Under section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, the ASC-based provisions of section 1848(a)(7)(D) of the Act shall apply to assessments of MIPS eligible clinicians under section 1848(q) of the Act with respect to the advancing care information performance category in an appropriate manner which may be similar to the manner in which such provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act. We believe our proposals set forth below for ASC-based MIPS eligible clinicians are an appropriate application of the provisions of section 1848(a)(7)(D) of the Act to MIPS eligible clinicians. Under the Medicare EHR Incentive Program an approved hardship exception exempted an EP from the payment adjustment. We believe that weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category.

To align with our hospital-based MIPS eligible clinician policy, we are proposing to define at §414.1305 an ASC-based MIPS eligible clinician as a MIPS eligible clinician who

furnishes 75 percent 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. We request comments on this proposal and solicit 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. We note that the ASC-based determination will be made independent of the hospital-based determination.

To determine a MIPS eligible clinician's ASC-based status, we are proposing 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, we would use a 12-month period as close as practicable to this time period. For example, for the 2018 performance period (2020 MIPS payment year), we would use the data available at the end of October 2017 for Medicare claims with dates of service between September 1, 2016 through August 31, 2017, to determine whether a MIPS eligible clinician is considered ASC-based under our proposed definition. We are proposing this timeline to allow us 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, we would not be able to notify MIPS eligible clinicians of their ASC-based status until after the final rule is published, which we anticipate would be later in 2017. We expect that we would provide this notification through QPP.cms.gov.

For MIPS eligible clinicians who we determine are ASC-based, we propose to assign a zero percent weighting to the advancing care information 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 advancing care information measures for the performance

period for the MIPS payment year for which they are determined ASC-based, we propose they would be scored on the advancing care information performance category like all other MIPS eligible clinicians, and the performance category would be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their advancing care information performance category score.

We are proposing these ASC-based policies would apply beginning with the 2017 performance period/2019 MIPS payment year.

We propose to amend §414.1380(c)(1) and (2) of the regulation text to reflect these proposals.

We request comments on these proposals.

(v) 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. Section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, states in part that the provisions of section 1848(a)(7)(B) of the Act shall apply to assessments of MIPS eligible clinicians with respect to the advancing care information performance category in an appropriate manner which may be similar to the manner in which such provisions apply with respect to the payment adjustment made under section 1848(a)(7)(A) of the Act.

We are proposing that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the advancing care information performance category is not possible because the CEHRT used by the MIPS eligible clinician has been

decertified under ONC's Health IT Certification Program. We are proposing that if the MIPS eligible clinician's demonstration is successful and an exception is granted, we would assign a zero percent weighting to the advancing care information performance category in the MIPS final score for the MIPS payment year. In accordance with section 1848(a)(7)(B) of the Act, 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. We are proposing this exception would be available beginning with the CY 2018 performance period and the 2020 MIPS payment year.

We are proposing 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. We believe that this timeframe is appropriate because the loss of certification may prevent a MIPS eligible clinician from reporting for the advancing care information performance category because it will require that the MIPS eligible clinician switch to an alternate CEHRT, a process that we believe may take up to 2 years. For example, for the 2020 MIPS payment year, if the MIPS eligible clinician's EHR technology was decertified during the CY 2018 performance period or during CY 2017, the MIPS eligible clinician may qualify for this exception. In addition, we are proposing 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. We are proposing a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by us by December 31st of the performance period, or a later date specified by us.

We believe that applying the exception in this way is an appropriate application of the provisions of section 1848(a)(7)(B) of the Act to MIPS eligible clinicians given that weighting the advancing care information performance category to zero percent is similar in effect to an

exemption from the requirements of that performance category. Under the Medicare EHR Incentive Program an approved hardship exception exempted an EP from the payment adjustment. We believe that weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category.

The ONC Health IT Certification Program: Enhanced Oversight and Accountability final rule ("EOA final rule") (81 FR 72404), effective December 19, 2016, created a regulatory framework for the ONC's direct review of health information technology (health IT) certified under the ONC Health IT Certification Program, including, when necessary, requiring the correction of non-conformities found in health IT certified under the Program and/or terminating certifications issued to certified health IT. Prior to the EOA final rule, ONC-Authorized Certification Bodies (ONC-ACBs) had the only authority to terminate or revoke certification of health IT under the program, which they used on previous occasions. On September 23, 2015, we posted an FAQ discussing the requirements for using a decertified CEHRT.[3]

Once all administrative processes, if any, are complete, then notice of a "termination of certification" is listed on the of the Certified Health IT Product List (CPHL) webpage.[4] As appropriate, ONC will also publicize the termination of certification of health IT through other communication channels (for example, ONC list serv(s)). Further, when ONC terminates the certification of a health IT product, the health IT developer is required to notify all potentially affected customers in a timely manner.

We further note that in comparison to termination actions taken by ONC and ONC-ACBs, a health IT developer may voluntarily withdraw a certification that is in good standing under the ONC Health IT Certification Program. A voluntary withdrawal may be the result of

[3]https://questions.cms.gov/faq.php?isDept=0&search=decertify&searchType=keyword&submitSearch=1&id=5005.
[4] The list is available at https://chpl.healthit.gov/#/decertifications/products.

the health IT developer going out of business, the developer no longer supporting the product, or for other reasons that are not in response to ONC-ACB surveillance, ONC direct review, or a finding of non-conformity by ONC or an ONC-ACB.[5] In such instances, ONC will list these products on the "Inactive Certificates"[6] webpage of the CHPL.

We propose to amend §414.1380(c)(1) and (2) of the regulation text to reflect these proposals. We are seeking comments on these proposals.

(b) Hospital-Based MIPS Eligible Clinicians

In the CY 2017 Quality Payment Program final rule (81 FR 77238 through 77240, we defined a hospital-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent 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.

We are proposing to modify our policy to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19) in the definition of hospital-based MIPS eligible clinician. POS 19 was developed in 2015 in order to capture the numerous physicians that are paid for a portion of their services in an "off campus-outpatient hospital" versus an on campus-outpatient hospital, (POS 22). We also believe that these MIPS eligible clinicians would not typically have control of the development and maintenance of their EHR systems, just like those who bill using POS 22. We propose to add POS 19 to our existing definition of a hospital-based MIPS eligible clinician beginning with the performance period in 2018.

We invite comment on this proposal.

[5] For further descriptions of certification statuses, please consult the CHPL Public User Guide.
[6] The "Inactive Certificates" Web page is available at https://chpl.healthit.gov/#/decertifications/inactive.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77243-77244), we discussed our belief that certain types of MIPS eligible clinicians (NPs, PAs, CNSs, and CRNAs) may lack experience with the adoption and use of CEHRT. Because many of these non-physician clinicians are not eligible to participate in the Medicare or Medicaid EHR Incentive Program, we stated that we have little evidence as to whether there are sufficient measures applicable and available to these types of MIPS eligible clinicians under the advancing care information performance category. We established a policy under section 1848(q)(5)(F) of the Act to assign a weight of zero to the advancing care information performance category in the MIPS final score if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. We will assign a weight of zero only in the event that an NP, PA, CRNA, or CNS does not submit any data for any of the measures specified for the advancing care information performance category. We encouraged all NPs, PAs, CRNAs, and CNSs to report on these measures to the extent they are applicable and available, however, we understand that some NPs, PAs, CRNAs, and CNSs may choose to accept a weight of zero for this performance category if they are unable to fully report the advancing care information measures. These MIPS eligible clinicians may choose to submit advancing care information measures should they determine that these measures are applicable and available to them; however, we noted that if they choose to report, they will be scored on the advancing care information 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 advancing care information performance category score.

We stated that this approach is appropriate for the first MIPS performance period based on the payment consequences associated with reporting, the fact that many of these types of

MIPS eligible clinicians may lack experience with EHR use, and our current uncertainty as to whether we have adopted sufficient measures that are applicable and available to these types of MIPS eligible clinicians. We noted that we would use the first MIPS performance period to further evaluate the participation of these MIPS eligible clinicians in the advancing care information performance category and would consider for subsequent years whether the measures specified for this category are applicable and available to these MIPS eligible clinicians. At this time we have no additional information because the first MIPS performance period is currently underway, and thus we propose the same policy for NPs, PAs, CRNAs, and CNSs for the 2018 performance period as well. We still intend to evaluate the participation of these MIPS eligible clinicians in the advancing care information performance category for 2017 and expect to adopt measures applicable and available to them in subsequent years.

We are seeking comment on how the advancing care information 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 we are seeking new measures that may be more broadly applicable to these additional types of MIPS eligible clinicians in future program years. For more information on the Call for Measures, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallForMeasures.html.

We are inviting public comment on these proposals.

(d) Scoring for MIPS Eligible Clinicians in Group Practices

In any of the situations described in the sections above, we would assign a zero percent weighting to the advancing care information performance category in the MIPS final score for the MIPS payment year if the MIPS eligible clinician meets certain specified requirements for this weighting. We noted that these MIPS eligible clinicians may choose to submit advancing care information measures; however, if they choose to report, they will be scored on the

advancing care information 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 advancing care information 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 (81 FR 77058). 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. We note that the data submission criteria for groups reporting advancing care information performance category described in the CY 2017 Quality Payment Program final rule (81 FR 77215) 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 zero percent weighting of the advancing care information 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 advancing care information 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 advancing care information performance category score.

(e) Timeline for Submission of Reweighting Applications

In the CY 2017 Quality Payment Program final rule (81 FR77240-77243), we established the timeline for the submission of applications to reweight the advancing care information performance category in the MIPS final score to align with the data submission

timeline for MIPS. We established that all applications for reweighting the advancing care information performance category be submitted by the MIPS eligible clinician or designated group representative in the form and manner specified by us. All applications may be submitted on a rolling basis, but must be received by us no later than the close of the submission period for the relevant performance period, or a later date specified by us. An application would need to be submitted annually to be considered for reweighting each year.

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.

We are proposing to change the submission deadline for the application as we believe that aligning the data submission deadline with the reweighting application deadline could disadvantages MIPS eligible clinicians. We are proposing to change the submission deadline for the CY 2017 performance period to December 31, 2017, or a later date specified by us. We believe this change would help MIPS eligible clinicians by allowing them to learn whether their application is approved prior to the data submission deadline for the CY 2017 performance period, March 31, 2018. We plan to have the application available in mid-2017. We encourage MIPS eligible clinicians to apply early as we expect to process the applications on a rolling basis. We note that if a MIPS eligible clinician submits data for the advancing care information category after an application has been submitted, the data would be scored, the application would be considered voided and the advancing care information performance category would not be reweighted.

We further propose that the submission deadline for the 2018 performance period will be December 31, 2018, or a later date as specified by us. We believe this 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.

We request comments on these proposals.

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

(1) Overview

Under section 1848(q)(1)(C)(ii)(1) of the Act, Qualifying APM Participants (QPs) are not MIPS eligible clinicians and are thus excluded from MIPS reporting requirements and payment adjustments. Similarly, under section 1848(q)(1)(c)(ii)(II) of the Act, 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, including those participating in MIPS APMs, are MIPS eligible clinicians and subject to MIPS reporting requirements and payment adjustments unless they are excluded on another basis such as being newly enrolled in Medicare or not exceeding the low volume threshold.

In the CY 2017 Quality Payment Program final rule (81 FR 77246-77269, 77543), we finalized the APM scoring standard, which is 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. We also sought to ensure that eligible clinicians in APM Entities that participate in certain types of APMs that assess their participants on quality and cost are assessed as consistently as possible across MIPS and their respective APMs. Given that many APMs already assess their participants on cost and quality of care and require engagement in certain improvement activities, we believe that without the APM scoring standard, misalignments could be quite common between the evaluation of performance under the terms of the APM and evaluation of performance on measures and activities under MIPS.

In the CY 2017 Quality Payment Program final rule (81 FR 77249), we identified the types of APMs for which the APM scoring standard would apply as MIPS APMs. We finalized that to be a MIPS APM, an APM must satisfy the following criteria: (1) APM Entities participate in the APM under an agreement with CMS or by law or regulation; (2) the APM requires that APM Entities include at least one MIPS eligible clinician on a Participation List;

and (3) the APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures. We specified that we will post the list of MIPS APMs prior to the first day of the MIPS performance year for each year (81 FR 77250). We finalized in the regulation at §414.1370(b) that for a new APM to be a MIPS APM, its first performance year must start on or before the first day of the MIPS performance year. A list of MIPS APMs is available at www.qpp.cms.gov.

We established in the regulation at §414.1370(c) that the MIPS performance year under §414.1320 of the regulations applies for the APM scoring standard.

We finalized that under section §414.1370(f) of our regulations on the APM scoring standard, MIPS eligible clinicians will be scored at the APM Entity group level and each eligible clinician will receive the APM Entity group's final score. The MIPS payment adjustment is applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity. The MIPS final score is comprised of the four MIPS performance category scores, as described in our regulation at §414.1370(g): quality, cost, improvement activities, and advancing care information. Both the Medicare Shared Savings Program and Next Generation ACO Model are MIPS APMs for the CY 2017 performance year. For these two MIPS APMs, in accordance with our regulation at §414.1370(h), the MIPS performance category scores are weighted as follows: quality at 50 percent; cost at zero percent; improvement activities at 20 percent; and advancing care information at 30 percent of the final score. For all other MIPS APMs for the CY 2017 performance year, quality and cost are each weighted at zero percent, improvement activities at 25 percent, and advancing care information at 75 percent of the final score.

As explained in the following sections, we propose to: add an APM participant assessment date for full TIN APMs; add the CAHPS for ACOs survey to the Shared Savings Program and Next Generation ACO quality measures included for scoring under the MIPS APM quality performance category; define Other MIPS APMs; and add scoring for quality

improvement to the MIPS APM quality performance category for MIPS APMs beginning in 2018. We also propose a Quality Payment Program 2018 performance year quality scoring methodology for Other MIPS APMs, and describe the scoring methodology for quality improvement for Other MIPS APMs as applicable.

In reviewing these proposals, we remind readers that the APM scoring standard is built upon the generally applicable MIPS scoring standard, but provides for special policies to address the unique circumstances of MIPS eligible clinicians who are in APM Entities participating in MIPS APMs. For the cost, improvement activities, and advancing care information performance categories, unless a separate policy has been established or is being proposed for the APM scoring standard, the generally applicable MIPS policies would be applicable. Additionally, unless we include a proposal to adopt a unique policy for the APM scoring standard, we propose to adopt the same generally applicable MIPS policies proposed elsewhere in this proposed rule, and would treat the APM Entity group as the group for purposes of MIPS. For the quality performance category, however, the APM scoring standard we propose is presented as a separate, unique standard, and therefore generally applicable MIPS policies would not be applied to the quality performance category under the APM scoring standard unless specifically stated. We seek comment on whether there may be 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.

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

In the CY 2017 Quality Payment Program final rule, we specified in the regulation at §414.1370(e) that the APM Entity group for purposes of scoring under the APM scoring standard is determined in the manner prescribed at §414.1425(b)(1), which provides that eligible clinicians who are on a Participation List on at least one of three dates (March 31, June 30, and August 31) would be considered part of the APM Entity group. Under these regulations, MIPS eligible clinicians who are not on a Participation List on one of these three assessment dates are not scored under the APM scoring standard. Instead, they would need to submit data to MIPS through one of the MIPS data submission mechanisms and their performance would be assessed either as individual MIPS eligible clinicians or as a group according to the generally applicable MIPS reporting and scoring criteria.

We will continue to use the three assessment dates of March 31, June 30, and August 31 to identify MIPS eligible clinicians who are on an APM Entity's Participation List and determine the APM Entity group that is used for purposes of the APM scoring standard. Beginning in the 2018 performance year, we propose to add a fourth assessment date of December 31 to identify those MIPS eligible clinicians who participate in a full TIN APM. We propose to define full TIN APM at §414.1305 to mean 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. An example of a full TIN APM is the Shared Savings Program which requires all individuals and entities that have reassigned their right to receive Medicare payment to the TIN of an ACO participant to participate in the ACO and comply with the requirements of the Shared Savings Program.

If an eligible clinician elects to reassign their billing rights to a TIN participating in a full TIN APM, the eligible clinician is necessarily participating in the full TIN APM. We propose to add this fourth date of December 31 only for eligible clinicians in a full TIN APM, and only for purposes of applying the APM scoring standard. We are not proposing to use this additional

assessment date of December 31 for purposes of QP determinations. Therefore, we propose to amend §414.1370(e) to identify the four assessment dates that would be used to identify the APM Entity group for purposes of the APM scoring standard, and to specify that the December 31 date would be used only to identify eligible clinicians on the APM Entity's Participation List for a MIPS APM that is a full TIN APM in order to add them to the APM Entity group that is scored under the APM scoring standard.

We propose to use this fourth assessment date of December 31 to extend the APM scoring standard to only those MIPS eligible clinicians participating in MIPS APMs that are full TIN APMs, ensuring that an eligible clinician who joins the full TIN APM late in the performance year would be scored under the APM scoring standard. We considered proposing to use the fourth assessment date more broadly for all MIPS APMs. However, we believe that this approach would have allowed MIPS eligible clinicians to 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. That is, for MIPS APMs that allow split TIN participation, it would be possible for eligible clinicians to briefly join a MIPS APM principally in order to benefit from the APM scoring standard, despite having limited opportunity to contribute to the APM Entity's performance in the MIPS APM. In contrast, we believe MIPS eligible clinicians would be less likely to join a full TIN APM principally to avail themselves of the APM scoring standard, since doing so would require either that the entire TIN join the MIPS APM or the administratively burdensome act of the eligible clinician reassigning their billing rights to the TIN of an entity participating in the full TIN APM.

We will continue to use only the three dates of March 31, June 30, and August 31 to determine, based on Participation Lists, the MIPS eligible clinicians who participate in MIPS APMs that are not full TIN APMs. We seek comment on the proposed addition of the fourth date

of December 31 to assess Participation Lists to identify MIPS eligible clinicians who participate in MIPS APMs that are full TIN APMs for purposes of the APM scoring standard.

(3) Calculating MIPS APM Performance Category Scores

In the CY 2017 Quality Payment Program final rule, we established a scoring standard for MIPS eligible clinicians participating in MIPS APMs to reduce participant reporting burden by reducing the need for eligible clinicians participating in these types of APMs to make duplicative data submissions for both MIPS and their respective APMs (81 FR 77246 through 77271). In accordance with section 1848(q)(1)(D)(i) of the Act, we proposed to assess the performance of a group of MIPS eligible clinicians in an APM Entity that participates in one or more MIPS APMs based on their collective performance as an APM Entity group, as defined at §414.1305.

In addition to reducing reporting burden, we sought to ensure that eligible clinicians in MIPS APMs are not assessed in multiple ways on the same performance activities. Depending on the terms of the particular MIPS APM, we believe that misalignments could be common between the evaluation of performance on quality and cost under MIPS versus under the terms of the APM. We believe requiring eligible clinicians in MIPS APMs to submit data, be scored on measures, and be subject to payment adjustments that are not aligned between MIPS and an APM could potentially undermine the validity of testing or performance evaluation under the APM. We also believe imposition of MIPS reporting requirements would result in reporting activity that provides little or no added value to the assessment of eligible clinicians, and could confuse eligible clinicians as to which CMS incentives should take priority over others in designing and implementing care improvement activities.

(a) Cost Performance Category

In the CY 2017 Quality Payment Program final rule, for MIPS eligible clinicians participating in MIPS APMs, we used our authority to waive requirements under the Medicare

statute to reduce the scoring weight for the cost performance category to zero (81 FR 77258, 77262, and 77266). We did this for MIPS APMs authorized under section 1115A of the Act using our authority under section 1115A(d)(1) of the Act to waive the requirement under section 1848(q)(5)(E)(i)(II) of the Act that specifies the scoring weight for the cost performance category. Having reduced the cost performance category weight to zero, we further used our authority under section 1115A(d)(1) of the Act to waive the requirements under sections 1848(q)(2)(B)(ii) and 1848(q)(2)(A)(ii) of the Act to specify and use, respectively, cost measures in calculating the MIPS final score for MIPS eligible clinicians participating in Other MIPS APMs (81 FR 77261 through 77262 and 77265 through 77266). Similarly, for MIPS eligible clinicians participating in the Medicare Shared Savings Program, we used our authority under section 1899(f) of the Act to waive the same requirements of section 1848 of the Act for the MIPS cost performance category (81 FR 77257 through 77258). We finalized this policy because: (1) APM Entity groups are already subject to cost and utilization performance assessment under the MIPS APMs; (2) MIPS APMs usually measure cost in terms of total cost of care, which is a broader accountability standard that inherently encompasses the purpose of the claims-based measures that have relatively narrow clinical scopes, and MIPS APMs that do not measure cost in terms of total cost of care may depart entirely from MIPS measures; and (3) the beneficiary attribution methodologies differ for measuring cost under APMs and MIPS, leading to an unpredictable degree of overlap (for eligible clinicians and for CMS) between the sets of beneficiaries for which eligible clinicians would be responsible that would vary based on the unique APM Entity characteristics such as which and how many eligible clinicians comprise an APM Entity group. We believe that with an APM Entity's finite resources for engaging in efforts to improve quality and lower costs for a specified beneficiary population, measurement of the population identified through the APM must take priority in order to ensure that the goals and the model evaluation associated with the APM are as clear and free of confounding factors as

possible. The potential for different, conflicting results across APMs and MIPS assessments may create uncertainty for MIPS eligible clinicians who are attempting to strategically transform their respective practices and succeed under the terms of the APM. We are not proposing changes to these policies.

We welcome comment on our proposal to continue to waive the weighting of the cost performance category for the 2020 payment year forward.

(i) Measuring Improvement in the Cost Performance Category

In setting performance standards with respect to measures and activities in each MIPS performance category, section 1848(q)(3)(B) of the Act requires us to consider, historical performance standards, improvement, and the opportunity for continued improvement. Section 1848(q)(5)(D)(i)(I) requires us to introduce the measurement of improvement into performance scores in the cost performance category for MIPS eligible clinicians for the 2020 MIPS Payment Year if data sufficient to measure improvement are available. Section 1848(q)(5)(D)(i)(II) permits us to take into account improvement in the case of performance scores in other performance categories. Given that we have in effect waivers of the scoring weight for the cost performance category, and of the requirement to specify and use cost measures in calculating the MIPS final score for MIPS eligible clinicians participating in MIPS APMs, and for the same reasons that we initially waived those requirements, we propose to use our authority under section 1115A(d)(1) of the Act for MIPS APMs authorized under section 1115A of the Act and under section 1899(f) of the Act for MIPS APMs under the Medicare Shared Savings Program, to waive the requirement under section 1848(q)(5)(D)(i)(I) of the Act to take improvement into account for performance scores in the cost performance category beginning with the 2018 MIPS performance year.

We seek comment on this proposal.

(b) Quality Performance Category

(i) Web Interface Reporters: Shared Savings Program and Next Generation ACO Model

(A) Quality Measures

We finalized in the CY 2017 Quality Payment Program final rule that under the APM scoring standard, participants in the Shared Savings Program and Next Generation ACO Model would be assessed for the purposes of generating a MIPS APM quality performance category score based exclusively on quality measures submitted using the CMS Web Interface (81 FR 77256 and 77261). In the CY 2017 Quality Payment Program final rule, we recognized that ACOs in both the Shared Savings Program and Next Generation ACO Model use the CMS Web Interface to submit data on quality measures, and that the measures they would report were also MIPS measures for 2017. For the Shared Savings Program and the Next Generation ACO Model, we finalized a policy to use quality measures and data submitted by the participant ACOs to the CMS Web Interface (as required under the rules for these initiatives) and MIPS benchmarks for these measures to score quality for MIPS eligible clinicians in these MIPS APMs at the APM Entity level (81 FR 77256, 77261). For these MIPS APMs, which we refer to as Web Interface reporters going forward, we established that quality performance data that are not submitted to the CMS Web Interface, for example the CAHPS for ACOs survey and claims-based measures, will not be included in the MIPS APM quality performance category score for 2017.

(aa) Addition of New Measures

For the Shared Savings Program and Next Generation ACO Model, we propose to score the CAHPS for ACOs survey, in addition to the CMS Web Interface measures that are used to calculate the MIPS APM quality performance category score for the Shared Savings Program and Next Generation ACO Model, beginning in the 2018 performance year. The CAHPS for ACOs survey is already required in the Shared Savings Program and Next Generation ACO Model, and including the CAHPS for ACOs survey would better align the measures on which

participants in these MIPS APMs are assessed under the APM scoring standard with the measures used to assess participants' quality performance under the APM.

We did not initially propose to include the CAHPS for ACOs survey as part of the MIPS APM quality performance category scoring for the Shared Savings Program and Next Generation ACO Model because we believed that the CAHPS for ACOs survey would not be collected and scored in time to produce a MIPS quality performance category score. However, operational efficiencies have recently been introduced that have made it possible to score the CAHPS for ACOs survey on the same timeline as the CAHPS for MIPS survey. Under our proposal, the CAHPS for ACOs survey would be added to the total number of quality performance category measures available for scoring in these MIPS APMs.

While the CAHPS for ACOs survey is new to MIPS APM scoring, the CG-CAHPS survey upon which it is based is also the basis for the CAHPS for MIPS survey, which was included on the MIPS final list for the 2017 performance year. For a further discussion of the CAHPS for ACOs survey, and the way it will be scored, we refer readers to II.C.6.b.(3)(a)(ii) of this proposed rule, which describes the identical CAHPS for MIPS survey and its scoring method that will be used for MIPS in the 2018 performance year. We note that although each question in the CAHPS for ACOs survey can also be found in the CAHPS for MIPS survey, the CAHPS for ACOs survey will have one fewer survey question the SSM entitled "Between Visit Communication", which has never been a scored measure with the Medicare Shared Savings Program CAHPS for ACOs Survey and which we believe to be inappropriate for use by ACOs.

TABLE 10: Web Interface Reporters: Shared Savings Program and Next Generation ACO Model New Measure

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
CAHPS for ACOs	N/A	Patient/ Caregiver Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (SSP) and Next Generation ACOs ask consumers about their experiences with health care. The CAHPS for ACOs Survey is collected from a sample of beneficiaries who get the majority of their care from an ACO, and the questions address care received from a named clinician within the ACO. Survey measures include: - Getting Timely Care, Appointments, and Information - How Well Your Providers Communicate - Patients' Rating of Providers - Access to Specialists - Health Promotion and Education - Shared Decision Making	Agency for Healthcare Research and Quality (AHRQ)

			- Health Status/ Functional Status - Stewardship of Patient Resources	

(B) Calculating Quality Scores

We refer readers to section II.C.7.a.(1)(h)(ii) of this proposed rule for our summary of finalized policies and proposed changes related to calculating the MIPS quality performance category percent score for MIPS eligible clinicians, including APM Entity groups reporting through the CMS Web Interface. Those policies and proposed changes in section II.C.7.a.(1)(h)(ii) of this proposed rule would apply in the same manner under the APM scoring standard except as otherwise noted in this section of the proposed rule. However, we propose not to subject MIPS APM Web Interface reporters to a 3 point floor because we do not believe it is necessary to apply this transition year policy to eligible clinicians participating in previously established MIPS APMs.

(C) Incentives to Report High Priority Measures

In the CY 2017 Quality Payment Program final rule, we finalized that for CMS Web Interface reporters, we will apply bonus points based on the finalized set of measures reportable through the CMS Web Interface. (81 FR 77291 through 77294). We will assign 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. We note that in addition to the measures required by the APM to be submitted through the CMS Web Interface, APM Entities in the Shared Savings Program and Next Generation ACO Models must also report the CAHPS for ACOs survey and we propose that beginning for the 2020 payment year forward they may receive bonus points under the APM scoring standard for submitting that measure. Participants in MIPS APMs, like all MIPS eligible clinicians, are also subject to the 10

percent cap on bonus points for reporting high priority measures. 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.

(D) Scoring Quality Improvement

Beginning in the CY 2018 performance year, section 1848(q)(5)(D)(i)(I) of the Act requires us to score improvement for the MIPS quality performance category for MIPS eligible clinicians, including those participating in MIPS APMs, if data sufficient to measure quality improvement are available. We propose to calculate the quality improvement score using the methodology described in section II.C.7.a.(1)(i) for scoring quality improvement for eligible clinicians submitting quality measures via the CMS Web Interface. We believe aligning the scoring methodology used for all CMS Web Interface submissions will minimize confusion among MIPS eligible clinicians receiving a MIPS score, including those participating in MIPS APMs.

(E) Total Quality Performance Category Score for CMS Web Interface Reporters

We propose to calculate the total quality percent score for MIPS eligible clinicians using the CMS Web Interface according to the methodology described in section II.C.7.a.(1)(h)(2) of this proposed rule.

We seek comment on our proposed quality performance category scoring methodology for CMS Web Interface reporters.

(ii) Other MIPS APMs

We propose to define the term Other MIPS APM at §414.1305 as a MIPS APM that does not require reporting through the CMS Web Interface. We propose to add this definition as we believe it will be useful in discussing our policies for the APM scoring standard. In the 2018

MIPS performance period, Other MIPS APMs will include the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model.

(A) Quality Measures

In the CY 2017 Quality Payment Program final rule, we explained that current MIPS APMs have requirements regarding the number of quality measures, measure specifications, as well as the measure reporting method(s) and frequency of reporting, and have an established mechanism for submission of these measures to us within the structure of the specific MIPS APM. We explained that operational considerations and constraints interfered with our ability to use the quality measure data from some MIPS APMs for the purpose of satisfying MIPS data submission requirements for the quality performance category for the first performance year. We concluded that there was insufficient time to adequately implement changes to the current MIPS APM quality measure data collection timelines and infrastructure in the first performance year to conduct a smooth hand-off to the MIPS system that would enable use of APM quality measure data to satisfy the MIPS quality performance category requirements in the first MIPS performance year (81 FR 77264). Out of concern that subjecting MIPS eligible clinicians who participate in MIPS APMs to multiple, potentially duplicative or inconsistent performance assessments could undermine the validity of testing or performance evaluation under the MIPS APMs; and that there was insufficient time to make adjustments in operationally complex systems and processes related to the alignment, submission and collection of APM quality measures for purposes of MIPS, we used our authority under section 1115A(d)(1) to waive certain requirements of section 1848(q).

We finalized that for the first MIPS performance year only, for MIPS eligible clinicians participating in APM Entities in Other MIPS APMs, the weight for the quality performance category is zero (81 FR 77268). To avoid risking adverse operational or program evaluation consequences for MIPS APMs while we worked toward incorporating MIPS APM quality

measures into scoring for future performance years, we used the authority provided by section 1115A(d)(1) of the Act to waive the quality performance category weight required under section 1848(q)(5)(E)(i)(I) of the Act, and we indicated that with the reduction of the quality performance category weight to zero, it was unnecessary to establish for MIPS APMs a final list of quality measures as required under section 1848(q)(2)(D) of the Act or to specify and use quality measures in determining the MIPS final score for these MIPS eligible clinicians. As such, we further waived the requirements under sections 1848(q)(2)(D), 1848(q)(2)(B)(i) and 1848(q)(2)(A)(i) of the Act to establish a final list of quality measures (using certain criteria and processes); and to specify and use, respectively, quality measures in calculating the MIPS final score for the first MIPS performance year.

In the CY 2017 Quality Payment Program final rule, we anticipated that beginning with the second MIPS performance year, the APM quality measure data submitted to us during the MIPS performance year would be used to derive a MIPS quality performance score for APM Entities in all MIPS APMs.

We also anticipated that it may be necessary to propose policies and waivers of requirements of the statute, such as section 1848(q)(2)(D) of the Act, to enable the use of non-MIPS quality measures in the quality performance category score. We anticipated that by the second performance year we would have had sufficient time to resolve operational constraints related to use of separate quality measure systems and to adjust quality measure data submission timelines. Accordingly, we stated our intention to, in future rulemaking, use our section 1115A(d)(1) waiver authority to establish that the quality measures and data that are used to evaluate performance for APM Entities in MIPS APMs would be used to calculate a MIPS quality performance score under the APM scoring standard.

We have since designed the means to overcome the operational constraints that prevented us from scoring quality under the APM scoring standard in the first performance year, and we

propose to adopt quality measures for use under the APM scoring standard, and begin collecting MIPS APM quality measure performance data in order to generate a MIPS quality performance category score for APM Entities participating in MIPS APMs beginning with the 2018 performance year.

(aa) APM Measures for MIPS

In the CY 2017 Quality Payment Program final rule, we explained the concerns that led us to express our intent to use the quality measures and data that apply in the MIPS APM for purposes of the APM scoring standard, including concerns about the application of multiple, potentially duplicative or inconsistent performance assessments that could negatively impact our ability to evaluate MIPS APMs (81 FR 77246). Additionally, the quality and cost/utilization measures that are used to calculate performance-based payments in MIPS APMs may vary from one MIPS APM to another. Factors such as the type and quantity of measures required, the MIPS APM's particular measure specifications, how frequently the measures must be reported, and the mechanisms used to collect or submit the measures all add to the diversity in the quality and cost/utilization measures used to evaluate performance among MIPS APMs. Given these concerns and the differences between and among the quality measures used to evaluate performance within MIPS APMs as opposed to those used more generally under MIPS, we propose to use our authority under section 1115A(d)(1) of the Act to waive requirements under section 1848(q)(2)(D) of the Act, which requires the Secretary to use certain criteria and processes to establish an annual MIPS final list of quality measures from which all MIPS eligible clinicians may choose measures for purposes of assessment, and instead to establish a MIPS APM quality measure list for purposes of the APM scoring standard. The MIPS APM quality measure list would be adopted as the final list of MIPS quality measures under the APM scoring standard, and would reflect the quality measures that are used to evaluate performance on quality within each MIPS APM.

The MIPS APM quality measure list we propose in Table 13, would define distinct measure sets for participants in each MIPS APM for purposes of the APM scoring standard, based on the measures that are used by the APM, and for which data will be collected by the close of the MIPS submission period. The measure sets on the MIPS APM measure list would represent all possible measures which may contribute to an APM Entity's MIPS score for the MIPS quality performance category, and may include measures that are the same as or similar to those used by MIPS. However, measures may ultimately not be used for scoring if a measure's data becomes inappropriate or unavailable for scoring; for example, if a measure's clinical guidelines are changed or the measure is otherwise modified by the APM during the performance year, the data collected during that performance year would not be uniform, and as such may be rendered unusable for purposes of the APM scoring standard (See Tables 14, 15, and 16).

(B) Measure Requirements for Other MIPS APMs

Because the quality measure sets for each Other MIPS APM are unique, we propose to calculate the MIPS quality performance category score using APM-specific quality measures. For purposes of the APM scoring standard, we will score only measures that: (1) are tied to payment as described under the terms of the APM, (2) are available for scoring near the close of the MIPS submission period, (3) have a minimum of 20 cases available for reporting, and (4) have an available benchmark. We discuss each of these requirements for Other MIPS APM quality measures below.

(aa) Tied to Payment

For purposes of the APM scoring standard, we will consider a measure to be tied to payment if an APM Entity group will receive a payment adjustment or other incentive payment under the terms of the APM, based on the APM Entity's performance on the measure.

(bb) Available for Scoring

Some MIPS APM quality measure results are not available until late in the calendar year subsequent to the MIPS performance year, which would prevent us from including them in the MIPS APM quality performance category score due to the larger programmatic timelines for providing MIPS eligible clinician performance feedback by July and issuing budget-neutral MIPS payment adjustments. Consequently, we propose to only use the MIPS APM quality measure data that are submitted by the close of the MIPS submission period and are available for scoring in time for inclusion to calculate a MIPS quality performance category score. Measures are to be submitted according to requirements under the terms of the APM; the measure data will then be aggregated and prepared for submission to MIPS for the purpose of creating a MIPS quality performance category score.

We believe using the Other MIPS APMs' quality measure data that have been submitted no later than the close of the MIPS submission period and have been processed and made available to MIPS for scoring in time to calculate a MIPS quality performance category score is consistent with our intent to decrease duplicative reporting for MIPS eligible clinicians who would otherwise need to report quality measures to both MIPS and their APM. Going forward, these are the measures to which we are referring when we limit scoring to measures that are available near the close of the MIPS submission period.

(cc) 20 Case Minimum

We also believe that a 20 case minimum, in alignment with the one finalized generally under MIPS in the CY 2017 Quality Payment Program final rule (81 FR 77288), is necessary to ensure the reliability of the measure data submitted, as explained the CY 2017 Quality Payment Program final rule.

As under the general policy for MIPS, when an APM Entity reports a quality measure that includes less than 20 cases, that measure would receive a null score for that measure's achievement points, and the measure would be removed from both the numerator and the

denominator of the MIPS quality performance category percentage. We propose to apply this policy under the APM scoring standard.

(dd) Available Benchmark

An APM Entity's score on each quality measure would be calculated in part by comparing the APM Entity's performance on the measure with a benchmark performance score. Therefore, we would need all scored measures to have a benchmark available by the time that the MIPS quality performance category score is calculated, in order to make that comparison.

We propose that, for the APM scoring standard, the benchmark score used for a quality measure would be the benchmark used in the MIPS APM for calculation of the performance based payments, where such a benchmark is available. If the APM does not produce a benchmark score for a reportable measure that is included on the APM measures list, we would use the benchmark score for the measure that is used for the MIPS quality performance category generally (outside of the APM scoring standard) for that performance year, provided the measure specifications for the measure are the same under both the MIPS final list and the APM measures list. If neither the APM nor MIPS has a benchmark available for a reported measure, the APM Entity that reported that measure would receive a null score for that measure's achievement points, and the measure would be removed from both the numerator and the denominator of the quality performance category percentage.

(C) Calculating the Quality Performance Category Percent Score

Eligible clinicians who participate in Other MIPS APMs are subject to specific quality measure reporting requirements within these APMs. To best align with APM design and objectives, we propose 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 in the calculation for the APM Entity score under the APM scoring standard. For example, if an Other MIPS APM

requires participating APM Entities to report nine of 14 quality measures by a specific date and the APM Entity misses the MIPS submission deadline, then for the purposes of calculating an APM Entity quality performance category score, the APM Entity would receive a zero for those measures. An APM Entity that does not submit any APM quality measures by the MIPS submission deadline would receive a zero for its MIPS APM quality performance category percent score for the performance year.

We propose that if an APM Entity submits some, but not all of the measures required by the MIPS APM by the close of the MIPS submission period, the APM Entity would receive points for the measures that were submitted, but would receive a score of 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.

For example, if an APM Entity in the above hypothetical MIPS APM submits quality performance data on three of the APM's measures, instead of the required nine, the APM Entity would receive quality points in the APM scoring standard quality performance category percent score for the three measures it submitted, but would receive zero points for each of the six remaining measures that were required under the terms of the MIPS APM. On the other hand, if an APM Entity reports on more than the minimum number of measures required to be reported under the MIPS APM and the measures meet the other criteria for scoring, only the measures with the highest scores, up to the number of measures required to be reported under the MIPS APM, would be counted; however, any bonus points earned by reporting on measures beyond the minimum number of required measures would be awarded.

If a measure is reported but fails to meet the 20 case minimum or does not have a benchmark available, there would be a null score for that measure, and it would be removed from both the numerator and the denominator, so as not to negatively affect the APM Entity's quality performance category score.

We propose to assign bonus points for reporting high priority measures or measures with end-to-end CEHRT reporting as described for general MIPS scoring in the CY 2017 Quality Payment Program final rule (81 FR 77297 through 77299).

(aa) Quality Measure Benchmarks

An APM Entity's MIPS quality measure score will be calculated by comparing the APM Entity's performance on a given measure with a benchmark performance score. We propose that the benchmark score used for a quality measure would be the benchmark used by the MIPS APM for calculation of the performance based payments within the APM, if possible, in order to best align the measure performance outcomes between the APM and MIPS programs. If the MIPS APM does not produce a benchmark score for a reportable measure that will be available at the close of the MIPS submission period, the benchmark score for the measure that is used for the MIPS quality performance category generally for that performance year would be used, provided the measure specifications are the same for both. If neither the APM nor MIPS has a benchmark available for a reported measure, the APM Entity that reported that measure will receive a null score for that measure's achievement points, and the measure will be removed from both the numerator and the denominator of the quality performance category percentage.

We are proposing that for measures that are pay for reporting or which do not measure performance on a continuum of performance, we will consider these measures to be lacking a benchmark and they will be treated as such. For example, if a model only requires that an APM Entity must surpass a threshold and does not measure APM Entities on performance beyond surpassing a threshold, we would not consider such a measure to measure performance on a continuum.

We propose to score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories, as described in the finalized MIPS quality scoring methodology (81 FR 77282 through 77284). For each benchmark, we will

calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls.

We propose to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile. For example, a raw score of 55 percent would fall within the sixth decile of 41.0 percent to 61.9 percent and would receive between 6.0 and 6.9 points.

We seek comment on this proposed method.

TABLE 11: Benchmark Decile Distribution

Sample Benchmark Decile	Sample Quality Measure	Graduated Points (with no floor)
Example Benchmark Decile 1	0-9.9%	1.0-1.9
Example Benchmark Decile 2	10.0%-17.9%	2.0-2.9
Example Benchmark Decile 3	18.0%-22.9%	3.0-3.9
Example Benchmark Decile 4	23.0-35.9%	4.0-4.9
Example Benchmark Decile 5	36.0-40.9%	5.0-5.9
Example Benchmark Decile 6	41.0-61.9%	6.0-6.9
Example Benchmark Decile 7	62.0-68.9%	7.0-7.9
Example Benchmark Decile 8	69.0-78.9%	8.0-8.9
Example Benchmark Decile 9	79.0-84.9%	9.0-9.9
Example Benchmark Decile 10	85.0%-100%	10.0

(bb) Assigning Quality Measure Points Based on Achievement

For the APM scoring standard quality performance category, we propose that each APM Entity that reports on quality measures would receive between 1 and 10 achievement points for each measure reported that can be reliably scored against a benchmark, up to the number of measures that are required to be reported by the APM. Because measures that lack benchmarks or 20 reported cases are removed from the numerator and denominator of the quality

performance category percentage, it is unnecessary to include a point-floor for scoring of Other MIPS APMs. Similarly, because the quality measures reported by the MIPS APM for MIPS eligible clinicians under the APM scoring standard are required to be submitted to the APM under the terms of participation in the APM, and the MIPS eligible clinicians do not select their APM measures, there will be no cap on topped out measures for MIPS APM participants being scored under the APM scoring standard, which differs from the policy for other MIPS eligible clinicians proposed at section II.C.7.a.(2)(c) of this proposed rule.

Beginning in the 2018 MIPS performance year, we propose that APM Entities in MIPS APMs, like other MIPS eligible clinicians, would be eligible to receive bonus points for the MIPS quality performance category for reporting on high priority measures or measures submitted via CEHRT (for example, end-to-end submission) according to the criteria described in section II.C.7.a.(1) of this proposed rule. For each Other MIPS APM, we propose to identify whether any of their available measures meets the criteria to receive a bonus, and add the bonus points to the quality achievement points. Further, we propose that the total number of awarded bonus points may not exceed 10 percent of the APM Entity's total available achievement points for the MIPS quality performance category score.

To generate the APM Entity's quality performance category percentage, achievement points would be added to any applicable bonus points, and then divided by the total number of available achievement points, with a cap of 100 percent. For more detail on the MIPS quality performance category percentage score calculation, we refer readers to section II.C.7.a.(1) of this proposed rule.

Under the APM scoring standard for Other MIPS APMs, the number of available achievement points would be the number of measures required under the terms of the APM and available for scoring multiplied by ten. If, however, an APM Entity reports on a required measure that fails the 20 case minimum requirement, or which has no available benchmark for

that performance year, the measure would receive a null score and all points from that measure would be removed from both the numerator and the denominator.

For example, if an APM Entity reports on four out of four measures required to be reported by the MIPS APM, and receives an achievement score of five on each and no bonus points, the APM Entity's quality performance category percentage would be [(5 points x 4 measures)+0 bonus points]/(4 measures x 10 max available points), or 50 percent. If, however, one of those measures failed the 20 case minimum requirement or had no benchmark available, that measure would have a null value and would be removed from both the numerator and denominator to create a quality performance category percentage of [(5 points x 3 measures)+0 bonus points]/(3measures x 10 max available points), or 50 percent.

If an APM Entity fails to meet the 20 case minimum on all available APM measures, that APM Entity would have its quality performance category score reweighted to zero, as described below.

We request comment on the above proposals for calculating the quality category percent score.

(D) Quality Improvement Scoring

Beginning in the 2018 performance year, we propose to score improvement as well as achievement in the quality performance category.

For the APM scoring standard, we propose that the quality improvement percentage points would be awarded based on the following formula:

Quality Improvement Score = (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points) / 10

For a more detailed discussion of improvement scoring for the quality performance category under the APM scoring standard, we refer readers to the discussion on calculating

improvement at the quality performance category level for MIPS at section II.C.7.a.(1)(i) of this proposed rule.

(E) Calculating Total Quality Performance Category Score

We propose that the APM Entity's total quality performance category score would be equal to [(achievement points + bonus points)/ total available achievement points] + quality improvement score. The APM Entity's total quality performance category score may not exceed 100 percent. We request comment on the above proposed quality scoring methodology.

We seek comment on the proposed quality performance category scoring methodology for APM Entities participating in Other MIPS APMs.

(c) Improvement Activities Performance Category

As finalized in the CY 2017 Quality Payment Program final rule, for all MIPS APMs we will assign the same improvement activities score to each APM Entity based on the activities involved in participation in a MIPS APM. APM Entities will receive a minimum of one half of the total possible points. This policy is in accordance with section 1848(q)(5)(C)(ii) of the Act. In the event that the assigned score does not represent the maximum improvement activities score, the APM Entity group will have the opportunity to report additional improvement activities to add points to the APM Entity level score.

(d) Advancing Care Information Performance Category

In the CY 2017 Quality Payment Program final rule, we finalized our policy to attribute one score to each MIPS eligible clinician in an APM Entity group by looking for both individual and group TIN level data submitted for a MIPS eligible clinician, and using the highest available score (81 FR 77268). We will then use these scores to create an APM Entity's score based on the average of the highest scores available for all MIPS eligible clinicians in the APM Entity group. If an individual or TIN did not report on the advancing care information 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, and we will use these to calculate a single APM Entity-level advancing care information performance category score.

We refer readers to section II.C.6.f.(6) of this proposed rule for our summary of proposed changes related to scoring the advancing care information performance category.

(i) Special Circumstances

As described in the CY 2017 Quality Payment Program final rule (81 FR 77238-77245), under the generally applicable MIPS scoring standard, we will assign a weight of zero percent to the advancing care information performance category in the final score for MIPS eligible clinicians who meet specific criteria: hospital-based MIPS eligible clinicians, MIPS eligible clinicians who are facing a significant hardship, and certain types of non-physician practitioners (NPs, PAs, CRNAs, CNSs) who are MIPS eligible clinicians. In section II.C.7.a.(6) of this proposed rule, we are also proposing to include in this weighting policy ASC-based MIPS eligible clinicians and MIPS eligible clinicians who are using decertified EHR technology.

Under the APM scoring standard, we propose that if a MIPS eligible clinician who qualifies for a zero percent weighting of the advancing care information performance category in the final score is part of a TIN that includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting , we would not apply the zero percent weighting to the qualifying MIPS eligible clinician, and the TIN would still be required to report on behalf of the group, although the TIN would not need to report data for the qualifying MIPS eligible clinician. All MIPS eligible clinicians in the TIN would count towards the TIN's weight when calculating an aggregated APM Entity score for the advancing care information performance category.

If, however, the MIPS eligible clinician is a solo practitioner and qualifies for a zero percent weighting, or if all MIPS eligible clinicians in a TIN qualify for the zero percent weighting, the TIN would not be required to report on the advancing care information

performance category, and if the TIN chooses not to report that TIN would be assigned a weight of 0 when calculating the APM Entity's advancing care information performance category score.

If advancing care information data are reported by one or more TINs in an APM Entity, an advancing care information performance category score will be calculated for, and will be applicable to, all MIPS eligible clinicians in the APM Entity group. If all MIPS eligible clinicians in all TINs in an APM Entity group qualify for a zero percent weighting of have the advancing care information performance category, or in the case of a solo practitioner who comprises an entire APM Entity and qualifies for zero percent weighting, the advancing care information performance category would be weighted at zero percent of the final score, and the advancing care information performance category's weight would be redistributed to the quality performance category.

(4) Calculating Total APM Entity Score

(a) Performance Category Weighting

As discussed in section II.C.6.g.(3)(a) of this proposed rule, we propose to continue to use our authority to waive sections 1848(q)(2)(B)(ii) and 1848(q)(2)(A)(ii) of the Act to specify and use, respectively, cost measures; and to maintain the cost performance category weight of zero under the APM scoring standard for the 2018 performance period and subsequent MIPS performance periods. Because the cost performance category would be reweighted to zero that weight would need to be redistributed to other performance categories. We propose to use our authority under section 1115A(d)(1) to waive requirements under sections 1848(q)(5)(E)(i)(I)(bb), 1848(q)(5)(E)(i)(III) and 1848(q)(5)(E)(i)(IV) of the Act that prescribe the weights, respectively, for the quality, improvement activities, and ACI performance categories. We propose to weight the quality performance category score to 50 percent, the improvement activities performance category to 20 percent, and the advancing care information performance category to 30 percent of the final score for all APM Entities in Other MIPS APMs.

We propose these weights to align the Other MIPS APM performance category weights with those assigned to the Web Interface reporters, which we adopted as explained in the CY 2017 Quality Payment Program final rule at 81 FR 77262 through 77263. We believe it is appropriate to align the performance category weights for APM Entities in MIPS APMs that require reporting through the Web Interface with those in Other MIPS APMs. By aligning the performance category weights among all MIPS APMs, we would create greater scoring parity among the MIPS eligible clinicians in MIPS APMs who are being scored under the APM scoring standard. These proposals are summarized in Table 12.

TABLE 12: APM Scoring Standard Performance Category Weights– Beginning for the 2018 Performance Period

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

MIPS Performance Category	APM Entity Submission Requirement	Performance Category Score	Performance Category Weight
Advancing Care Information	Each MIPS eligible clinician in the APM Entity group is required to report advancing care information to MIPS through either group TIN or individual reporting.	We will attribute the same score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinicians will be averaged for a single APM Entity score.	30%

It is possible that there could be instances where an Other MIPS APM has no measures available to score for the quality performance category for a MIPS performance period; for example, it is possible that none of the Other MIPS APM's measures would be available for calculating a quality performance category score by or shortly after the close of the MIPS submission period because the measures were removed due to changes in clinical practice guidelines. In addition, as explained in section II.C.6.g.(3)(d)(i) of this proposed rule, the MIPS eligible clinicians in an APM Entity may qualify for a zero percent weighting for the advancing care information performance category. In such instances, under the APM scoring standard, we propose to reweight the affected performance category to zero, in accordance with section 1848(q)(5)(F) of the Act.

If the quality performance category is reweighted to zero, we propose to reweight the improvement activities and advancing care information performance categories to 25 and 75 percent, respectively. If the advancing care information performance category is reweighted to zero, the quality performance category weight would be increased to 80 percent. These proposals are summarized in Table 13.

TABLE 13: APM Scoring Standard Performance Category Weights for Other MIPS APMs with Performance Categories Weighted to 0– beginning for the 2018 Performance Period

MIPS Performance Category	APM Entity Submission Requirement	Performance Category Score	Performance Category Weight (No Quality)	Performance Category Weight (No Advancing Care Information)
Quality	The APM Entity would not be assessed on quality under MIPS if no quality data are available at the close of the MIPS submission period. The APM Entity will submit quality measures to CMS as required by the MIPS APM.	CMS will assign the same quality category performance score to each TIN/ NPI in an APM Entity group based on the APM Entity's total quality score, derived from available APM quality measures.	0%	80%
Cost	The APM Entity group will not be assessed on cost under MIPS.	N/A	0%	0%
Improvement Activities	MIPS eligible clinicians do not need to report improvement activities data unless the CMS-assigned improvement activities scores is below the maximum improvement activities score.	CMS will assign the same improvement activities score to each APM Entity group based on the activities involved in participation in the MIPS APM. APM Entities will receive a minimum of one half of the total possible points. In the event that the assigned score does not represent the maximum improvement activities score, the APM Entity will have the opportunity to report additional improvement activities to add points to the APM Entity level score.	25%	20%
Advancing Care Information	Each MIPS eligible clinician in the APM Entity group reports advancing care information to MIPS through either group TIN or individual reporting.	We will attribute the same score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinicians will be averaged for a single APM Entity score.	75%	0%

We seek comment on the proposed reweighting for APM Entities participating in MIPS APMs.

(b) Risk Factor Score

Section 1848(q)(1)(G) of the Act requires us to consider risk factors in our scoring methodology. Specifically, that section provides that the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on individuals' health status and other risk factors, assess appropriate adjustments to quality measures, cost measures, and other measures used under MIPS and assess and implement appropriate adjustments to payment adjustments, final scores, scores for performance categories, or scores for measures or activities under the MIPS.

We refer readers to II.C.7.b.(1) of this proposed rule for a description of the risk factor adjustment and its application to APM Entities.

(c) Small Practice Bonus

We believe an adjustment for eligible clinicians in small practices (referred to herein as the small practice bonus) is appropriate to recognize barriers faced by small practices, such as unique challenges related to financial and other resources, environmental factors, and access to health information technology, and to incentivize eligible clinicians in small practices to participate in the Quality Payment Program and to overcome any performance discrepancy due to practice size.

We refer readers to section II.C.7.b.(2) of this proposed rule for a discussion of the small practice adjustment and its application to APM Entities.

(d) Final Score Methodology

In the CY 2017 Quality Payment Program final rule, we finalized the methodology for calculating a final score of 0-100 based on the four performance categories (81 FR 77320). We refer readers to section II.C.7.c. of this proposed rule for a discussion of the changes we are proposing for the final score methodology.

(5) MIPS APM Performance Feedback

In the CY 2017 Quality Payment Program final rule (81 FR 77270), we finalized that all MIPS eligible clinicians scored under the APM scoring standard will receive performance feedback as specified under section 1848(q)(12) of the Act on the quality and cost performance categories to the extent applicable, based on data collected in the September 2016 QRUR, unless they did not have data included in the September 2016 QRUR. Those eligible clinicians without data included in the September 2016 QRUR will not receive any performance feedback until performance data is available for feedback.

Beginning with the 2018 performance year, we propose that MIPS eligible clinicians whose MIPS payment adjustment is based on their score under the APM scoring standard will receive performance feedback as specified under section 1848(q)(12) of the Act for the quality, advancing care information, and improvement activities performance categories to the extent data are available for the MIPS performance year. Further, we propose 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 zero for that performance year, we would not provide performance feedback on that MIPS performance category.

We believe that with an APM Entity's finite resources for engaging in efforts to improve quality and lower costs for a 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. The potential for different, conflicting messages in performance feedback provided by the APMs and that provided by MIPS may create uncertainty for MIPS eligible clinicians who are attempting to strategically transform their respective practices and succeed under the terms of the APM. Accordingly, under section 1115A(d)(1) and section 1899(f), for all performance years we propose to waive—for MIPS eligible clinicians participating in MIPS APMs—the requirement

under section 1848(q)(12)(A)(i)(I) of the Act to provide performance feedback for the cost performance category.

We request comment on these proposals to waive requirements for performance feedback on the cost performance category indefinitely, and for the other performance categories in years for which the weight for those categories has been reweighted to zero.

(6) Summary of Proposals

In summary, we have proposed the following in this section:

- We propose to amend the regulation at §414.1370(e) to identify the four assessment dates that would be used to identify the APM Entity group for purposes of the APM scoring standard, and to specify that the December 31 date will be used only to identify eligible clinicians on the APM Entity's Participation List for a MIPS APM that is a full TIN APM in order to add them to the APM Entity group that is scored under the APM scoring standard. We propose to use this fourth assessment date of December 31 to extend the APM scoring standard to only those MIPS eligible clinicians participating in MIPS APMs that are full TIN APMs, ensuring that an eligible clinician who joins the full TIN APM late in the performance year would be scored under the APM scoring standard.

- We propose to continue to weight the cost performance category under the APM scoring standard for Web Interface reporters at zero percent for the 2020 payment year forward.

- Aligned with our proposal to weight the cost performance category at zero percent, we propose not to take improvement into account for performance scores in the cost performance category for Web Interface reporters beginning with the 2020 MIPS Payment Year.

- We propose to score the CAHPS for ACOs survey, in addition to the CMS Web Interface measures that are used to calculate the MIPS APM quality performance category score for Web Interface reporters including the Shared Savings Program and Next Generation ACO Model), beginning in the 2018 performance year.

- We propose that, beginning for the 2018 performance year, eligible clinicians in MIPS APMs that are Web Interface reporters may receive bonus points under the APM scoring standard for submitting the CAHPS for ACOs survey.

- We propose to calculate the quality improvement score for MIPS eligible clinicians submitting quality measures via the CMS Web Interface using the methodology described in section II.C.7.a.(1)(i).

- We propose to calculate the total quality percent score for MIPS eligible clinicians using the CMS Web Interface according to the methodology described in section II.C.7.a.(1)(h)(2) of this proposed rule.

- We propose to establish a separate MIPS final list of quality measures for each Other MIPS APM that would be the quality measure list used for purposes of the APM scoring standard.

- We propose to calculate the MIPS quality performance category score for Other MIPS APMs using MIPS APM-specific quality measures. For purposes of the APM scoring standard, we would score only measures that: (1) are tied to payment as described under the terms of the APM, (2) are available for scoring near the close of the MIPS submission period, (3) have a minimum of 20 cases available for reporting, and (4) have an available benchmark.

- We propose to only use the MIPS APM quality measure data that are submitted by the close of the MIPS submission period and are available for scoring in time for inclusion to calculate a MIPS quality performance category score.

- We propose that, for the APM scoring standard, the benchmark score used for a quality measure would be the benchmark used in the MIPS APM for calculation of the performance based payments, where such a benchmark is available. If the APM does not produce a benchmark score for a reportable measure that is included on the APM measures list, we would use the benchmark score for the measure that is used for the MIPS quality performance category

generally (outside of the APM scoring standard) for that performance year, provided the measure specifications for the measure are the same under both the MIPS final list and the APM measures list.

- We propose that the minimum number of quality measures required to be reported for the APM scoring standard would be the minimum number of quality measures that are required within the MIPS APM and are collected and available in time to be included in the calculation for the APM Entity score under the APM scoring standard. We propose that if an APM Entity submits some, but not all of the measures required by the MIPS APM by the close of the MIPS submission period, the APM Entity would receive points for the measures that were submitted, but would receive a score of 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.

- We propose that the benchmark score used for a quality measure would be the benchmark used by the MIPS APM for calculation of the performance based payments within the APM, if possible, in order to best align the measure performance outcomes between the two programs. We are proposing that for measures that are pay for reporting or which do not measure performance on a continuum of performance, we will consider these measures to be lacking a benchmark and they will be treated as such.

- We propose to score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories, as described in the finalized MIPS quality scoring methodology. We propose to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile.

- We propose that each APM Entity that reports on quality measures would receive between 1 and 10 achievement points for each measure reported that can be reliably scored against a benchmark, up to the number of measures that are required to be reported by the APM.

- We propose that APM Entities in MIPS APMs, like other MIPS eligible clinicians, would be eligible to receive bonus points for the MIPS quality performance category for reporting on high priority measures or measures submitted via CEHRT. For each Other MIPS APM, we propose to identify whether any of their available measures meets the criteria to receive a bonus, and add the bonus points to the quality achievement points.

- Beginning in the 2018 performance year, we propose to score improvement as well as achievement in the quality performance category. For the APM scoring standard, we propose that the improvement percentage points would be awarded based on the following formula:

Quality Improvement Score = (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points) / 10.

- We propose that the APM Entity's total quality performance category score would be equal to [(achievement points + bonus points)/ total available achievement points] + quality improvement score.

- Under the APM scoring standard, we propose that if a MIPS eligible clinician who qualifies for a zero percent weighting of the advancing care information performance category in the final score is part of a TIN that includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting , we would not apply the zero percent weighting to the qualifying MIPS eligible clinician, and the TIN would still be required to report on behalf of the group, although the TIN would not need to report data for the qualifying MIPS eligible clinician.

- We propose to maintain the cost performance category weight of zero for Other MIPS APMs under the APM scoring standard for the 2020 MIPS payment year and subsequent MIPS payment years. Because the cost performance category would be reweighted to zero that weight would need to be redistributed to other performance categories. We propose to align the Other MIPS APM performance category weights with those proposed for Web Interface reporters and weight the quality performance category to 50 percent, the improvement activities performance

category to 20 percent, and the advancing care information performance category to 30 percent of the APM Entity final score.

- It is possible that none of the Other MIPS APM's measures would be available for calculating a quality performance category score by or shortly after the close of the MIPS submission period, for example, due to changes in clinical practice guidelines. In addition, the MIPS eligible clinicians in an APM Entity may qualify for a zero percent weighting for the advancing care information performance category. In such instances, under the APM scoring standard, we propose to reweight the affected performance category to zero.

- Beginning with the 2018 performance year, we propose that MIPS eligible clinicians whose MIPS payment adjustment is based on their score under the APM scoring standard will receive performance feedback as specified under section 1848(q)(12) of the Act for the quality, advancing care information, and improvement activities performance categories to the extent data are available for the MIPS performance year. Further, we propose that in cases where the MIPS APM performance category has been weighted to zero for that performance year, we would not provide performance feedback on that MIPS performance category.

The following tables represent the measures being introduced for notice and comment, and would serve as the measure set used by participants in the identified MIPS APMs in order to create a MIPS score under the APM scoring standard, as described in section II.C.6.g.(3)(b)(ii)(A) of this proposed rule. Once this list is finalized, no measures may be added to this list.

TABLE 14: MIPS APM Measures List—Oncology Care Model

Measure Name	NQF/ Quality Number (if applicable	National Quality Strategy Domain	Measure Description	Primary Measure Steward
Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	NA	Effective Clinical Care	Percentage of OCM-attributed FFS beneficiaries who were had an acute-care hospital stay during the measurement period	NA
Risk-adjusted proportion of patients with all-cause ED visits or observation stays that did not result in a hospital admission within the 6-month episode	NA	Effective Clinical Care	Percentage of OCM-attributed FFS beneficiaries who had an ER visit that did not result in a hospital stay during the measurement period	
Proportion of patients who died who were admitted to hospice for 3 days or more	NA	Effective Clinical Care	Percentage of OCM-attributed FFS beneficiaries who died and spent at least 3 days in hospice during the measurement time period	NA
Oncology: Medical and Radiation – Pain Intensity Quantified	0384/143	Person and Caregiver Centered Experience	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Physician Consortium for Performance Improvement Foundations (PCPI)
Oncology: Medical and Radiation – Plan of Care for Pain	0383/144	Person and Caregiver Centered Experience	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	American Society of Clinical Oncology
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	0418/134	Community/ Population Health	Percentage of patients aged 12 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is	Centers for Medicare & Medicaid Services

Measure Name	NQF/ Quality Number (if applicable	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			documented on the date of the positive screen	
Patient-Reported Experience of Care	NA	Person and Caregiver Centered Experience	Summary/Survey Measures may include: - Overall measure of patient experience - Exchanging Information with Patients - Access - Shared Decision Making - Enabling Self-Management - Affective Communicatio n	NA
Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer	0390/104	Effective Clinical Care	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam and radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin releasing hormone] agonist or antagonist)	American Urological Association Education and Research
Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer.	0223	Communicatio n and Care Coordination	Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is recommended and not received or administered within 4 months (120 days) of diagnosis	Commission on Cancer, American College of Surgeons
Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone	0559	Communicatio n and Care Coordination	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage T1cN0M0 (tumor greater than 1 cm), or Stage IB -III, whose primary tumor is	Commission on Cancer, American College of Surgeons

Measure Name	NQF/ Quality Number (if applicable	National Quality Strategy Domain	Measure Description	Primary Measure Steward
receptor negative breast cancer			progesterone and estrogen receptor negative recommended for multiagent chemotherapy (recommended or administered) within 4 months (120 days) of diagnosis	
Trastuzumab administered to patients with AJCC stage I (T1c) - III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy	1858/450	Efficiency and Cost Reduction	Proportion of female patients (aged 18 years and older) with AJCC stage I (Tlc)- Ill, human epidermal growth factor receptor 2 (HER2) positive breast cancer receiving adjuvant chemotherapy	American Society of Clinical Oncology
Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	0387	Communication and Care Coordination	Percentage of female patients aged 18 years and older with Stage I (T1b) through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	AMA-convened Physician Consortium for Performance Improvement
Documentation of Current Medications in the Medical Record	0419/130	Patient Safety	Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary AND must contain the medications' name, dosage, frequency and route of administration	Centers for Medicare & Medicaid Services

TABLE 15: MIPS APM Measures List— Comprehensive ESRD Care

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
ESCO Standardized Mortality Ratio	0101/154	Patient Safety	Falls: Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within for Quality 12 months	National Committee for Quality Assurance
Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls	0101/154	Communication and Coordination	Falls: Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within for Quality 12 months	National Committee for Quality Assurance
Advance Care Plan	0326/ 47	Patient Safety	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	National Committee for Quality Assurance
ICH-CAHPS: Nephrologists' Communication and Caring	0258	Person and Caregiver Centered Experience and Outcome	Summary/Survey Measures may include: - Getting timely care, appointments, and information - How well providers communicate - Patients' rating of provider - Access to specialists - Health promotion and education - Shared Decision-making - Health status and functional status - Courteous and	Agency for Healthcare Research and Quality

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			helpful office staff - Care coordination - Between visit communication - Helping you to take medications as directed, and - Stewardship of patient resources	
ICH-CAHPS: ICH-CAHPS: Rating of Dialysis Center	0258	Person and Caregiver Centered Experience and Outcome	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease	Agency for Healthcare Research and Quality
ICH-CAHPS: Quality of Dialysis Center Care and Operations	0258		Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease	Agency for Healthcare Research and Quality
ICH-CAHPS: Providing Information to Patients	0258		Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-	Agency for Healthcare Research and Quality

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			medical staff, the quality of dialysis care they receive, and information sharing about their disease	
ICH-CAHPS: Rating of Kidney Doctors	0258		Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease	Agency for Healthcare Research and Quality
ICH-CAHPS: Rating of Dialysis Center Staff ICH-CAHPS: Rating of Dialysis Center	0258		Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease	Agency for Healthcare Research and Quality
Medication Reconciliation Post Discharge	0554	Communication and Care Coordination	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following the discharge in the office by the physicians, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom	National Committee for Quality Assurance

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and Older	
Diabetes Care: Eye Exam	0055/117	Effective Clinical Care	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	National Committee for Quality Assurance
Diabetes Care: Foot Exam	0056/163	Effective Clinical Care	Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the previous measurement year	National Committee for Quality Assurance
Influenza Immunization for the ESRD Population	0041/110, 0226	Community/ Population Health	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Kidney Care Quality Alliance (KCQA)
Pneumococcal Vaccination Status	0043/111	Community/ Population Health	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
Screening for	0418/134	Community/	Percentage of patients	Centers for Medicare

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
Clinical Depression and Follow-Up Plan		Population Health	aged 12 and older screened for depression on the date of the encounter and using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	and Medicaid Services
Tobacco Use: Screening and Cessation Intervention	0028/226	Community/ Population Health	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Physician Consortium for Performance Improvement Foundations (PCPI)

TABLE 16: MIPS APM Measures List—Comprehensive Primary Care Plus (CPC+)

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
Depression Remission at Twelve Months	0710 / 370	Effective Clinical Care	Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment	Minnesota Community Measurement
Controlling High Blood Pressure	0018 / 236	Effective Clinical Care	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg)	National Committee for Quality Assurance

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			during the measurement period	
Diabetes: Eye Exam	0055/117	Effective Clinical Care	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	National Committee for Quality Assurance
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	0059 / 001	Effective Clinical Care	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c> 9.0% during the measurement period	National Committee for Quality Assurance
Use of High-Risk Medications in the Elderly	0022 / 238	Patient Safety	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high0risk medication. b. Percentage of patients who were ordered at least two different high0risk medications	National Committee for Quality Assurance
Dementia: Cognitive Assessment	NA / 281	Effective Clinical Care	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	Physician Consortium for Performance Improvement Foundation (PCPI)
Falls: Screening for Future Fall Risk	0101 / 318	Patient Safety	Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period	National Committee for Quality Assurance
Initiation and Engagement of Alcohol and Other Drug	0004 / 305	Effective Clinical Care	Percentage of patients 13 years of age and older with a new episode of alcohol and	National Committee for Quality Assurance

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
Dependence Treatment			other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	
Closing the Referral Loop: Receipt of Specialist Report	NA / 374	Communicatio n and Care Coordination	Percentage of Patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	Centers for Medicare and Medicaid Services
Cervical Cancer Screening	0032 / 309	Effective Clinical Care	Percentage of women 21-64 years of age, who were screened for cervical cancer using either of the following criteria. • Women age 21-64 who had cervical cytology performed every 3 years • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	National Committee for Quality Assurance
Colorectal Cancer Screening	0034 / 113	Effective Clinical Care	Percentage of patients, 50-75 years of age who had appropriate screening for colorectal cancer	National Committee for Quality Assurance
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028 / 226	Community/ Population Health	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received	Physician Consortium for Performance Improvement Foundations (PCPI)

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			cessation counseling intervention if identified as a tobacco user	
Breast Cancer Screening	2372 / 112	Effective Clinical Care	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	National Committee for Quality Assurance
Preventive Care and Screening: Influenza Immunization	0041 / 110	Community/ Population Health	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	PCPI(R) Foundation (PCPI[R])
Pneumonia Vaccination Status for Older Adults	0043 / 111	Community/ Population Health	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
Diabetes: Medical Attention for Nephropathy	0062 / 119	Effective Clinical Care	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	National Committee for Quality Assurance
Ischemic Vascular Disease (IVD): Use of Aspirin or Another	0068 / 204	Effective Clinical Care	Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	National Committee Quality Assurance
Hypertension: Improvement in	NA / 373	Effective Clinical Care	Percentage of patients aged 18-85 years of age	Centers for Medicare & Medicaid Services

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
Blood Pressure			with a diagnosis of hypertension whose blood pressure improved during the measurement period	(CMS)
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	0418 / 134	Community/ Population Health	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Centers for Medicare & Medicaid Services (CMS)
Diabetes: Foot Exam	0056 / 163	Effective Clinical Care	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year	National Committee for Quality Assurance
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	NA /438	*Not provided in the measure*	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: *Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR *Adults aged >=21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or	Quality Insights

Measure Name	NQF/ Quality Number (if applicable)	National Quality Strategy Domain	Measure Description	Primary Measure Steward
			pure hypercholesterolemia; OR *Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	
Inpatient Hospital Utilization (IHU)	NA		For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine, and Total	National Committee for Quality Assurance
Emergency Department Utilization (EDU)	NA		For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year	National Committee for Quality Assurance
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0421	Community/ Population Health	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services (CMS)
CAHPS	CPC+ specific; different than CAHPS for MIPS		CG -CAHPS Survey 3.0	AHRQ

7. MIPS Final Score Methodology

For the 2020 MIPS payment year, we intend to build on the scoring methodology we finalized for the transition year, which allows for accountability and alignment across the performance categories and minimizes burden on MIPS eligible clinicians, while continuing to prepare MIPS eligible clinicians for the performance threshold required for the 2021 MIPS payment year. Our rationale for our scoring methodology continues to be grounded in the understanding that the MIPS scoring system has many components and numerous moving parts.

As we continue to move forward in implementing the MIPS program, we strive to balance the statutory requirements and programmatic goals with the ease of use, stability, and meaningfulness for MIPS eligible clinicians, while also emphasizing simplicity and scoring that is understandable for MIPS eligible clinicians. In this section, we propose refinements to the performance standards, the methodology for determining a score for each of the four performance categories (the "performance category score"), and the methodology for determining a final score based on the performance category scores.

We intend to continue the transition of MIPS by proposing the following policies:

● 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.

We believe these sets of proposed policies will help clinicians smoothly transition from the transition year to the 2021 MIPS payment year, for which the performance threshold (which represents the final score that would earn a neutral MIPS adjustment) will be either the mean or median (as selected by the Secretary) of the MIPS final scores for all MIPS eligible clinicians from a previous period specified by the Secretary.

Unless otherwise noted, for purposes of this section II.C.7. on scoring, 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 scoring rules for facility-based measurement are discussed in section II.C.7.a.(4). of this proposed rule. We also note that 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, scoring for MIPS eligible clinicians as described in this section II.C.7. on scoring will apply. We refer readers to section II.C.6.g. of this proposed rule for additional information about the APM scoring standard.

a. Converting Measures and Activities into Performance Category Scores

(1) Policies That Apply Across Multiple Performance Categories

The detailed policies and proposals for scoring the four performance categories are described in detail in section II.C.7.a. of this proposed rule. However, as the four performance categories collectively create a single MIPS final score, there are several policies that apply across categories, which we discuss in section II.C.7.a.(1) of this proposed rule.

(a) Performance Standards

In accordance with section 1848(q)(3) of the Act, in the CY 2017 Quality Payment Program final rule, we finalized performance standards for the four performance categories. We

refer readers to the CY 2017 Quality Payment Program final rule for a description of the performance standards against which measures and activities in the four performance categories are scored (81 FR 77271 through 77272).

As discussed in section II.C.7.a.(1)(b)(i) of this proposed rule, we are proposing to add an improvement scoring standard to the quality and cost performance categories starting for the 2020 MIPS payment year.

(b) Policies Related to Scoring Improvement

(i) Background

In accordance with section 1848(q)(5)(D)(i) of the Act, 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.

In the CY 2017 Quality Payment Program final rule, we summarized public comments received on the proposed rule regarding potential ways to incorporate improvement into the scoring methodology moving forward, including approaches based on methodologies used in the Hospital VBP Program, the Shared Savings Program, and Medicare Advantage 5-star Ratings Program (81 FR 77306 through 77308). We did not finalize a policy at that time on this topic and indicated we would take comments into account in developing a proposal for future rulemaking.

When considering the applicability of these programs to MIPS, we looked at the approach that was used to measure improvement for each of the programs and how improvement was incorporated into the overall scoring system. An approach that focuses on measure-level comparison enables a more granular assessment of improvement because performance on a specific measure can be considered and compared from year to year. All options that we considered last year use a standard set of measures that do not provide for choice of measures to assess performance; therefore, they are better structured to compare changes in performance based on the same measure from year to year. The aforementioned programs do not use a category-level approach; however, we believe that a category-level approach would provide a broader perspective, particularly in the absence of a standard set of measures, because it would allow for a more flexible approach that enables MIPS eligible clinicians to select measures and data submission mechanisms that can change from year to year and be more appropriate to their practice in a given year.

We believe that both approaches are viable options for measuring improvement. Accordingly, we believe that an appropriate approach for measuring improvement for the quality performance category and the cost performance category should consider the unique characteristics of each performance category rather than necessarily applying a uniform approach across both performance categories. For the quality performance category, clinicians are offered a variety of different measures which can be submitted by different mechanisms, rather than a standard set of measures or a single data submission mechanism. For the cost performance category, however, clinicians are scored on the same set of cost measures to the extent each measure is applicable and available to them; clinicians cannot choose which cost measures they will be scored on. In addition, all of the cost measures are derived from administrative claims data with no additional submission required by the clinician.

When considering the applicability of these programs to MIPS, we also considered how scoring improvement is incorporated into the overall scoring system, including when only achievement or improvement is incorporated into a final score or when improvement and achievement are both incorporated into a final score.

We considered whether we could adapt the Hospital VBP Program's general approach for assessing improvement to MIPS and note that many commenters, in response to the CY 2017 Quality Payment Program proposed rule, recommended this methodology for MIPS because it is familiar to the health care community. However, we decided that the Hospital VBP Program's improvement scoring methodology, which compares changes in performance based on the same measure from year to year, is not fully translatable to MIPS for the quality performance category and the cost performance category. The scoring methodology used to assess achievement in the Hospital VBP Program, as required by section 1886(o)(5)(B)(ii) of the Act, does not reward points for achievement in the same method as MIPS, because hospitals that fall below the achievement threshold (the median performance during the benchmark period) are not awarded achievement points. We refer readers to the Hospital Inpatient VBP Program Final Rule (76 FR 26516 through 26525) for additional discussion of the Hospital VBP Program's scoring methodology. In addition, the Hospital VBP Program requires the use of either the achievement score or the improvement points, but not both, for the Program's performance scoring calculation. Adopting the Hospital VBP Program method for MIPS would require significant changes to the scoring methodology used for the quality and cost performance categories. For the quality performance category, there are a wide variety of measures available in MIPS, and clinicians have flexibility in selecting measures and submission mechanisms, with the potential for clinicians to select different measures from year to year, which would affect our ability to capture performance changes at the measure level.

We continue to believe that flexibility for clinicians to select meaningful measures is appropriate for MIPS, especially for the quality performance category. The Hospital VBP Program methodology, which relies on consistent measures from year to year in order to track improvement, would limit our ability to measure improvement in MIPS.

We also considered adopting the Shared Savings Program's approach for assessing improvement, where participants can receive bonus points for improving on quality measures over time. The Shared Savings Program methodology could be adopted without an underlying change to the scoring of achievement in the quality and cost performance categories with an approach that considers both achievement and improvement in its overall scoring calculation and would align MIPS and the Shared Savings Program. However, we believe that the Shared Savings Program's improvement methodology would not be appropriate for the MIPS quality performance category because we are again concerned about the wide variety of quality measures available in MIPS and the flexibility clinicians have in selecting measures and submission mechanisms that could affect our ability to capture performance changes at the measure level. We seek to balance a system that allows for meaningful measurement to clinicians and accommodates the various practice types by allowing for a choice of measures and submission mechanisms that may differ from year to year for the quality performance category. However, as we discuss in section II.C.7.a.(3)(a) of this proposed rule, we do believe the Shared Savings Program measure level methodology could be translated for cost measures in the cost performance category.

Finally, we also considered adopting the Medicare Advantage Program's 5-Star Rating approach for assessing improvement, where Medicare Advantage contracts are rated on quality and performance measures. Under this approach, we would identify an overall "improvement measure score" by comparing the underlying numeric data for measures from the prior year with the data from measures for the performance period. To obtain an "improvement measure score"

MIPS eligible clinicians would need to have data for both years in at least half of the required measures for the quality performance category (81 FR 77307). We are again concerned that the wide variety of measures available in MIPS and the flexibility clinicians have in selecting different measures and submission mechanisms from year to year could affect our ability to capture performance changes at the measure level, particularly for the quality performance category. Accordingly, we do not believe this is an appropriate approach for the quality performance category. Although this approach could be considered for the cost performance category, we believe that the Shared Savings Program is more analogous to MIPS and that the improvement methodology used in that program is one with which more stakeholders in MIPS would be familiar.

After taking all of this into consideration, we are proposing two different approaches for scoring improvement from year to year. As described in section II.C.7.a.(2)(i)(i) of this proposed rule, we are proposing to measure improvement at the performance category level for the quality performance category score. Because clinicians can elect the submission mechanisms and quality measures that are most meaningful to their practice, and these choices can change from year to year, we want a flexible methodology that allows for improvement scoring even when the quality measures change. This is particularly important as we encourage MIPS eligible clinicians to move away from topped out measures and toward more outcome measures. We do not want the flexibility that is offered to MIPS eligible clinicians in the quality performance category to limit clinicians' ability to move towards outcome measures, or limit our ability to measure improvement. Our proposal for taking improvement into account as part of the quality performance category score is addressed in detail in sections II.C.7.a.(2)(i) through II.C.7.a.(2)(j) of this proposed rule.

We believe that there is reason to adopt a different methodology for scoring improvement for the cost performance category from that used for the quality performance category. In

contrast to the quality performance category, for the cost performance category, MIPS eligible clinicians do not have a choice in measures or submission mechanisms; rather, all MIPS eligible clinicians are assessed on all measures based on the availability and applicability of the measure to their practice, and all measures are derived from administrative claims data. Therefore, for the cost performance category, we propose in section II.C.7.a.(3)(a)(i) of this proposed rule to measure improvement at the measure level. We also note, that while we are statutorily required to measure improvement for the cost performance category beginning with the second MIPS payment year if data sufficient to measure improvement is available, we are also proposing at II.C.6.d.(2) of this proposed rule to weight the cost performance category at zero percent for the 2018 MIPS performance period/2020 MIPS payment year. Therefore, the improvement score for the cost performance category would not affect the MIPS final score for the 2018 MIPS performance period/2020 MIPS payment year and would be for informational purposes only.

We are not proposing to score improvement in the improvement activities performance category or the advancing care information performance category at this time, though we may address improvement scoring for these performance categories in future rulemaking.

We propose to amend §414.1380(a)(1)(i) to add that improvement scoring is available for performance in the quality performance category and for the cost performance category at §414.1380(a)(1)(ii) beginning with the 2020 MIPS payment year.

We invite public comment on our proposals to score improvement for the quality and cost performance categories starting with the 2020 MIPS payment year.

(ii) Data Sufficiency Standard to Measure Improvement

Section 1848(q)(5)(D)(i) of the Act requires us to measure improvement for the quality and cost performance categories of MIPS if data sufficient to measure improvement are available, which we interpret to mean that we would measure improvement when we can identify data from a current performance period that can be compared to data from a prior performance

period or data that compares performance from year to year. In section II.C.7.a.(2)(i)(ii) of this proposed rule, we propose for the quality performance category that we would measure improvement when data are available because there is a performance category score for the prior performance period. In section II.C.7.a.(3)(a)(i) of this proposed rule, we propose for the cost performance category that we would measure improvement when data are available which is when there is sufficient case volume to provide measurable data on measures in subsequent years with the same identifier. We refer readers to the noted sections for details on these proposals.

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

The quality and cost performance categories rely on measures that use detailed measure specifications that include ICD-10-CM/PCS ("ICD-10") code sets. We annually issue new ICD-10 coding updates, which are effective from October 1, through September 30 (https://www.cms.gov/Medicare/Coding/ICD10/ICD10OmbudsmanandICD10CoordinationCenterICC.html). As part of this update, codes are added as well as removed from the ICD-10 code set.

To provide scoring flexibility for MIPS eligible clinicians and groups for measures impacted by ICD-10 coding changes in the final quarter of the Quality Payment Program performance period—which may render the measures no longer comparable to the historical benchmark— we propose at §414.1380(b)(1)(xviii) and §414.1320(c)(2) to provide that we will assess performance on measures considered significantly impacted by ICD-10 updates based only on the first 9 months of the 12-month performance period (for example, January 1, 2018 through September 30, 2018, for the 2018 MIPS performance period). We believe it would be appropriate to assess performance for significantly impacted measures based on the first 9 months of the performance period, rather than the full 12 months, because the indicated performance for the last quarter could be affected by the coding changes rather than actual

differences in performance. 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 (January 1 through December 31).

Any measure that relies on an ICD-10 code which is added, modified, or removed, such as in the measure numerator, denominator, exclusions, or exceptions, could have an impact on the indicated performance on the measure, although the impact may not always be significant. We propose an annual review process to analyze the measures that have a code impact and assess the subset of measures significantly impacted by ICD-10 coding changes during the performance period. Depending on the data available, we anticipate that our determination as to whether a measure is significantly impacted by ICD-10 coding changes would include these factors: a more than 10 percent change in codes in the measure numerator, denominator, exclusions, and exceptions; guideline changes or new products or procedures reflected in ICD-10 code changes; and feedback on a measure received from measure developers and stewards. We considered an approach where we would consider any change in ICD-10 coding to impact performance on a measure and thus only rely on the first 9 months of the 12-month performance period for such measures. However, we believe such an approach would be too broad and truncate measurement for too many measures where performance may not be significantly affected. We believe that our proposed approach ensures the measures on which individual MIPS eligible clinicians and groups will have their performance assessed are accurate for the performance period and are consistent with the benchmark set for the performance period.

We propose to publish on the CMS website which measures are significantly impacted by ICD-10 coding changes and would require the 9-month assessment. We propose 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.

We request comment on the proposal to address ICD-10 measures specification changes during the performance period by relying on the first 9 months of the 12-month performance period. We also request comment on potential alternate approaches to address measures that are significantly impacted due to ICD-10 changes during the performance period, including the factors we might use to determine whether a measure is significantly impacted.

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

Many comments submitted in response to the CY 2017 Quality Payment Program final rule requested additional clarification on our finalized scoring methodology for the 2019 MIPS payment year. To provide further clarity to MIPS eligible clinicians about the transition year scoring policies, before describing our proposed scoring policies for the 2020 MIPS payment year, we provide a summary of the scoring policies finalized in the CY 2017 Quality Payment Program final rule along with examples of how they apply under several scenarios.

In the CY 2017 Quality Payment Program final rule (81 FR 77286 through 77287), we finalized that the quality performance category would be scored by assigning achievement points to each submitted measure, which we refer to in this section of the proposed rule as "measure achievement points" and we propose to amend various paragraphs in §414.1380(b)(1) to use this term in place of "achievement points". MIPS eligible clinicians can also earn bonus points for certain measures (81 FR 77293 through 77294; 81 FR 77297 through 77299), which we refer to as "measure bonus points", and we propose to amend §414.1380(b)(1)(xiii) (which we propose to redesignate as §414.1380(b)(1)(xiv) in this proposed rule[7]), §414.1380(b)(1)(xiv) (which we

[7] In section II.C.7.a.(2)(c) of this proposed rule, we propose a new provision to be codified at §414.1380(b)(1)(xiii), and in section II.C.7.a.(2)(i) of this proposed rule, we propose a new provision to be codified at §414.1380(b)(1)(xvi). As a result, we propose as well that the remaining paragraphs be redesignated in order following the new provisions.

propose to redesignate as §414.1380(b)(1)(xv) in this proposed rule), and §414.1380(b)(1)(xv) (which we propose to redesignate as §414.1380(b)(1)(xvii) in this proposed rule) to use this term in place of "bonus points". The measure achievement points assigned to each measure would be added with any measure bonus points and then divided by the total possible points (§414.1380(b)(1)(xv) (which we propose to redesignate as §414.1380(b)(1)(xvii)). In this section of the proposed rule we refer to the total possible points as "total available measure achievement points", and we propose to amend §414.1380(b)(1)(xv) to use this term in place of "total possible points". We also propose to amend these terms in §414.1380(b)(1)(xiii)(D) (which we propose to redesignate as §414.1380(b)(1)(xiv)(D) in this proposed rule), and §414.1380(b)(1)(xiv) (which we propose to redesignate as §414.1380(b)(1)(xv) in this proposed rule).

This resulting quality performance category score is a fraction from zero to 1, which can be formatted as a percent; therefore, for this section, we will present the quality performance category score as a percent and refer to it as "quality performance category percent score." We also propose to amend §414.1380(b)(1)(xv) (which we propose to redesignate as §414.1380(b)(1)(xvii) in this proposed rule) to use this term in place of "quality performance category score". Thus, the formula for the quality performance category percent score that we will use in this section is as follows:

(total measure achievement points + total measure bonus points)/total available measure achievement points = quality performance category percent score.

In the CY 2017 Quality Payment Program final rule, we finalized that for the quality performance category, an individual MIPS eligible clinician or group that submits data on quality measures via EHR, QCDR, qualified registry, claims, or a CMS-approved survey vendor for the CAHPS for MIPS survey will be assigned measure achievement points for 6 measures (1 outcome or, if an outcome measure is not available, other high priority measure and the next 5

highest scoring measures) as available and applicable, and will receive applicable measure bonus points for all measures submitted that meet the bonus criteria (81 FR 77282 through 77301).

In addition, for groups of 16 or more clinicians who meet the case minimum of 200, we will also automatically score the administrative claims-based all-cause hospital readmission measure as a seventh measure (81 FR 77287). For individual MIPS eligible clinicians and groups for whom the readmission measure does not apply, the denominator is generally 60 (10 available measure achievement points multiplied by 6 available measures). For groups for whom the readmission measure applies, the denominator is generally 70 points.

If we determined that a MIPS eligible clinician has fewer than 6 measures available and applicable, we will score only the number of measures that are available and adjust the denominator accordingly to the total available measure achievement points (81 FR 77291). We refer readers to section II.C.7.a.(2)(e) of this proposed rule, for a description of the validation process to determine measure availability.

For the 2019 MIPS payment year, a MIPS eligible clinician that submits quality measure data via claims, EHR, or third party data submission options (that is, QCDR, qualified registry, EHR, or CMS-approved survey vendor for the CAHPS for MIPS survey), can earn between 3 and 10 measure achievement points for quality measures submitted for the performance period of greater than or equal to 90 continuous days during CY 2017. A MIPS eligible clinician can earn measure bonus points (subject to a cap) if they submit additional high priority measures with a performance rate that is greater than zero, and that meet the case minimum and data completeness requirements, or submit a measure using an end-to-end electronic pathway. An individual MIPS eligible clinician that has 6 or more quality measures available and applicable will have 60 total available measure achievement points. For example, as shown in Table 17, if an individual MIPS eligible clinician submits 7 measures, including one required outcome measure and 2 additional high priority measures, the MIPS eligible clinician will be assigned

points based on achievement for the required outcome measure and the next 5 measures with the highest number of measure achievement points. In this example, the second high priority measure has the lowest number of measure achievement points and therefore is not included in the total measure achievement points calculated (81 FR 77300), but the MIPS eligible clinician will still receive a bonus point for submitting a high priority measure (81 FR 77291 through 77294). We note that in the CY 2017 Quality Payment Program proposed rule, we proposed that bonus points would be available for high priority measures that are not scored (not included in the top 6 measures for the quality performance category score) as long as the measure has the required case minimum, data completeness, and has a performance rate greater than zero, because we believed these qualities would allow us to include the measure in future benchmark development (81 FR 28255). Although we received public comments on this policy, responded to those comments, and reiterated this proposal in the CY 2017 Quality Payment Program final rule (81 FR 77292), we would like to clarify that our policy to assign measure bonus points for high priority measures, even if the measure's achievement points are not included in the total measure achievement points for calculating the quality performance category percent score, as long as the measure has the required case minimum, data completeness, and has a performance rate greater than zero, applies beginning with the transition year. We propose to amend §414.1380(b)(1)(xiii)(A) (which we propose to redesignate as §414.1380(b)(1)(xiv)(A)) to state 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. We also propose a technical correction to the second sentence of that paragraph to state that to qualify for measure bonus points, each measure must be reported with sufficient case volume to meet the required case minimum, meet the required data completeness criteria, and not have a zero percent performance rate.

TABLE 17: Example Calculation of the Quality Performance Category Percent Score for an Individual for the Transition Year

	Measure Achievement Points	Measure Bonus Points*	Total Available Measure Achievement Points	Performance Category Percent Score
Measure 1 (Outcome – required)	3	n/a	10	(measure achievement points from 6 measures + measure bonus points)/total available measure achievement points
Measure 2	6	n/a	10	
Measure 3	6	n/a	10	
Measure 4	6	n/a	10	
Measure 5	6	n/a	10	
Measure 6 (High priority)	4	1	10	
Measure 7 (High priority)	3 (not included for achievement)	1	n/a	
Total	**31**	**2**	**60**	(31+2)/60 = **55%**

* Assumes the measures meet the required case minimum, data completeness, and has performance greater than zero. Assumes no bonus points for end-to-end electronic submission. This example does not apply to CMS Web Interface Reporters because individuals are not able to submit data via that mechanism.

A group of 16 or more clinicians will also be automatically scored on the hospital readmission measure if they meet the case minimum. Table 18 illustrates an example of a group that submitted the 6 required quality measures, including an additional high priority measure, and received 3 measure achievement points for each submitted measure and the all-cause readmission measure.

TABLE 18: Example Calculation of the Quality Performance Category Percent Score for a Group of 16 or More Clinicians, Non-CMS Web Interface Reporter for the Transition Year

	Measure Achievement Points	Measure Bonus Points*	Total Available Measure Achievement Points	Performance Category Percent Score
Measure 1 (Outcome – required)	3	n/a	10	(measure achievement points from 7 measures + measure bonus points)/total available measure achievement points
Measure 2 (High priority)	3	1	10	
Measure 3	3	n/a	10	
Measure 4	3	n/a	10	
Measure 5	3	n/a	10	
Measure 6	3	n/a	10	
Measure 7 – (readmission measure with 200+ cases)	3	n/a	10	
Total	**21**	**1**	**70**	(21+1)/70 = **31.4%**

* Assumes the measures meet the required case minimum, data completeness, and has performance greater than zero. Assumes no bonus points for end-to-end electronic submission.

In the CY 2017 Quality Payment Program final rule, we also finalized scoring policies specific to groups of 25 or more that submit their quality performance measures using the CMS Web Interface (81 FR 77278 through 77306).

Although we are not proposing to change the basic scoring system that we finalized in the CY 2017 Quality Payment Program final rule for the 2020 MIPS payment year, we are proposing several modifications to scoring the quality performance category, including adjusting scoring for measures that do not meet the data completeness criteria, adding a method for scoring measures submitted via multiple mechanisms, adding a method for scoring selected topped out measures, and adding a method for scoring improvement. We also note that in section II.C.7.a.(4) of this proposed rule, we are also proposing an additional option for facility-based scoring for the quality performance category.

(a) Quality Measure Benchmarks

We are not proposing to change the policies on benchmarking finalized in the CY 2017 Quality Payment Program final rule and codified at paragraphs (b)(1)(i) through (iii) of §414.1380; however, we are proposing a technical correction to paragraphs (i) and (ii) to clarify that measure benchmark data are separated into decile categories based on percentile distribution, and that, other than using performance period data, performance period benchmarks are created in the same manner as historical benchmarks using decile categories based on a percentile distribution and that each benchmark must have a minimum of 20 individual clinicians or groups who reported on the measure meeting the data completeness requirement and case minimum case size criteria and performance greater than zero. We refer readers to the discussion at 81 FR 77282 for more details on that policy.

We note that in section II.C.2.c. of this proposed rule, we are proposing to increase the low-volume threshold which, because we include MIPS eligible clinicians and comparable APMs that meet our benchmark criteria in our measure benchmarks, could have an impact on our MIPS benchmarks, specifically by reducing the number of individual eligible clinicians and groups that meet the definition of a MIPS eligible clinician and contribute to our benchmarks. Therefore, we seek feedback on whether we should broaden the criteria for creating our MIPS benchmarks to include PQRS and any data from MIPS, including voluntary reporters, that meet our benchmark performance, case minimum and data completeness criteria when creating our benchmarks.

In the CY 2017 Quality Payment Program final rule, we did not stratify benchmarks by practice characteristics, such as practice size, because we did not believe there was a compelling rationale for such an approach, and we believed that stratifying could have unintended negative consequences for the stability of the benchmarks, equity across practices, and quality of care for beneficiaries (81 FR 77282). However, we sought comment on any rationales for or against stratifying by practice size we may not have considered. We note that we do create separate

benchmarks for each of the following submission mechanisms: EHR submission options; QCDR and qualified registry submission options; claims submission options; CMS Web Interface submission options; CMS-approved survey vendor for CAHPS for MIPS submission options; and administrative claims submission options (for measures derived from claims data, such as the all-cause hospital readmission measure) (81 FR 77282).

Several commenters who responded to our solicitation of comment in the final rule supported stratifying measure benchmarks by practice size because the commenters believed it would help small practices, which have limited resources compared to larger practices, and because quality measures may have characteristics that are less favorable to small groups. One commenter recommended that we stratify by practice size during the 5 years in which technical assistance is available. One commenter recommended that we develop criteria for determining when a benchmark should be stratified by group size, and another commenter recommended if we do not stratify benchmarks by practice size, we adjust MIPS payment adjustments for practice size. Several commenters recommended that we stratify benchmarks beyond practice size and include adjustments for disease severity and socioeconomic status of patients, specialty or sub-specialty, geographic region, and/or site of service. One commenter specifically suggested that we use peer comparison groups when establishing measure benchmarks.

After consideration of the comments we received, we are not proposing to change our policies related to stratifying benchmarks by practice size for the 2020 MIPS payment year. For many measures, the benchmarks may not need stratification as they are only meaningful to certain specialties and only expected to be submitted by those certain specialists. We would like to further clarify that in the majority of instances our current benchmarking approach only compares like clinicians to like clinicians. We continue to believe that stratifying by practice size could have unintended negative consequences for the stability of the benchmarks, equity across practices, and quality of care for beneficiaries. However, we seek comment on methods

by which we could stratify benchmarks, while maintaining reliability and stability of the benchmarks, to use in developing future rulemaking for future performance and payment years. Specifically, we seek comment on methods for stratifying benchmarks by specialty or by place of service. We also request comment on specific criteria to consider for stratifying measures, such as how we should stratify submissions by multi-specialty practices or by practices that operate in multiple places of service.

(b) Assigning Points Based on Achievement

In the CY 2017 Quality Payment Program final rule, we finalized at §414.1380(b)(1) that a MIPS quality measure must have a measure benchmark to be scored based on performance. MIPS quality measures that do not have a benchmark (for example, because fewer than 20 MIPS eligible clinicians or groups submitted data that met our criteria to create a reliable benchmark) will not be scored based on performance (81 FR 77286). We are not proposing any changes to this policy, but we are proposing a technical correction to the regulatory text at §414.1380(b)(1) to delete the term "MIPS" before "quality measure" in third sentence of that paragraph and to delete the term MIPS before "quality measures" in the fourth sentence of that paragraph because this policy applies to all quality measures, including the measures finalized for the MIPS program and the quality measures submitted through a QCDR that have been approved for MIPS.

We are also not proposing to change the policies to score quality measure performance using a percentile distribution, separated by decile categories and assign partial points based on the percentile distribution finalized in the CY 2017 Quality Payment Program final rule and codified at paragraphs (b)(1)(ix), (x), and (xi) of §414.1380; however, we propose a technical correction to paragraph (ix) to clarify that measures are scored against measure benchmarks. We refer readers to the discussion at 81 FR 77286 for more details on those policies.

For illustration, Table 19 provides an example of assigning points for performance based on benchmarks using a percentile distribution, separated by decile categories. The example is of the benchmarks for Measure 130 Documentation of Current Medications in the Medical Record, which is based on our 2015 benchmark file for the 2017 MIPS performance period.

TABLE 19: Example of Assigning Points for Performance Based on a Benchmark, Separated by Deciles

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

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

In Table 19, the cells with "--" represent where there is a cluster at the top of benchmark distribution. For example, for the claims benchmark, over 50 percent of the MIPS eligible clinicians submitting that measure had a performance rate of 100 percent based on 2015 PQRS data. Because of the cluster, clinicians who are at the 6, 7, 8, and 9th decile all would have performance rates of 100 percent and would all receive a score of 10 points, indicated by dashes for those deciles. Based on this clustered distribution, those clinicians with performance of 99.99 percent fall into decile 5 and receive points in the range from 5.0 to 5.9 points. For this measure, the benchmark for each submission mechanism is topped out.

We note that for quality measures for which baseline period data is available, we will publish the numerical baseline period benchmarks with deciles prior to the start of the performance period (or as soon as possible thereafter) (81 FR 77282). For quality measures for which there is no comparable data from the baseline period, we will publish the numerical performance period benchmarks after the end of the performance period (81 FR 77282). We will also publish further explanation of how we calculate partial points at qpp.cms.gov.

(i) Floor for Scored Quality Measures

For the 2017 MIPS performance period, we also finalized at §414.1380(b)(1) a global 3-point floor for each scored quality measure, as well as for the hospital readmission measure (if applicable), such that MIPS eligible clinicians would receive between 3 and 10 measure achievement points for each submitted measure that can be reliably scored against a benchmark, which requires meeting the case minimum and data completeness requirements (81 FR 77286 through 77287). Likewise, for measures without a benchmark based on the baseline period, we stated that we would continue to assign between 3 and 10 measure achievement points for performance years after the first transition year because it would help to ensure that the MIPS eligible clinicians are protected from a poor performance score that they would not be able to anticipate (81 FR 77282; 81 FR 77287). For measures with benchmarks based on the baseline period, we stated the 3-point floor was for the transition year and that we would revisit the 3-point floor in future years (81 FR 77286 through 77287).

For the 2018 MIPS performance period, we propose to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period, and to amend §414.1380(b)(1) accordingly. We refer readers to section II.C.7.a.(2)(h)(ii) of this rule, for our proposal to score measures in the CMS Web Interface for the Quality Payment Program for which performance is below the 30th percentile. We will revisit the 3-point floor for such measures again in future rulemaking.

We invite public comment on this proposal to again apply this 3-point floor for quality measures that can be reliably scored against a baseline benchmark in the 2018 MIPS performance period.

(ii) Additional Policies for the CAHPS for MIPS Measure Score

In the CY 2017 Quality Payment Program final rule, we finalized a policy for the CAHPS for MIPS measure, such that each Summary Survey Measure (SSM) will have an individual

benchmark, that we will score each SSM individually and compare it against the benchmark to establish the number of points, and the CAHPS score will be the average number of points across SSMs (81 FR 77284).

As described in section II.C.6.b.(3)(a)(iii) of this proposed rule, we are proposing to remove two SSMs from the CAHPS for MIPS survey, which would result in the collection of 10 SSMs in the CAHPS for MIPS survey. 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 we can measure the effect one practice has compared to other practices participating in MIPS. The "Health Status and Functional Status" SSM, however, assesses underlying characteristics of a group's patient population characteristics and is less of a reflection of patient experience of care with the group. Moreover, to the extent that health and functional status reflects experience with the practice, case-mix adjustment is not sufficient to separate how much of the score is due to patient experience versus due to aspects of the underlying health of patients. The "Access to Specialists" SSM has low reliability; historically it has had small sample sizes, and therefore, the majority of groups do not achieve adequate reliability, which means there is limited ability to distinguish between practices' performance.

For these reasons, we propose not to score the "Health Status and Functional Status" SSM and the "Access to Specialists" SSM beginning with the 2018 MIPS performance period. Despite not being suitable for scoring, both SSMs provide important information about patient care. Qualitative work suggests that "Access to Specialists" is a critical issue for Medicare FFS beneficiaries. The survey is also a useful tool for assessing beneficiaries' self-reported health status and functional status, even if this measure is not used for scoring practices' care experiences. Therefore, we believe that continued collection of the data for these two SSMs is appropriate even though we do not propose to score them.

Other than these two SSMs, we propose to score the remaining 8 SSMs because they 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 we can measure the effect one practice has compared to other practices participating in MIPS. Table 20 summarizes the proposed SSMs included in the CAHPS for MIPS survey and illustrates application of our proposal to score only 8 measures.

TABLE 20: Proposed SSM for CAHPS for MIPS Scoring

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

We invite comment on our proposal not to score the "Health Status and Functional Status" and "Access to Specialists" SSMs beginning with the 2018 MIPS performance period.

We note that in section II.C.6.g.(3)(b)(i)(A) of this proposed rule, we are proposing to add the CAHPS for ACOs survey as an available measure for calculating the MIPS APM score for the Shared Savings Program and Next Generation ACO Model. We refer readers participating in ACOs to section II.C.6.g.(3)(b) of this proposed rule for the CAHPS for ACOs scoring methodology.

(c) Identifying and Assigning Measure Achievement Points for Topped Out Measures

Section 1848(q)(3)(B) of the Act requires that, in establishing performance standards with respect to measures and activities, we consider, among other things, the opportunity for continued improvement. We finalized in the CY 2017 Quality Payment Program final rule that we would identify topped out process measures as those with a median performance rate of 95

percent or higher (81 FR 77286). For non-process measures we finalized a topped out definition similar to the definition used in the Hospital VBP Program: Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors (81 FR 77286). When a measure is topped out, a large majority of clinicians submitting the measure performs at or very near the top of the distribution; therefore, there is little or no room for the majority of MIPS eligible clinicians who submit the measure to improve. We understand that every measure we have identified as topped out may offer room for improvement for some MIPS eligible clinicians; however, we believe asking clinicians to submit measures that we have identified as topped out and measures for which they already excel is an unnecessary burden that does not add value or improve beneficiary outcomes.

Based on 2015 historic benchmark data,[8] approximately 45 percent of the quality measure benchmarks currently meet the definition of topped out, with some submission mechanisms having a higher percent of topped out measures than others. Approximately 70 percent of claims measures are topped out, 10 percent of EHR measures are topped out, and 45 percent of registry/QCDR measures are topped out.

In the CY 2017 Quality Payment Program final rule, we finalized that for the 2019 MIPS payment year, we would score topped out quality measures in the same manner as other measures (81 FR 77286). We finalized that we would not modify the benchmark methodology for topped out measures for the first year that the measure has been identified as topped out, but that we would modify the benchmark methodology for topped out measures beginning with the 2020 MIPS payment year, provided that it is the second year the measure has been identified as topped out. As described in detail later in this section, we are proposing a phased in approach to apply special scoring to topped out measures, beginning with the 2018 MIPS performance period

[8] The topped out determination is calculated on historic performance data and the percentage of topped out measures may change when evaluated for the most applicable annual period.

(2020 MIPS payment year), rather than modifying the benchmark methodology for topped out measures as indicated in the CY 2017 Quality Payment Program final rule.

In the CY 2017 Quality Payment Program final rule, we sought comment on how topped out measures should be scored provided that it is the second year the measure has been identified as topped out (81 FR 77286). We suggested three possible options: (1) score the measures using a mid-cluster approach; (2) remove topped out measures; or (3) apply a flat percentage in building the benchmarks for topped out measures. Flat percentages assign points based directly on the percentage of performance rather than by a percentile distribution by decile. Flat-rate would provide high scores to virtually all clinicians submitting the measure because performance rates tend to be high. Cluster-based benchmarks for topped out measures are based on a percentile distribution, but because many submitters are clustered at the top of performance, there can be large drops in points assigned for relatively small differences in performance. The current top of the cluster approach can result in many clinicians receiving 10 points. A mid-cluster approach would limit the maximum number of points a topped out measure can achieve based on how clustered the score are, and could still result in large drops, although less than with the top of the cluster approach, in points assigned for relatively small differences in performance. We also noted in the CY 2017 Quality Payment Program final rule that we anticipate removing topped out measures over time and sought comment on what point in time we should remove topped out measures from MIPS (81 FR 77286). The comments and our proposed policy for removing topped out measures are described in section II.C.6.c.(2) of this proposed rule.

In response to our request for comment in the CY 2017 Quality Payment Program final rule, a few commenters believed that we should not score topped out measures differently from other measures because commenters believed changing the scoring could reduce quality, add complexity to the program, and reduce incentives to participate in MIPS. Several commenters recommended that if we do score topped out measures differently, we use flat percentages rather

than cluster-based benchmarks, with a few commenters noting that using flat percentages could help ensure those with high performance on a measure are not penalized as low performers and another noting that allowing high scorers to earn maximum or near maximum points is similar to the approach in the Shared Savings Program. A few commenters recommended that we publish information about topped out and potentially topped out measures prior to the performance period to allow clinicians time to adjust their reporting strategies, with one commenter noting that improvement may be rewarded in addition to achievement. One commenter recommended pushing back the baseline performance period for identifying topped out measures to the 2018 MIPS performance period because in the transition year it is unclear how many eligible clinicians will be reporting at different times and for what period they will report.

As described in section II.C.6.c.(2) of this proposed rule, we are proposing 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, subject to the phased in approach described in section II.C.6.c.(2) of this proposed rule.

As part of the lifecycle for topped out measures, we also propose in this section II.C.7.a.(2)(c) of this proposed rule, a method to phase in special scoring for topped out measure benchmarks starting with the 2018 MIPS performance period, provided that is the second consecutive year the measure benchmark is identified as topped out in the benchmarks published for the performance period. This special scoring would not apply to measures in the CMS Web Interface, as explained later in this section. The phased-in approach described in this section represents our first step in methodically implementing special scoring for topped out measures.

We are not proposing to remove topped out measures for the 2018 MIPS performance period because we recognize that there are currently a large number of topped out measures and

removing them may impact the ability of some MIPS eligible clinicians to submit 6 measures and may impact some specialties more than others. We note, however, that as described in section II.C.6.c.(2) of this proposed rule, we are proposing a timeline for removing topped out measures in future years. We believe this provides MIPS eligible clinicians the ability to anticipate and plan for the removal of specific topped out measures, while providing measure developers time to develop new measures.

We note that because we create a separate benchmark for each submission mechanism available for a measure, a benchmark for one submission mechanism for the measure may be identified as topped out while another submission mechanism's benchmark may not be topped out. The topped out designation and special scoring apply only to the specific benchmark that is topped out, not necessarily every benchmark for a measure. For example, the benchmark for the claims submission mechanism may be topped out for a measure, but the benchmark for the EHR submission mechanisms for that same measure may not be topped out. In this case, the topped out scoring would only apply to measures submitted via the claims submission mechanism, which has the topped out benchmark. We also describe in section II.C.6.c.(2) of this proposed rule that, similarly, only the submission mechanism that is topped out for the measure would be removed.

We propose to cap the score of topped out measures at 6 measure achievement points. We are proposing a 6-point cap for multiple reasons. First, we believe applying a cap to the current method of scoring a measure against a benchmark is a simple approach that can easily be predicted by clinicians. Second, the cap will create incentives for clinicians to submit other measures for which they can improve and earn future improvement points. Third, considering our proposed topped out measure lifecycle, we believe this cap would only be used for a few years and the simplicity of a cap on the current benchmarks would outweigh the cluster-based options or applying a cap on benchmarks based on flat-percentage, which are more complicated.

The rationale for a 6-point cap is that 6 points is the median score for any measure as it represents the start of the 6th decile for performance and represents the spot between the bottom 5 deciles and start of the top 5 deciles.

We believe this proposed capped scoring methodology will incentivize MIPS eligible clinicians to begin submitting non-topped out measures without performing below the median score. This methodology also would not impact scoring for those MIPS eligible clinicians that do not perform near the top of the measure and therefore have significant room to improve on the measure. We may also consider lowering the cap below 6 points in future years, especially if we remove the 3-point floor for performance in future years.

We note that although we are proposing a new methodology for assigning measure achievement points for topped out measures, we are not changing the policy for awarding measure bonus points for topped out measures. Topped out measures will still be eligible for measure bonus points if they meet the required criteria. We refer readers to sections II.C.7.a.(2)(f) and II.C.7.a.(2)(g) of this proposed rule for more information about measure bonus points.

We request comments on our 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, we seek feedback on whether 6 points is the appropriate cap or whether we should consider another value. We also seek comment on other possible options for scoring topped out measures that would meet our policy goals to encourage clinicians to begin to submit measures that are not topped out while also providing stability for MIPS eligible clinicians.

While we believe it is important to score topped out measures differently because they could have a disproportionate impact on the scores for certain MIPS eligible clinicians and topped out measures provide little room for improvement for the majority of MIPS eligible clinicians who submit them, we also recognize that numerous measure benchmarks are currently

identified as topped out and special scoring for topped out measures could impact some specialties more than others. Therefore, we considered ways to phase in special scoring for topped out measures in a way that will begin to apply special scoring, but would not overwhelm any one specialty and would also provide additional time to evaluate the impact of topped out measures before implementing it for all topped out measures, while also beginning to encourage submission of measures that are not topped out.

We believe the best way to accomplish this is by applying special topped out scoring to a select number of measures for the 2018 performance period and to then apply the special topped out scoring to all topped out measures for the 2019 performance period, provided it is the second consecutive year the measure is topped out. We believe this approach allows us time to further evaluate the impact of topped out measures and allows for a methodical way to phase in topped out scoring.

We identified measures we believe should be scored with the special topped out scoring for the 2018 performance period by using the following set criteria, which are only intended as a way to phase in our topped-out measure policy for selected measures and are not intended to be criteria for use in future policies:

- Measure is topped out and there is no difference in performance between decile 3 through decile 10. We applied this limitation because, based on historical data, there is no room for improvement for over 80 percent of MIPS eligible clinicians that reported on these measures.
- Process measures only because we want to continue to encourage reporting on high priority outcome measures, and the small subset of structure measures was confined to only three specialties.
- MIPS measures only (which does not include measures that can only be reported through a QCDR) given that QCDR measures go through a separate process for approval and because we want to encourage use of QCDRs required by section 1848(q)(1)(E) of the Act.

- Measure is topped out for all mechanisms by which the measure can be submitted.

Because we create a separate benchmark for each submission mechanism available for a measure, a benchmark for one submission mechanism for the measure may be identified as topped out while another submission mechanism's benchmark may not be topped out. For example, the benchmark for the claims submission mechanism may be topped out for a measure, but the benchmark for the EHR submission mechanisms for that same measure may not be topped out. We decided to limit our criteria to only measures that were topped out for all measures for simplicity and to avoid confusion about what scoring is applied to a measure.

- Measure is in a specialty set with at least 10 measures, because 2 measures in the pathology specialty set, which only has 8 measures total would have been included.

Applying these criteria results in the 6 measures as listed in Table 21.

TABLE 21: Topped Out Measures Proposed for Special Scoring for the 2018 MIPS Performance Period

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

Measure Name	Measure ID	Measure Type	Topped Out for All Submission Mechanisms	Specialty Set
Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	52	Process	Yes	n/a

We propose to apply the special topped out scoring method that we finalize for the 2018 performance period to only the 6 measures in Table 21 for the 2018 performance period, provided they are again identified as topped out in the benchmarks for the 2018 performance period. If these measures are not identified as topped out in the benchmarks published for the 2018 performance period, they will not be scored differently because they would not be topped out for a second consecutive year.

We seek comment on our proposal to apply special topped out scoring only to the 6 measures identified in Table 21 for the 2018 performance period.

Starting with the 2019 performance period, we propose 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. We seek comment on our 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.

We illustrate the lifecycle for scoring and removing topped out measures based on our proposals as follows:

- Year 1: Measure benchmarks are identified as topped out, which in this example would be in the benchmarks published for the 2017 MIPS performance period.
- Year 2: Measure benchmarks are identified as topped out, which in this example would be in the benchmarks published for the 2018 MIPS performance period. Measures identified in Table 21 have special scoring applied, provided they are identified as topped out for

the 2018 MIPS performance period, meaning it is the second consecutive year they are identified as topped out.

- Year 3: Measure benchmarks are identified as topped out in the benchmarks published for the 2019 MIPS performance period. All measure benchmarks identified as topped out for the second (or more) consecutive year have special scoring applied for the 2019 MIPS performance period. In Year 3 we would also consider removal of the select set of topped out measures identified in Table 21, through notice and comment rulemaking, provided they are identified as topped out during the previous two (or more) consecutive years. In our example, Year 3 would be the 2019 performance period.

- Year 4: Measure benchmarks are identified as topped out in the benchmarks published for the 2020 MIPS performance period. Measure benchmarks identified as topped out for a second (or more) consecutive year continue to have special scoring applied. Topped out measures finalized for removal for the 2020 MIPS performance period are no longer available for reporting.

An example of applying the proposed scoring cap compared to scoring applied for the 2017 MIPS performance period is provided in Table 22.

TABLE 22: Proposed Scoring for Topped Out Measures* Starting in the CY 2018 MIPS Performance Period Compared to the Transition Year Scoring

Scoring Policy	Measure 1 (topped out)	Measure 2 (topped out)	Measure 3 (topped out)	Measure 4 (topped out)	Measure 5 (not topped out)	Measure 6 (not topped out)	Quality Cate-gory Percent Score*
2017 MIPS performance period Scoring	10 measure achieve-ment points	10 measure achieve-ment points	10 measure achieve-ment points	4 measure achieve-ment points (did not get max score)	10 measure achieve-ment points	5 measure achieve-ment points	49/60 = 81.67%
Proposed Capped Scoring applied	6 measure achieve-ment points	6 measure achieve-ment points	6 measure achieve-ment points	4 measure achieve-ment points	10 measure achieve-ment points	5 measure achieve-ment points	37/60 = 61.67%
Notes	Topped out measures scored with 6-point measure achievement point cap.				Still possible to earn maximum measure		

Scoring Policy	Measure 1 (topped out)	Measure 2 (topped out)	Measure 3 (topped out)	Measure 4 (topped out)	Measure 5 (not topped out)	Measure 6 (not topped out)	Quality Cate-gory Percent Score*
	Cap does not impact score if the MIPS eligible clinician's score is below the cap.				achievement points on the non-topped out measures		

*This example would only apply to the 6 measures identified in Table 21 for the CY 2018 MIPS Performance Period. This example also excludes bonus points and improvement scoring proposed in section II.C.7.a.(2)(i) of this proposed rule.

Together the proposed policies for phasing in capped scoring and removing topped out measures are intended to provide an incentive for MIPS eligible clinicians to begin to submit measures that are not topped out while also providing stability by allowing MIPS eligible clinicians who have few alternative measures to continue to receive standard scoring for most topped out measures for an additional year, and not perform below the median score for those 6 measures that receive special scoring. It also provides MIPS eligible clinicians the ability to anticipate and plan for the removal of specific topped out measures, while providing measure developers time to develop new measures.

We propose to add a new paragraph at §414.1380(b)(1)(xiii) to codify our proposal for the lifecycle for removing topped out measures.

We also propose to add at §414.1380(b)(1)(xiii)(A) that for the 2018 MIPS performance period, the 6 measures identified in Table 21 will receive a maximum of 6 measure achievement points, provided that the measure benchmarks are identified as topped out again in the benchmarks published for the 2018 MIPS performance period. We also propose to add at §414.1380(b)(1)(xiii)(B) that beginning with the 2019 MIPS performance period, measure benchmarks, except for measures in the CMS Web Interface, that are identified as topped out for two 2 or more consecutive years will receive a maximum of 6 measure achievement points in the second consecutive year it is identified as topped out, and beyond. We specifically seek 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. We note that we would like to encourage groups to report the CAHPS for MIPS survey as it incorporates beneficiary feedback.

We stated in the CY 2017 Quality Payment Program final rule that we do not believe it would be appropriate to remove topped out measures from the CMS Web Interface for the Quality Payment Program because the CMS Web Interface measures are used in MIPS and in APMs such as the Shared Savings Program and because we have aligned policies, where possible, with the Shared Savings Program, such as using the Shared Savings Program benchmarks for the CMS Web Interface measures (81 FR 77285). In the CY 2017 Quality Payment Program final rule, we also finalized that MIPS eligible clinicians submitting via the CMS Web Interface must submit all measures included in the CMS Web Interface (81 FR 77116). Thus, if a CMS Web Interface measure is topped out, the CMS Web Interface submitter cannot select other measures. Because of the lack of ability to select measures, we are not proposing to apply a special scoring adjustment to topped out measures for CMS Web Interface for the Quality Payment Program.

Additionally, because the Shared Savings Program incorporates a methodology for measures with high performance into the benchmark, we do not believe capping benchmarks from the CMS Web Interface for the Quality Payment Program is appropriate. We finalized in the CY 2017 Quality Payment Program final rule at §414.1380(b)(1)(ii)(A) to use benchmarks from the corresponding reporting year of the Shared Savings Program. The Shared Savings Program adjusts some benchmarks to a flat percentage when the 60th percentile is equal to or greater than 80.00 percent for individual measures (78 FR 74759 through 74763), and, for other measures, benchmarks are set using flat percentages when the 90th percentile for a measure are equal to or greater than 95.00 percent (79 FR 67925). Thus, we are not proposing to apply the topped out measure cap to measures in the CMS Web Interface for the Quality Payment Program.

We seek comment on this proposal not to apply the topped out measure cap to measures in the CMS Web Interface for the Quality Payment Program.

(d) Case Minimum Requirements and Measure Reliability and Validity

To help ensure reliable measurement, in the CY 2017 Quality Payment Program final rule (81 FR 77288), we finalized a 20-case minimum for all quality measures except the all-cause hospital readmission measure. For the all-cause hospital readmission measure, we finalized in the CY 2017 Quality Payment Program final rule a 200-case minimum and finalized to apply the all-cause hospital readmission measure only to groups of 16 or more clinicians that meet the 200-case minimum requirement (81 FR 77288).

We are not proposing any changes to these policies.

For the 2019 MIPS payment year, we finalized in the CY 2017 Quality Payment Program final rule that if the measure is submitted but is unable to be scored because it does not meet the required case minimum, does not have a benchmark, or does not meet the data completeness requirement, the measure would receive a score of 3 points (81 FR 77288 through 77289). We identified two classes of measures for the transition year. Class[9] 1 measures are measures that can be scored based on performance because they have a benchmark, meet the case minimum requirement, and meet the data completeness standard. We finalized that Class 1 measures would receive 3 to 10 points based on performance compared to the benchmark (81 FR 77289). Class 2 measures are measures that cannot be scored based on performance because they do not have a benchmark, do not have at least 20 cases, or the submitted measure does not meet data completeness criteria. We finalized that Class 2 measures, which do not include measures submitted with the CMS Web Interface or administrative claims-based measures, receive 3 points (81 FR 77289).

[9] References to "Classes" of measures in this section II.C.7.a.(2)(d) are intended only to characterize the measures for ease of discussion.

We propose to maintain the policy to assign 3 points for measures that are submitted but do not meet the required case minimum or does not have a benchmark for the 2020 MIPS payment year and amend §414.1380(b)(1)(vii) accordingly.

We also propose a change to the policy for scoring measures that do not meet the data completeness requirement for the 2020 MIPS payment year.

To encourage complete reporting, we are proposing that in the 2020 MIPS payment year, measures that do not meet data completeness standards will receive 1 point instead of the 3 points that were awarded in the 2019 MIPS payment year. We propose lowering the point floor to 1 for measures that do not meet data completeness standards for several reasons. First, we want to encourage complete reporting because data completeness is needed to reliably measure quality. Second, unlike case minimum and availability of a benchmark, data completeness is within the direct control of the MIPS eligible clinician. In the future, we intend that measures that do not meet the completeness criteria will receive zero points; however, we believe that during the second year of transitioning to MIPS, clinicians should continue to receive at least 1 measure achievement point for any submitted measure, even if the measure does not meet the data completeness standards.

We are concerned, however, that data completeness may be harder to achieve for small practices. For example, small practices tend to have small case volume and missing one or two cases could cause the MIPS eligible clinician to miss the data completeness standard as each case may represent multiple percentage points for data completeness. For example, for a small practice with only 20 cases for a measure, each case is worth 5 percentage points, and if they miss reporting just 11 or more cases, they would fail to meet the data completeness threshold, whereas for a practice with 200 cases, each case is worth 0.5 percentage points towards data completeness and the practice would have to miss more than 100 cases to fail to meet the data completeness criteria. Applying 1 point for missing data completeness based on missing a

relatively small number of cases could disadvantage these clinicians, who may have additional burdens for reporting in MIPS, although we also recognize that failing to report on 10 or more patients is undesirable. In addition, we know that many small practices may have less experience with submitting quality performance category data and may not yet have systems in place to ensure they can meet the data completeness criteria. Thus, we are also proposing an exception to the proposed policy for measures submitted by small practices, as defined in §414.1305. We propose that these clinicians would continue to receive 3 points for measures that do not meet data completeness.

Therefore, we propose 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. We also propose to create Class 3 measures, which are measures that do not meet the data completeness requirement. We propose that the revised Class 2 measure would continue to receive 3 points. The proposed Class 3 measures would receive 1 point, except if the measure is submitted by a small practice in which case the Class 3 measure would receive 3 points. However, consistent with the policy finalized in the CY 2017 Quality Payment Program final rule, 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. A summary of the proposals is provided in Table 23.

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

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

We propose to amend §414.1380(b)(1)(vii) to assign 3 points for measures that do not meet the case minimum or do not have a benchmark in the 2020 MIPS payment year, and to assign 1 point for measures that do not meet data completeness requirements, unless the measure is submitted by a small practice, in which case it would receive 3 points.

We invite comment on our proposal to assign 1 point to measures that do not meet data completeness criteria, with an exception for measures submitted by small practices.

We are not proposing to change the methodology we use to score measures submitted via the CMS Web Interface that do not meet the case minimum, do not have a benchmark, or do not

meet the data completeness requirement finalized in the CY 2017 Quality Payment Program final rule and codified at paragraph (b)(1)(viii) of §414.1380. However, we note that as described in section II.C.7.a.(2)(h)(ii) of this proposed rule, we are proposing to add that CMS Web Interface measures with a benchmark that are redesignated from pay for performance to pay for reporting by the Shared Savings Program will not be scored. We refer readers to the discussion at 81 FR 77288 for more details on our previously finalized policy.

We are 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 finalized in the CY 2017 Quality Payment Program final rule and codified at paragraph (b)(1)(viii) of §414.1380. We refer readers to the discussion at 81 FR 77288 for more details on that policy.

To clarify the exclusion of measures submitted via the CMS Web Interface and based on administrative claims from the policy changes proposed to be codified at paragraph (b)(1)(vii) previously, we are amending paragraph (b)(1)(vii) to make it subject to paragraph (b)(1)(viii), which codifies the exclusion.

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

In the CY 2017 Quality Payment Program final rule, we finalized that MIPS eligible clinicians who fail to submit a measure that is required to satisfy the quality performance category submission criteria would receive zero points for that measure (81 FR 77291). For each required measure that is not submitted, a MIPS eligible clinician would receive zero points out of 10. For example, if a MIPS eligible clinician had 6 measures available and applicable but submitted only 4 measures, the MIPS eligible clinician would be assigned zero out of 10 measure achievement points for the 2 missing measures, which would be calculated into their performance category percent score.

We are not proposing any changes to the policy to assign zero points for failing to submit a measure that is required in this proposed rule.

In the CY 2017 Quality Payment Program final rule, we also finalized implementation of a validation process for claims and registry submissions to validate whether MIPS eligible clinicians have 6 applicable and available measures, whether an outcome measure is available or whether another high priority measure is available if an outcome measure is not available (81 FR 77290 through 77291).

We are not proposing any changes to apply a process to validate whether MIPS eligible clinicians that submit measures via claims and registry submissions have measures available and applicable. As stated in the CY 2017 Quality Payment Program final rule (81 FR 77290), we did not intend to establish a validation process for QCDRs because we expect that MIPS eligible clinicians that enroll in QCDRs will have sufficient meaningful measures to meet the quality performance category criteria (81 FR 77290 through 77291). We do not propose any changes to this policy.

We also stated 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 (81 FR 77290 through 77291). Under our proposals in section II.C.6.a.(1) of this proposed rule to allow measures to be submitted and scored via multiple mechanisms within a performance category, we anticipate that MIPS eligible clinicians that submit fewer than 6 measures via EHR will have sufficient additional measures available via a combination of submission mechanisms to submit the measures required to meet the quality performance category criteria. For example, the MIPS eligible clinician could submit 2 measures via EHR and supplement that with 4 measures via QCDR or registry.

Therefore, given our proposal to score multiple mechanisms, if a MIPS eligible clinician submits any quality measures via EHR or QCDR, we would not conduct a validation process because we expect these MIPS eligible clinicians to have sufficient measures available to meet the quality performance category requirements.

Given our proposal in section II.C.7.a.(2)(h) of this proposed rule to score measures submitted via multiple mechanisms, we propose 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, we propose that we will apply the validation process to determine if other measures are available and applicable broadly across claims and registry submission options. We will not check if there are measures available via EHR or QCDR submission options for these reporters. We note that groups cannot report via claims and therefore groups and virtual groups will only have validation applied across registries. We would validate the availability and applicability of a measure through a clinically related measure analysis based on patient type, procedure, or clinical action associated with the measure specifications. For us 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. Given our proposal in section II.C.7.a.(2)(h) of this proposed rule to score measures submitted via multiple mechanisms, 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.

We recognize that in extremely rare instances there may be a MIPS eligible clinician who may not have available and applicable quality measures. For example, a subspecialist who focuses on a very targeted clinical area may not have any measures available. However, in many

cases, the clinician may be part of a broader group or would have the ability to select some of the cross-cutting measures that are available. Given the wide array of submission options, including QCDRs which have the flexibility to develop additional measures, we believe this scenario should be extremely rare. If we are not able to score the quality performance category, we may reweight their score according to the reweighting policies described in section II.C.7.b.(3)(b) and II.C.7.b.(3)(d) of this proposed rule. We note that we anticipate this will be a rare circumstance given our proposals to allow measures to be submitted and scored via multiple mechanisms within a performance category and to allow facility-based measurement for the quality performance category.

(f) Incentives to Report High Priority Measures

In the CY 2017 Quality Payment Program final rule, we finalized that we would award 2 bonus points for each outcome or patient experience measure and 1 bonus point for each additional high priority measure that is reported in addition to the 1 high priority measure that is already required to be reported under the quality performance category submission criteria, provided the measure has a performance rate greater than zero, and the measure meets the case minimum and data completeness requirements (81 FR 77293). High priority measures were defined as outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures, as identified in Tables A and E in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77558 and 77686). We also finalized that we will apply measure bonus points for the CMS Web Interface for the Quality Payment Program based on the finalized set of measures reportable through that submission mechanism (81 FR 77293). We note that in addition to the 14 required measures, CMS Web Interface reporters may also report the CAHPS for MIPS survey and receive measure bonus points for submitting that measure.

We are not proposing any changes to these policies for awarding measure bonus points for reporting high priority measures in this proposed rule.

In the CY 2017 Quality Payment Program final rule, we finalized a cap on high priority measure bonus points at 10 percent of the denominator (total possible measure achievement points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category for the first 2 years of MIPS (81 FR 77294). Groups that submit via the CMS Web Interface for the Quality Payment Program are also subject to the 10 percent cap on high priority measure bonus points. We are not proposing any changes to the cap on measure bonus points for reporting high priority measures, which is codified at §414.1380(b)(1)(xiv)(D)[10], in this proposed rule.

(g) Incentives to Use CEHRT to Support Quality Performance Category Submissions

Section 1848(q)(5)(B)(ii) of the Act outlines specific scoring rules to encourage the use of CEHRT under the quality performance category. For more of the statutory background and description of the proposed and finalized policies, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77294 through 77299).

In the CY 2017 Quality Payment Program final rule at §414.1380(b)(1)(xiv), we codified that 1 bonus point is available for each quality measure submitted with end-to-end electronic reporting, under certain criteria described below (81 FR 77297). We also finalized a policy capping the number of bonus points available for electronic end-to-end reporting at 10 percent of the denominator of the quality performance category percent score, for the first 2 years of the program (81 FR 77297). For example, when the denominator is 60, the number of measure bonus points will be capped at 6 points. We also finalized that the CEHRT bonus would be available to all submission mechanisms except claims submissions. Specifically, MIPS eligible clinicians who report via qualified registries, QCDRs, EHR submission mechanisms, or the CMS Web Interface for the Quality Payment Program, in a manner that meets the end-to-end reporting

[10] Redesignated from §414.1380(b)(1)(xiii)(D).

requirements, may receive 1 bonus point for each reported measure with a cap as described (81 FR 77297).

We are not proposing changes to these policies related to bonus points for using CEHRT for end-to-end reporting in this proposed rule. However, we are seeking 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? We welcome public comment on these questions.

(h) Calculating Total Measure Achievement and Measure Bonus Points

In section II.C.7.a.(2)(i) of this proposed rule, we are proposing a new methodology to reward improvement based on achievement, from 1 year to another, which requires modifying the calculation of the quality performance category percent score. In this section II.C.7.a.(2)(h) of the proposed rule, we are summarizing the policies for calculating the total measure achievement points and total measure bonus points, prior to scoring improvement and the final quality performance category percent score. We note that we will refer to policies finalized in the CY 2017 Quality Payment Program final rule that apply to the quality performance category score, which is referred to as the quality performance category percent score in this proposed rule, in this section. We are also proposing some refinements to address the ability for MIPS eligible clinicians to submit quality data via multiple submission mechanisms.

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

In the CY 2017 Quality Payment Program final rule (81 FR 77300), we 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 we will only include the scores for the measures with the highest number of assigned points, once the first outcome measure is scored, or if an outcome measure is not available, once another high priority measure is scored. We are not proposing any changes to the policy to score the measures with the highest number of assigned points in this proposed rule; however, we are proposing refinements to account for measures being submitted across multiple submission mechanisms.

In the CY 2017 Quality Payment Program final rule, we sought comment on whether to score measures submitted across multiple submission mechanisms (81 FR 77275). As described in section II.C.6.a.(1) of this proposed rule, we are proposing that MIPS eligible clinicians be able to submit measures within a performance category via multiple submission mechanisms. In the CY 2017 Quality Payment Program final rule, we also sought comment on what approach we should use to combine the scores for quality measures from multiple submission mechanisms into a single aggregate score for the quality performance category (81 FR 77275). Examples of possible scoring options were a weighted average score on quality measures submitted through two or more different mechanisms or taking the highest scores for any submitted measure regardless of how the measure is submitted. A few comments received in response to the CY 2017 Quality Payment Program final rule did not support developing different weights for different submission methods. One commenter recommended that we take the highest score for any submitted measure, regardless of submission mechanisms, or alternatively, calculate independent scores that would each contribute equally to the final score.

After consideration of the comments we received, we are proposing, beginning with the 2018 MIPS performance period, a method to score quality measures if a MIPS eligible clinician submits measures via more than one of the following submission mechanisms: claims, qualified

registry, EHR or QCDR submission options. We believe that allowing MIPS eligible clinicians to be scored across these data submission mechanisms in the quality performance category will provide additional options for MIPS eligible clinicians to report the measures required to meet the quality performance category criteria, and encourage MIPS eligible clinicians to begin using electronic submission mechanisms, even if they may not have 6 measures to report via a single electronic submission mechanism alone. We note that we also continue to score the CMS-approved survey vendor for CAHPS for MIPS submission options in conjunction with other submission mechanisms (81 FR 77275) as noted in Table 24.

We propose to score measures across multiple mechanisms using the following rules:

- As with the rest of MIPS, we will only score measures within a single identifier. For example, as codified in §414.1310(e), eligible clinicians and MIPS eligible clinicians within a group aggregate their performance data across the TIN in order for their performance to be assessed as a group. Therefore, measures can only be scored across multiple mechanisms if reported by the same individual MIPS eligible clinician, group, virtual group or APM Entity, as described in Table 24.

- We do not propose to aggregate measure results across different submitters to create a single score for an individual measure (for example, we are not going to aggregate scores from different TINs within a virtual group TIN to create a single virtual group score for the measures; rather, virtual groups must perform that aggregation across TINs prior to data submission to CMS). 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. Then the same rules apply for selecting which measures are used for scoring. In other words, 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, we 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 our other scoring principles, where, for virtual groups, all quality measures are scored at the virtual group level.

- Separately, as also described in Table 24, because CMS Web Interface and facility-based measurement each have a comprehensive set of measures that meet the proposed MIPS submission requirements, we do 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). We refer readers to section II.C.7.a.(2)(h)(ii) of this proposed rule for discussion of calculating the total measure achievement and measure bonus points for CMS Web Interface reporters and to section II.C.7.a.(4) of this proposed rule for a description of our proposed policies on facility-based measurement. We list these submission mechanisms in Table 24, to illustrate that CMS Web Interface submissions and facility-based measurement cannot be combined with other submission options, except that the CAHPS for MIPS survey can be combined with CMS Web Interface, as described in section II.C.7.a.(2)(h)(ii) of this proposed rule.

TABLE 24: Scoring Allowed Across Multiple Mechanisms by Submission Mechanism (Determined by MIPS Identifier and Submission Mechanism)

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

MIPS APMs reporting Web Interface or other quality measures	MIPS APMs are subject to separate scoring standards and cannot be combined with other submission mechanisms.

- If a MIPS eligible clinician submits the same measure via 2 different submission mechanisms, we will score each mechanism by which the measure is submitted for achievement and take the highest measure achievement points of the 2 mechanisms.

- Measure bonus points for high priority measures would be added for all measures submitted via all the different submission mechanisms available, even if more than 6 measures are submitted, but high priority measure bonus points are only available once for each unique measure (as noted by the measure number) that meets the criteria for earning the bonus point. For example, if a MIPS eligible clinician submits 8 measures - 6 process and 2 outcome - and both outcome measures meet the criteria for a high priority bonus (meeting the required data completeness, case minimum, and has a performance rate greater than zero), the outcome measure with the highest measure achievement points would be scored as the required outcome measure and then the measures with the next 5 highest measure achievement points will contribute to the final quality score. This could include the second outcome measure but does not have to. Even if the measure achievement points for the second outcome measure are not part of the quality performance category percent score, measure bonus points would still be available for submitting a second outcome measure and meeting the requirement for the high priority measure bonus points. The rationale for providing measure bonus points for measures that do not contribute measure achievement points to the quality performance category percent score is that it would help create better benchmarks for outcome and other high priority measures by encouraging clinicians to report them even if they may not have high performance on the measure. We also want to encourage MIPS eligible clinicians to submit to us all of their available MIPS data, not only the data that they or their intermediary deem to be their best data.

We believe it will be in the best interest of all MIPS eligible clinicians that we determine which measures will result in the clinician receiving the highest MIPS score. If the same measure is submitted through multiple submission mechanisms, we would apply the bonus points only once to the measure. We propose to amend §414.1380(b)(1)(xiv) (as redesignated from §414.1380(b)(1)(xiii)) to add paragraph (b)(1)(xiv)(E) that if the same high priority measure is submitted via two or more submission mechanisms, as determined using the measure ID, the measure will receive high priority measure bonus points only once for the measure. The total measure bonus points for high-priority measures would still be capped at 10 percent of the total possible measure achievement points.

- 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 we would apply the bonus points only once to the measure. For example, if the same measure is submitted using end-to-end reporting via both a QCDR and EHR reporting mechanism, the measure would only get a measure bonus point one time. We propose to amend §414.1380(b)(1)(xv) (as redesignated) to add that if the same measure is submitted via two or more submission mechanisms, as determined using the measure ID, the measure will receive measure bonus points only once for the measure. The total measure bonus points for end-to-end electronic reporting would still be capped at 10 percent of the total available measure achievement points.

Although we provide a policy to account for scoring in those circumstances when the same measure is submitted via multiple mechanisms, we anticipate that this will be a rare circumstance and do not encourage clinicians to submit the same measure via multiple mechanisms. Table 25 illustrates how we would assign total measure achievement points and total measure bonus points across multiple submission mechanisms under our proposal. In this

example, a MIPS eligible clinician elects to submit quality data via 3 submission mechanisms: 3 measures via registry, 4 measures via claims, and 5 measures via EHR. The 3 registry measures are also submitted via claims (as noted by the same measure letter in this example). The EHR measures do not overlap with either the registry or claims measures. In this example, we assign measure achievement and bonus points for each measure. If the same measure (as determined by measure ID) is submitted, then we use the highest achievement points for that measure. For the bonus points, we assess which of the outcome measures meets the outcome measure requirement and then we identify any other unique measures that qualify for the high priority bonus. We also identify the unique measures that qualify for end-to-end electronic reporting bonus.

TABLE 25: Example of Assigning Total Measure Achievement and Bonus Points for an Individual MIPS Eligible Clinician that Submits Measures Across Multiple Submission Mechanisms

	Measure Achievement Points	**6 Scored Measures**	**High Priority Measure Bonus Points**	**Incentive for CEHRT Measure Bonus Points**
Registry				
Measure A (Outcome)	7.1	7.1 (Outcome measure with highest achievement points)	(required outcome measure does not receive bonus points)	
Measure B	6.2 (points not considered because it is lower than the 8.2 points for the same claims measure)			
Measure C (high priority patient safety measure that meets requirements for additional bonus points)	5.1 (points not considered because it is lower than the 6.0 points for the same claims measure)		1	
Claims				
Measure A (Outcome)	4.1 (points not considered because it is lower than the 7.1 points for the same measure submitted via a registry)		No bonus points because the registry submission of the same measure satisfies requirement for	

			outcome measure.	
Measure B	8.2	8.2		
Measure C (High priority patient safety measure that meets requirements for additional bonus points)	6.0	6.0	No bonus (Bonus applied to the registry measure)	
Measure D (outcome measure <50% of data submitted)	1.0	1.0	(no high priority bonus points because below data completeness)	
EHR (using end-to-end)				*Reporting that meets CEHRT bonus point criteria*
Measure E	5.1	5.1		1
Measure F	5.0	5.0		1
Measure G	4.1			1
Measure H	4.2	4.2		1
Measure I (high priority patient safety measure that is below case minimum)	3.0		(no high priority bonus points because below case minimum)	1
		35.6	1 (below 10% cap[1])	5 (below 10% cap)
Quality Performance Category Percent Score Prior to Improvement Scoring		(35.6 + 1 + 5) / 60 = 69.33%		

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

We propose to amend §414.1380(b)(1)(xii) to add paragraph (A) to state that if a MIPS eligible clinician submits measures via claims, qualified registry, EHR, or QCDR submission options, and submits more than the required number of measures, they are scored on the required measures with the highest assigned measure achievement points. MIPS eligible clinicians that report a measure via more than 1 submission mechanism can be scored on only 1 submission mechanism, which will be the submission mechanism with the highest measure achievement points. Groups that submit via these submission mechanisms may also submit and be scored on CMS-approved survey vendor for CAHPS for MIPS submission mechanisms.

We invite comments on our proposal to calculate the total measure achievement points by using the measures with the 6 highest measure achievement points across multiple submission mechanisms. We invite comments on our proposal that if the same measure is submitted via 2 or more mechanisms, we will only take the one with the highest measure achievement points. We invite comments on our proposal to assign high priority measure bonus points to all measures, with performance greater than zero, that meet case minimums, and that meet data completeness requirements, regardless of submission mechanism and to assign measure bonus points for each unique measure submitted using end-to-end electronic reporting. We invite comments on our proposal that if the same measure is submitted using 2 different mechanisms, the measure will receive measure bonus points once.

We are not proposing any changes to our policy that if a MIPS eligible clinician does not have any scored measures, then a quality performance category percent score will not be calculated as finalized in the CY 2017 Quality Payment Program final rule at 81 FR 77300. We refer readers to the discussion at 81 FR 77299 through 77300 for more details on that policy. As stated in section II.C.7.a.(2)(e) of this proposed rule, we anticipate 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.

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

In the CY 2017 Quality Payment Program final rule, we finalized that CMS Web Interface reporters are required to report 14 measures, 13 individual measures, and a 2-component measure for diabetes (81 FR 77302 through 77305). We note that for the transition year, 3 measures did not have a benchmark in the Shared Savings Program. Therefore, for the transition year, CMS Web Interface reporters are scored on 11 of the total 14 required measures, provided that they report all 14 required measures.

In the CY 2017 Quality Payment Program final rule, we finalized a global floor of 3 points for all CMS Web Interface measures submitted in the transition year, even with measures at zero percent performance rate, provided that these measures have met the data completeness criteria, have a benchmark and meet the case minimum requirements (82 FR 77305). Therefore, measures with performance below the 30th percentile will be assigned a value of 3 points during the transition year to be consistent with the floor established for other measures and because the Shared Savings Program does not publish benchmarks below the 30th percentile (82 FR 77305). We stated that we will reassess scoring for measures below the 30th percentile in future years.

We propose to continue to assign 3 points for measures with performance below the 30th percentile, provided the measure meets data completeness, has a benchmark, and meets the case minimum requirements for the 2018 MIPS performance year; we make 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. We will reassess this policy again next year through rulemaking.

We are not proposing any changes to our 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 our policy that measures that are not submitted and measures submitted below the data completeness requirements will receive a zero score (82 FR 77305). However, to further increase alignment with the Shared Savings Program, we propose 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, although we will recognize the measure was submitted. While the Shared Savings Program designates measures that are pay for performance in advance of the reporting year, the Shared Savings Program may redesignate a measure as pay for reporting under certain circumstances (see 42 CFR 425.502(a)(5)). Therefore, we propose to amend §414.1380(b)(1)(viii) to add that CMS Web

Interface measures that have a measure benchmark but are redesignated as pay for reporting for all Shared Savings Program ACOs by the Shared Savings Program will not be scored, as long as the data completeness requirement is met.

We invite comment on our proposal to not score CMS Web Interface measures redesignated as pay for reporting by the Shared Savings Program.

We also note that, while we did not state explicitly in the CY 2017 Quality Payment Program final rule, groups that choose to report quality measures via the CMS Web Interface may, in addition to the 14 required measures, also submit the CAHPS for MIPS survey in the quality performance category (81 FR 77094 through 77095; 81 FR 77292). If they do so, they can receive bonus points for submitting this high priority measure and will be scored on it as an additional measure. Therefore, we propose to amend §414.1380(b)(1)(xii) to add paragraph (B) to state that groups that submit measures via the CMS Web Interface may also submit and be scored on CMS-approved survey vendor for CAHPS for MIPS submission options.

In addition, groups of 16 or more eligible clinicians that meet the case minimum for administrative claims measures will automatically be scored on the all-cause hospital readmission measure and have that measure score included in their quality category performance percent score.

We are not proposing any changes to calculating the total measure achievement points and measure bonus points for CMS Web Interface measures in this proposed rule, although we are proposing to add improvement to the quality performance category percent score for such submissions (as well as other submission mechanisms) in section II.C.7.a.(2)(j) of this proposed rule.

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

(i) Calculating Improvement at the Quality Performance Category Level

In the CY 2017 Quality Payment Program final rule, we noted that we consider achievement to mean how a MIPS eligible clinician performs relative to performance standards, and improvement to mean how a MIPS eligible clinician performs compared to the MIPS eligible clinician's own previous performance on measures and activities in the performance category (81 FR 77274). We also solicited public comments in the CY 2017 Quality Payment Program proposed rule on potential ways to incorporate improvement in the scoring methodology. In section II.C.7.a.(1)(b)(i) of this proposed rule, we explain why we believe that the options set forth in the CY 2017 Quality Payment Program proposed rule, including the Hospital VBP Program, the Shared Savings Program, and Medicare Advantage 5-star Ratings Program, were not fully translatable to MIPS. Beginning with the 2018 MIPS performance period, we propose here to score improvement as well as achievement in the quality performance category level when data is sufficient. We believe that scoring improvement at the performance category level, rather than measuring improvement at the measure level, for the quality performance category would allow improvement to be available to the broadest number of MIPS eligible clinicians because we are connecting performance to previous MIPS quality performance as a whole rather than changes in performance for individual measures. Just as we believe it is important for a MIPS eligible clinician to have the flexibility to choose measures that are meaningful to their practice, we want them to be able to adopt new measures without concern about losing the ability to be measured on improvement. In addition, we are encouraging MIPS eligible clinicians to select more outcome measures and to move away from topped out measures. We do not want to remove the opportunity to score improvement from those who select different measures between performance periods for the quality performance category; therefore, we are proposing to measure improvement at the category level which can be calculated with different measures.

We propose at §414.1380(b)(1)(xvi)(E) to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category percent score. We also propose at §414.1380(b)(1)(xvi)(C) that an improvement percent score would be assessed at the quality performance category level and included in the calculation of the quality performance category percent score. When we evaluated different improvement scoring options, we saw two general methods for incorporating improvement. One method measures both achievement and improvement and takes the higher of the two scores for each measure that is compared. The Hospital VBP Program incorporates such a methodology. The second method is to calculate an achievement score and then add an improvement score if improvement is measured. The Shared Savings Program utilizes a similar methodology for measuring improvement. For the quality performance category, we are proposing to calculate improvement at the category level and believe adding improvement to an existing achievement percent score would be the most straight-forward and simple way to incorporate improvement. For the purpose of improvement scoring methodology, the term "quality performance category achievement percent score" means the total measure achievement points divided by the total possible available measure achievement points, without consideration of bonus points or improvement adjustments and is discussed in section II.C.7.a.(2)(i)(iv) of this proposed rule.

Consistent with bonuses available in the quality performance category, we propose at §414.1380(b)(1)(xvi)(B) that the improvement percent score may not total more than 10 percentage points.

We invite public comments on these proposals.

(ii) Data Sufficiency Standard to Measure Improvement for Quality Performance Category

Section 1848(q)(5)(D)(i) of the Act stipulates that beginning with the second year to which the MIPS applies, if data sufficient to measure improvement is available then we shall measure improvement for the quality performance category. Measuring improvement requires a

direct comparison of data from one Quality Payment Program year to another. Starting with the 2020 MIPS payment year, we propose that a MIPS eligible clinician's data would be sufficient to score improvement in the quality performance category if the MIPS eligible clinician had a comparable quality performance category achievement percent score for the MIPS performance period immediately prior to the current MIPS performance period; we explain our proposal to identify how we will identify "comparable" quality performance category achievement percent scores below. We believe that this approach would allow improvement to be broadly available to MIPS eligible clinicians and encourage continued participation in the MIPS program. Moreover, this approach would encourage MIPS eligible clinicians to focus on efforts to improve the quality of care delivered. We note that, by measuring improvement based only on the overall quality performance category achievement percent score, some MIPS eligible clinicians and groups may generate an improvement score simply by switching to measures on which they perform more highly, rather than actually improving at the same measures. We will monitor how frequently improvement is due to actual improvement versus potentially perceived improvement by switching measures and will address through future rulemaking, as needed. We also solicit comment on whether we should require some level of year to year consistency when scoring improvement.

We propose that "comparability" of quality performance category achievement percent scores would be established by looking first at the submitter of the data. As discussed in more detail in section II.C.7.a.(2)(i)(i) of this proposed rule, we are comparing results at the category, rather than the performance measure level because we believe that the performance category score from 1 year is comparable to the performance category score from the prior year, even if the measures in the performance category have changed from year to year.

We propose to compare results from an identifier when we receive 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. However, if we do not have the same identifier for two consecutive performance periods, we propose a methodology to create a comparable performance category score that can be used for improvement measurement. Just as we do not want to remove the opportunity to earn an improvement score from those who elect new measures between performance periods for the quality performance category, we also do not want to restrict improvement for those MIPS eligible clinicians who elect to participate in MIPS using a different identifier.

There are times when submissions from a particular individual clinician or group of clinicians use different identifiers between 2 years. For example, a group of 20 MIPS eligible clinicians could choose to submit as a group (using their TIN identifier) for the current performance period. If the group also submitted as a group for the previous year's performance period, we would simply compare the group scores associated with the previous performance period to the current performance period (following the methodology explained in section II.C.7.a.(2)(i)(iv) of this proposed rule). However, if the group members had previously elected to submit to MIPS as individual clinicians, we would not have a group score at the TIN level from the previous performance period to which to compare the current performance period.

In circumstances where we do not have the same identifier for two consecutive performance periods, we propose 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 we do not have a quality performance category achievement percent score for the same individual identifier in the immediately prior period, then we propose to apply the hierarchy logic that is described in section II.C.8.a.(2) of this proposed rule 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 example, if there is no historical score for the TIN/NPI, but there is a TIN score (because in the previous period the TIN submitted as a group),

then we would use the quality performance category achievement percent score associated with the TIN's prior performance. If the NPI had changed TINs and there was no historical score for the same TIN/NPI, then we would take the highest prior score associated with the NPI.

When we do not have a comparable TIN group, virtual group, or APM Entity score, we propose to calculate a score based on the individual TIN/NPIs in the practice for the current performance period. For example, in a group of 20 clinicians that previously participated in MIPS as individuals, but now want to participate as a group, we would not have a comparable TIN score to use for scoring improvement. We believe however it is still important to provide to the MIPS eligible clinicians the improvement points they have earned. Similarly, in cases where a group of clinicians previously participated in MIPS as individuals, but now participates as a new TIN, or a new virtual group, or a new APM Entity submitting data in the performance period, we would not have a comparable TIN, virtual group, or APM Entity score to use for scoring improvement. Therefore, we propose 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 we have more than one quality performance category achievement percent score for the same individual identifier in the immediately prior period, then we propose to apply the hierarchy logic that is described in section II.C.8.a.(2) of this proposed rule to identify the quality performance category score associated with the final score that would be applied to the TIN/NPI for payment purposes. We would exclude any TIN/NPI's that did not have a final score because they were not eligible for MIPS. We would include quality performance category achievement percent scores of zero in the average.

There are instances where we would not be able to measure improvement due to lack of sufficient data. For example, if the MIPS eligible clinicians did not participate in MIPS in the previous performance period because they were not eligible for MIPS, we could not calculate

improvement because we would not have a previous quality performance category achievement percent score.

Table 26 summarizes the different cases when a group or individual would be eligible for improvement scoring under this proposal.

TABLE 26: Eligibility for Improvement Scoring Examples

Scenario	Current MIPS Performance Period Identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
No change in identifier.	Individual (TIN A/NPI 1)	Individual (TIN A/NPI 1)	Yes	Current individual score is compared to individual score from prior performance period.
No change in identifier.	Group (TIN A)	Group (TIN A)	Yes	Current group score is compared to group score from prior performance period.
Individual is with same group, but selects to submit as an individual whereas previously the group submitted as a group.	Individual (TIN A/ NPI 1)	Group (TIN A)	Yes	Current individual score is compared to the group score associated with the TIN/NPI from the prior performance period.
Individual changes practices, but submitted to MIPS previously as an individual.	Individual (TIN B/NPI)	Individual (TIN A/NPI)	Yes	Current individual score is compared to the individual score from the prior performance period.
Individual changes practices and has multiple scores in prior performance period.	Individual (TIN C/NPI)	Group (TIN A/NPI); Individual (TIN B/NPI)	Yes.	Current individual score is compared to highest score from the prior performance period.
Group does not have a previous group score from prior performance period.	Group (TIN A)	Individual scores (TIN A/NPI 1, TIN A/NPI 2, TIN A/NPI 3, etc.)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Virtual group does not have previous group score from prior performance period.	Virtual Group (Virtual Group Identifier A) (Assume virtual group has 2 TINs with 2 clinicians.)	Individuals (TINA/NPI 1, TIN A/NPI 2, TIN B/NPI 1, TIN B/NPI 2)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Individual does not have a quality performance category achievement score for the prior performance period.	Individual (TIN A/NPI 1)	Individual was not eligible for MIPS and did not voluntarily submit any quality measures to MIPS.	No	The individual quality performance category score is missing for the prior performance period and not eligible for improvement scoring.

We propose at §414.1380(b)(1)(xvi)(A) to state that improvement scoring is available when the data sufficiency standard is met, which means when data are available and a MIPS eligible clinician or group has a quality performance category achievement percent score for the previous performance period. We also propose at §414.1380(b)(1)(xvi)(A)(1) that data must be comparable to meet the requirement of data sufficiency, which means that the quality performance category achievement percent score is available for the current performance period and the previous performance period and, therefore, quality performance category achievement percent scores can be compared. We also propose at §414.1380(b)(1)(xvi)(A)(2) that quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods. We also propose an exception at §414.1380(b)(1)(xvi)(A)(3) that if the identifier is not the same for 2 consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment. For group, virtual group, and APM entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group. As noted above, these proposals are designed to offer improvement scoring to all MIPS eligible clinicians with sufficient data in the prior MIPS performance period. We invite public comments on our proposals as they relate to data sufficiency for improvement scoring.

We also seek comment on an alternative to this proposal: whether we should restrict improvement to those who submit quality performance data using the same identifier for two consecutive MIPS performance periods. We believe this option would be simpler to apply, communicate and understand than our 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.

(iii) Additional Requirement for Full Participation to Measure Improvement for Quality Performance Category

To receive a quality performance category improvement percent score greater than zero, we are also proposing that MIPS eligible clinicians must fully participate, which we propose in §414.1380(b)(1)(xvi)(F) to mean compliance with §414.1330 and §414.1340, in the current performance year. Compliance with those referenced regulations entails the submission of all required measures, including meeting data completeness, for the quality performance category for the current performance period. For example, for MIPS eligible clinicians submitting via QCDR, full participation would generally mean submitting 6 measures including 1 outcome measure if an outcome measure is available or 1 high priority measure if an outcome measure is not available, and meeting the 50 percent data completeness criteria for each of the 6 measures.

We believe that improvement is most meaningful and valid when we have a full set of quality measures. A comparison of data resulting from full participation of a MIPS eligible clinician from 1 year to another enables a more accurate assessment of improvement because the performance being compared is based on the applicable and available measures for the performance periods and not from changes in participation. While we are not requiring full participation for both performance periods, requiring full participation for the current performance period means that any future improvement scores for a clinician or group would be derived solely from changes in performance and not because the clinician or group submitted more measures. We propose at §414.1380(b)(1)(xvi)(C)(5) 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.

Because we want to award improvement for net increases in performance and not just improved participation in MIPS, we want to measure improvement above a floor for the 2018 MIPS performance period, to account for our transition year policies. We considered that MIPS eligible clinicians who chose the "test" option of the "pick your pace" approach for the transition year may not have submitted all the required measures and, as a result, may have a relatively low quality performance category achievement score for the 2017 MIPS performance period. Due to the transition year policy to award at least 3 measure achievement points for any submitted measure via claims, EHR, QCDR, qualified registry, and CMS-approved survey vendor for CAHPS for MIPS, and the 3-point floor for the all-cause readmission measure (if the measure applies), a MIPS eligible clinician that submitted some data via these mechanisms on the required number of measures would automatically have a quality performance category achievement score of at least 30 percent because they would receive at least 3 of 10 possible measure achievement points for each required measure. For example, if a solo practitioner submitted 6 measures and received 3 points for each measure, then the solo practitioner would have 18 measure achievement points out of a possible 60 total possible measure achievement points (3 measure achievement points x 6 measures). The quality performance category achievement percent score is 18/60 which equals 30 percent. For groups with 16 or more clinicians that submitted 6 measures and receive 3 measure achievement points for each submitted measure as well as the all-cause hospital readmission measure, then the group would have 21 measure achievement points out of 70 total possible measure achievement points or a quality performance category achievement percent score of 21/70 which equals 30 percent (3 measure achievement points x 7 measures). For the CMS Web Interface submission option, MIPS eligible clinicians that fully participate by submitting and meeting data completeness for all measures, would also be able to achieve a quality performance category achievement percent

score of at least 30 percent, as each scored measure would receive 3 measure achievement points out of 10 possible measure achievement points.

Therefore, we propose at §414.1380(b)(1)(xvi)(C)(4) that if a MIPS eligible clinician has a previous year quality performance category score less than or equal to 30 percent, we would compare 2018 performance to an assumed 2017 quality performance category achievement percent score of 30 percent. In effect, for the MIPS 2018 performance period, improvement would be measured only if the clinician's 2018 quality performance category achievement percent score for the quality performance category exceeds 30 percent. We believe 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.

We invite public comment on these proposals.

(iv) Measuring Improvement Based on Changes in Achievement

To calculate improvement with a focus on quality performance, we are proposing to focus on improvement based on achievement performance and would not consider measure bonus points in our improvement algorithm. Bonus points may be awarded for reasons not directly related to performance such as the use of end-to-end electronic reporting. We believe that improvement points should be awarded based on improvement related to achievement. Accordingly, we are proposing to use an individual MIPS eligible clinician's or group's total measure achievement points from the prior MIPS performance period without the bonus points the individual MIPS eligible clinician or group may have received, to calculate improvement. Therefore, to measure improvement at the quality performance category level, we will use the quality performance category achievement percent score excluding measure bonus points (and any improvement score) for the applicable years. We propose at §414.1380(b)(1)(xvi)(D) to call

this score, which is based on achievement only, the "quality performance category achievement percent score" which is calculated using the following formula:

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

Table 27 illustrates how the quality performance category achievement percent score is calculated. For simplicity, we assume the MIPS eligible clinician received 6 measure achievement points for each of the submitted 6 required measures in the current performance period, which equals 36 total measure achievement points. This is compared to the previous performance period when the MIPS eligible clinician received only 5 measure achievement points per measure, for 30 total measure achievement points. The quality performance category achievement percent score is represented in line 2. For improvement, performance in the current 2018 MIPS performance period (60 percent) is compared to the performance category achievement percent score in the 2017 MIPS performance period (50 percent).

TABLE 27: Comparison of Quality Performance Category Achievement Percent Scores.

	Current MIPS Performance Period	**Previous MIPS Performance Period**
(1) Total Measure Achievement Points	6 measure achievement points x 6 measures = 36 total measure achievement points	5 measure achievement points x 6 measures = 30 total measure achievement points
(2) Quality Performance Category Achievement Percent Score (measure achievement points/60 for this example)	36/60= 60 percent	30/60 = 50 percent

The current MIPS performance period quality performance category achievement percent score is compared to the previous performance period quality performance category achievement percent 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.

We propose to amend the regulatory text at §414.1380(b)(1)(xvi) to state that improvement scoring is available to MIPS eligible clinicians and groups that demonstrate improvement in performance in the current MIPS performance period compared to the performance in the previous MIPS performance period, based on achievement. Bonus points or improvement percent score adjustments made to the category score in the prior or current performance period are not taken into account when determining whether an improvement has occurred or the size of any improvement percent score.

We invite public comment on our proposal to award improvement based on changes in the quality performance category achievement percent score.

(v) Improvement Scoring Methodology for the Quality Performance Category

We believe the improvement scoring methodology that we are proposing for the quality performance category recognizes the rate of increase in quality performance category scores of MIPS eligible clinicians from one performance period to another performance period so that a higher rate of improvement results in a higher improvement percent score. We believe this is particularly true for those clinicians with lower performance who will be incentivized to begin improving with the opportunity to increase their improvement significantly and achieve a higher improvement percent score.

We propose to award an "improvement percent score" based on the following formula:

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

Using the example from Table 27, the quality performance category achievement percent score for the current performance period is 60 percent, and the previous performance period achievement percent score is 50 percent. The increase in achievement is 10 percentage points

(60 percent – 50 percent). Therefore, the improvement percent score is 10 percent (increase in achievement)/50 percent (previous performance period achievement percent score) * 10 percent = 2 percentage points. Another way to explain the logic is a 20 percent rate of improvement for achievement (for example increasing the achievement percent score 10 percentage points which is 20 percent higher than the original 50 percent achievement percent score) is worth a 2 percentage point increase to the quality performance category achievement percent score.

We believe that this improvement scoring methodology provides an easily explained and applied approach that is consistent for all MIPS eligible clinicians. Additionally, it provides additional incentives for MIPS eligible clinicians who are lower performers to improve performance. We believe that providing larger incentives for MIPS eligible clinicians with lower quality performance category scores to improve will not only increase the quality performance category scores but also will have the greatest impact on improving quality for beneficiaries.

We also propose that the improvement percent score cannot be negative (that is, lower than zero percentage points). The improvement percent score would be zero for those who do not have sufficient data or who are not eligible under our proposal for improvement points. For example, as noted in section II.C.7.a.(2)(i)(ii) of this proposed rule, a MIPS eligible clinician would not be eligible for improvement if the clinician was not eligible for MIPS in the prior performance period and did not have a quality performance category achievement percent score. We are also proposing to cap the size of the improvement award at 10 percentage points, which we believe appropriately rewards improvement and does not outweigh percentage points available through achievement. In effect, 10 percentage points under our proposed formula would represent 100 percent improvement – or doubling of achievement measure points – over the immediately preceding period. For the reasons stated, we anticipate that this amount will encourage participation by individual MIPS eligible clinicians and groups and will provide an appropriate recognition and award for the largest increases in performance improvement.

Table 28 illustrates examples of the proposed improvement percent scoring methodology, which is based on rate of increase in quality performance category achievement percent scores.

TABLE 28: Improvement Scoring Examples Based on Rate of Increase in Quality Performance Category Achievement Percent Scores

	Year 1 Quality Performance Category Achievement Percent Score	Year 2 Quality Performance Category Achievement Percent Score	Increase in Achievement	Rate of Improvement	Improvement Percent Score	
Individual Eligible Clinician #1 (Pick your Pace Test Option)	5% (Will substitute 30% which is the lowest score a clinician can achieve with complete reporting in year 1.)	50%	20% Because the year 1 score is below 30%, we measure improvement above 30%.	20%/30%= 0.67	0.67*10% = 6.7% No cap needed.	
Individual Eligible Clinician #2	60%	66%	6%	6%/60%= 0.10	0.10*10% = 1.0% No cap needed	
Individual Eligible Clinician #3	90%	93%	3%	3%/90%= 0.033	0.033*10% = 0.3% No cap needed	
Individual Eligible Clinician #4	30%	70%	40%	40%/30%=1.33	1.33*10%=13.3% Apply cap at 10%	

We also considered an alternative to measuring the rate of improvement. The alternative would use band levels to determine the improvement points for MIPS eligible clinicians who qualify for improvement points. Under the band level methodology, a MIPS eligible clinician's improvement points would be determined by an improvement in the quality performance category achievement percent score from 1 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 percent) 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 percent of the total score.

In Table 29, we illustrate the band levels we considered as part of this alternative proposal. The chart depicts the band level and the improvement points allotted for the increases in improvement scores that fall within the transition year score range.

TABLE 29: Band Level and Improvement Points Allotted for Determining Improvement Percent Scores

Transition Year Score Range	% credit for each percent increase in achievement
1-50	100% of increase in achievement
51-75	75% of increase in achievement
75-100	50% of increase in achievement

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, we believe the policy we proposed would provide a score that better represents true improvement at the performance category level, rather than comparing simple increases in performance category scores.

TABLE 30: Examples of Improvement Scoring Methodology Based on Band Levels

	Year 1 Quality Performance Category Achievement Percent Score	Year 2 Quality Performance Category Achievement Percent Score	Increase in Achievement	Band for Improvement Adjustment	Improvement Percent Score (after applying the cap)
Individual Eligible Clinician #1 (Pick your Pace Test Option)	5% (Will substitute 30% which is the lowest score a clinician can achieve with complete reporting in year 1.)	50%	20% Because the year 1 score is below 30%, we measure improvement above 30%.	100%	20%*100%= 20% which is capped at 10%.
Individual Eligible Clinician #2	60%	66%	6%	75%	6%*75%= 4.5% No cap needed
Individual Eligible Clinician #3	90%	93%	3%	50%	3%*50%= 1.5% No cap needed

In addition, we considered another alternative that would adopt the improvement scoring methodology of the Shared Savings Program[11] for CMS Web Interface submissions in the quality performance category, but decided to not adopt this approach. 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 we 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. We believed it could be beneficial to align improvement between the programs

[11] For additional information on the Shared Savings Program's scoring methodology, we refer readers to the Quality Measurement Methodology and Resources, September 2016, Version 1 and the Medicare Shared Savings Program Quality Measure Benchmarks for the 2016 and 2017 Reporting Years (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf.)

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. We 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. We would next divide the Net Improvement in each domain by the number of eligible measures in the domain to calculate the Improvement Score. We would cap the number of possible improvement percentage points at 10.

We considered the Shared Savings Program methodology because it would promote alignment with ACOs. We ultimately decided not to adopt this scoring methodology because we believe having a single performance category level approach for all quality performance category scores encourages a uniformity in our approach to improvement scoring and simplifies the scoring rules for MIPS eligible clinicians. It also allows us greater flexibility to compare performance scores across the diverse submission mechanisms, which makes improvement scoring more broadly available to eligible clinicians and groups that elect different ways of participating in MIPS.

We propose to add regulatory text at §414.1380(b)(1)(xvi)(C)(3) to state that an improvement percent score cannot be negative (that is, lower than zero percentage points). We also propose to add regulatory text at §414.1380(b)(1)(xvi)(C)(1) to state that improvement scoring is awarded based on the rate of increase in the quality performance category achievement percent score of individual MIPS eligible clinicians or groups from the current MIPS performance period compared to the score in the year immediately prior to the current MIPS performance period. We also propose to add regulatory text at §414.1380(b)(1)(xvi)(C)(2) to state that an improvement percent score is calculated by dividing the increase in the quality performance category achievement percent score of an individual MIPS eligible clinician or

group, which is calculated by comparing the quality performance category achievement percent score the current MIPS performance period to the quality performance category achievement percent score from the MIPS performance period in the year immediately prior to the current MIPS performance period, by the prior year quality performance category achievement percent score, and multiplying by 10 percent.

We invite public comments on our 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.

(j) Calculating the Quality Performance Category Percent Score Including Improvement

In the CY 2017 Quality Payment Program final rule, we finalized at §414.1380(b)(1)(xv) 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 (81 FR 77300). Using the terminology proposed in section II.C.7.a.(2) of this proposed rule, this formula can be represented as:

Quality performance category percent score = (total measure achievement points + measure bonus points)/total available measure achievement points.

We propose to incorporate the improvement percent score, which is proposed in section II.C.7.a.(2)(i)(i) of this proposed rule, into the quality performance category percent score. We propose to amend §414.1380(b)(1)(xv) (redesignated as §414.1380(b)(1)(xvii)) to add the improvement percent score (as calculated pursuant to proposed paragraph (b)(1)(xvi)(A) through (F)) to the quality performance score. We also propose to amend §414.1380(b)(1)(xv) (redesignated as §414.1380(b)(1)(xvii)) to amend the text that states the quality performance category percent score cannot exceed the total possible points for the quality performance category to clarify that the total possible points for the quality performance category cannot

exceed 100 percentage points. Thus, the 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 percent.

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. In this example, an individual MIPS eligible clinician received measure achievement points for their 6 required measures, and received 6 measure bonus points. Because this is an individual clinician and the administrative claims based measure is not applicable, the total available measure achievement points for this clinician is 60. The improvement percent score would be calculated based on the proposal in section II.C.7.a.(2)(i) of this proposed rule; Table 31 does not illustrate the underlying calculations for the improvement percent score. To calculate the quality performance category percent score, the total measures achievement points would be summed with the total measure bonus points and then divided by the total available measure achievement points. The improvement percent score would be added to that calculation. The resulting quality performance category percent score cannot exceed 100 percentage points.

TABLE 31: Example of Scoring the Quality Performance Category Percent Score Including Improvement

	Total Measure Achievement Points	**Total Measure Bonus Points**	**Total Available Measure Achievement Points**	**Calculation Prior to Improvement**	**Improvement Percent Score**	**Quality Performance Category Percent Score**
Individual Eligible Clinician	35.6	6	60	(35.6 + 6)/60 = 69.33%	1.9%	69.33% + 1.9% = 71.23%
Individual Eligible Clinician (did not submit in Year 1)	35.6	6	60	(35.6 + 6)/60 = 69.33%	0%	69.33% + 0% = 69.33%
Individual Eligible Clinician (with maximum improvement)	50	6	60	(50 + 6)/60 = 93.33%	10%	93.33% + 10% = 103.33%, which is capped at 100%

We note that the quality performance category percent score is then multiplied by the performance category weight for calculating the final score.

We invite public comment on this overall methodology and formula for calculating the quality performance category percent score.

(3) Scoring the Cost Performance Category

We score the cost performance category using a methodology that is generally consistent with the methodology used for the quality performance category. In the CY 2017 Quality Payment Program final rule (81 FR 77309), we codified at §414.1380(b)(2) that a MIPS eligible clinician receives 1 to 10 achievement points for each cost measure attributed to the MIPS eligible clinician based on the MIPS eligible clinician's performance compared to the measure benchmark. We establish a single benchmark for each cost measure and base those benchmarks on the performance period (81 FR 77309). Because we base the benchmarks on the performance period, we will not be able to publish the actual numerical benchmarks in advance of the performance period (81 FR 77309). We develop a benchmark for a cost measure only if at least 20 groups (for those MIPS eligible clinicians participating in MIPS as a group practice) or TIN/NPI combinations (for those MIPS eligible clinicians participating in MIPS as an individual) can be attributed the case minimum for the measure (81 FR 77309). If a benchmark is not developed, the cost measure is not scored or included in the performance category (81 FR 77309). For each set of benchmarks, we calculate the decile breaks based on cost measure performance during the performance period and assign 1 to 10 achievement points for each measure based on which benchmark decile range the MIPS eligible clinician's performance on the measure is between (81 FR 77309 through 77310). We also codified at §414.1380(b)(2)(iii) that a MIPS eligible clinician's cost performance category score is the equally-weighted average of all scored cost measures (81 FR 77311).

In the CY 2017 Quality Payment Program final rule (81 FR 77311), we adopted a final policy to not calculate a cost performance category score if a MIPS eligible clinician or group is not attributed any cost measures because the MIPS eligible clinician or group has not met the case minimum requirements for any of the cost measures or a benchmark has not been created for any of the cost measures that would otherwise be attributed to the clinician or group. We

inadvertently failed to include this policy in the regulation text and are proposing to codify it under §414.1380(b)(2)(v).

For more of the statutory background and descriptions of our current policies for the cost performance category, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77308 through 77311).

In section II.C.7.a.(3)(a) of this proposed rule, we propose to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year. We do not propose any changes to the methodology for scoring achievement in the cost performance category for the 2020 MIPS payment year other than the method used for facility-based measurement described in II.C.7.a.(4) of this proposed rule. We are proposing 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. In section II.C.7.a.(2) of this proposed rule, we propose to calculate a "quality performance category percent score" which is reflective of performance in the quality performance category based on dividing the sum of total measure achievement points and bonus points by the total available measure achievement points. We propose to revise §414.1380(b)(2)(iii) to provide that a MIPS eligible clinician's cost performance category percent score is the sum of the following, not to exceed 100 percent: the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points (which can be expressed as a percentage); and the cost improvement score. This terminology change to refer to the score as a percentage is consistent with the change in section II.C.7.a.(2) for the quality performance category. We discuss our proposals for improvement scoring in the cost performance category in section II.C.7.b.3.(a) of this proposed rule.

(a) Measuring Improvement

(i) Calculating Improvement at the Cost Measure Level

In section II.C.7.a.(1)(b) of this proposed rule, we propose to make available to MIPS eligible clinicians and groups a method of measuring improvement in the quality and cost performance categories. In section II.C.7.a.(2)(i) of this proposed rule, for the quality performance category, we propose to assess improvement on the basis of the score at the performance category level. For the cost performance category, similar to the quality performance category, we propose at §414.1380(b)(2)(iv) 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 (for example, demonstrating improvement in the 2018 MIPS performance period over the 2017 MIPS performance period).

In section II.C.7.a.(2)(i) of this proposed rule, we note the various challenges associated with attempting to measure improvement in the quality performance category at the measure level, given the many opportunities available to clinicians to select which measures to report. The cost performance category is not subject to this same issue of measure selection. Cost measures are calculated based on Medicare administrative claims data maintained by CMS, without any additional data input from or reporting by clinicians, and MIPS eligible clinicians are not given the opportunity to select which cost measures apply to them. We believe that there are advantages to measuring cost improvement at the measure level. Principally, MIPS eligible clinicians could see their performance on each cost measure and better understand how practice improvement changes can drive changes for each specific cost measure. Additionally, as discussed in section II.C.7.a.(1)(b)(i) of this proposed rule, other Medicare value-based purchasing programs generally assess performance improvement at the measure level. Therefore, we propose at section §414.1380(b)(2)(iv)(A) to measure cost improvement at the measure level for the cost performance category.

As described in section II.C.7.a.(1)(b)(ii) of this proposed rule, we believe that we would have data sufficient to measure improvement when we can measure performance in the current performance period compared to the prior performance period. Due to the differences in our proposals for measuring improvement for the quality and cost performance categories, such as measuring improvement at the measure level versus the performance category level, we are proposing a different data sufficiency standard for the cost performance category than for the quality performance category, which is proposed in section II.C.7.a.(2)(i)(ii) of this proposed rule. 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. For the 2020 MIPS payment year, only 2 cost measures, the MSPB measure and the total per capita cost measure, would be eligible for improvement scoring. For a measure to be scored in either performance period, a MIPS eligible clinician would need to a have a sufficient number of attributed cases to meet or exceed the case minimum for the measure.

In addition, 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. We wish to encourage action on the part of clinicians in reviewing and understanding their contribution to patient costs. For example, a clinician who is shown to have lower performance on the MSPB measure could focus on the efficient use of post-acute care and be able to see that improvement reflected in the cost improvement score in future years. This review could highlight opportunities for better stewardship of healthcare costs such as better recognition of unnecessary costs related to common ordering practices. For these reasons, we believe that improvement should be evaluated only when there is a consistent identifier.

Therefore, for the cost performance category, we are proposing at §414.1380(b)(2)(iv)(B) that we would calculate a cost improvement score only when data sufficient to measure improvement is available. We are proposing that sufficient data would be available when a MIPS eligible clinician participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods (for example, in the 2017 MIPS performance period and the 2018 MIPS performance period). If the cost improvement score cannot be calculated because sufficient data is not available, we are proposing to assign a cost improvement score of zero percentage points. While the total available cost improvement score would be limited at first because only 2 cost measures would be included in both the first and second performance periods of the program (total per capita cost and MSPB), more opportunities for improvement scoring would be available in the future as additional cost measures, including episode-based measures, are added in future rulemaking. MIPS eligible clinicians would be able to review their performance feedback and make improvements compared to the score in their previous feedback.

We invite public comments on these proposals.

(ii) Improvement Scoring Methodology

In section II.C.7.a.(1)(b)(i) of this proposed rule, we discuss a number of different programs and how they measure improvement at the category or measure level as part of their scoring systems. For example, the Hospital Value-Based Purchasing (VBP) Program awards either measure improvement or measure achievement, but not both. In the proposed method for the quality performance category, we compare the overall rate of achievement on all the underlying measures in the quality performance category and measure a rate of overall improvement to calculate an improvement percent score. We then add the improvement percent score after taking into account measure achievement points and measure bonus points as described in proposed §414.1380(b)(1)(xvii). In reviewing the methodologies that are specified

in section II.C.7.a.(1)(b)(i) of this proposed rule that include consideration of improvement at the measure level, we noted that the methodology used in the Shared Savings Program would best reward achievement and improvement for the cost performance category because this program includes measures for clinicians, the methodology is straightforward, and it only recognizes significant improvement. We propose to quantify improvement in the cost performance category by comparing the number of cost measures with significant improvement in performance and the number of cost measures with significant declines in performance. We propose at §414.1380(b)(2)(iv)(C) to determine the cost improvement score by subtracting the number of cost measures with significant declines from the number of cost measures with significant improvement, and then dividing the result by the number of cost measures for which the MIPS eligible clinician or group was scored in both performance periods, and then multiplying the result by the maximum cost improvement score. For the 2020 MIPS payment year, improvement scoring would be possible for the total per capita cost measure and the MSPB measure as those 2 measures would be available for 2 consecutive performance periods under our proposals in section II.C.6.d.(3)(a). As in our proposed quality improvement methodology, we propose at §414.1380(b)(2)(iv)(D) that the cost improvement score could not be lower than zero, and therefore, could only be positive.

We propose 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 (79 FR 67930 through 67931). The t-test's statistical significance and the t-test's effect size are the 2 primary outputs of the t-test. Statistical significance indicates whether the difference between sample averages is likely to represent an actual difference between populations and the effect size indicates whether that difference is large enough to be practically meaningful. Statistical significance testing in this case assesses how unlikely it is that differences as large as those observed would be due to

chance when the performance is actually the same. The test recognizes and appropriately adjusts measures at both high and low levels of performance for statistically significant levels of change. However, as an alternative, we welcome public comments on whether we should consider instead adopting an improvement scoring methodology that measures improvement in the cost performance category the same way we propose to do in the quality performance category; that is, using the rate of improvement and without requiring statistical significance. We refer readers to section II.C.7.a.(2)(i) of this proposed rule for our proposal related to measuring improvement in the quality performance category.

Section 1848(q)(5)(D)(ii) of the Act specifies that the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible clinician than with respect to any improvement of such clinician with respect to a measure, activity, or category described in paragraph (2). We believe that there are many opportunities for clinicians to actively work on improving their performance on cost measures, through more active care management or reductions in certain services. However, we recognize that most clinicians are still learning about their opportunities in cost measurement. We aim to continue to educate clinicians about opportunities in cost measurement and continue to develop opportunities for robust feedback and measures that better recognize the role of clinicians. Since MIPS is still in its beginning years and we understand that clinicians are working hard to understand how we measure costs for purposes of the cost performance category, as well as how we score their performance in all other aspects of the program, we believe improvement scoring in the cost performance category should be limited to avoid creating additional confusion. Based on these considerations, we propose in section II.C.6.d.(2) of this proposed rule to weight the cost performance category at zero percent for the 2020 MIPS payment year/ 2018 MIPS performance period. With the entire cost performance category proposed to be weighted at zero percent, we believe that the focus of clinicians should be on achievement as opposed to improvement, and

therefore we propose at §414.1380(b)(2)(iv)(E) 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. Section 1848(q)(5)(D)(ii) of the Act provides discretion for the Secretary to assign a higher scoring weight under subparagraph (F), which refers to section 1848(q)(5)(F) of the Act, with respect to achievement than with respect to improvement. Section 1848(q)(5)(F) of the Act provides if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician, the Secretary shall assign different scoring weights (including a weight of zero) for measures, activities, and/or performance categories. When read together, we interpret sections 1848(q)(5)(D)(ii) and 1848(q)(5)(F) of the Act to provide discretion to the Secretary to assign a scoring weight of zero for improvement on the measures specified for the cost performance category. Under the improvement scoring methodology we have proposed, we believe a maximum cost improvement score of zero would be effectively the same as a scoring weight of zero. As a result of our proposal, the cost improvement score would not contribute to the cost performance category percent score calculated for the 2020 MIPS payment year. In other words, we would calculate a cost improvement score, but the cost improvement score would not contribute any points to the cost performance category percent score for the 2020 MIPS payment year.

In section II.C.6.d.(2) of this proposed rule, we consider an alternative to make no changes to the previously finalized weight of 10 percent for the cost performance category for the 2020 MIPS payment year. If we finalize this alternative, we believe that improvement should be given weight towards the cost performance category percent score, but it should still be limited. Therefore, we propose that if we maintain a weight of 10 percent 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. If a clinician were measured on

only one measure consistently from one performance period to the next and met the requirements for improvement, the clinician would receive one improvement percentage point in the cost performance category percent score. If a clinician were measured on 2 measures consistently, improved significantly on one, and did not show significant improvement on the other (as measured by the t-test method described above), the clinician would receive 0.5 improvement percentage points.

We invite comments on these proposals as well as alternative ways to measure changes in statistical significance for the cost measure.

(b) Calculating the Cost Performance Category Percent Score with Achievement and Improvement

In section II.C.7.a.(1)(b) of this proposed rule, we evaluated different improvement scoring options used in other CMS programs. In those programs, we saw 2 general methods for incorporating improvement. One method measures both achievement and improvement and takes the higher of the 2 scores for each measure that is compared. The Hospital VBP Program incorporates such a methodology. The second method is to calculate an achievement score and then add an improvement score if improvement is measured. The Shared Savings Program utilizes a similar methodology for measuring improvement. For the cost performance category, we are proposing to evaluate improvement at the measure level, unlike the quality performance category where we are proposing to evaluate improvement at the performance category level. For both the quality performance category and the cost performance category, we are proposing to add improvement to an existing category percent score. We believe this is the most straight-forward and simple way to incorporate improvement. It is also consistent with other Medicare programs that reward improvement.

As noted in section II.7.b.(3) of this proposed rule, we have proposed a change in terminology to express the cost performance category percent score as a percentage. We propose

to revise §414.1380(b)(2)(iii) to provide that a MIPS eligible clinician's cost performance category percent score is the sum of the following, not to exceed 100 percent: the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points (which can be expressed as a percentage); and the cost improvement score. With these two proposed changes, the formula would be (Cost Achievement Points/Available Cost Achievement Points) + (Cost Improvement Score) = (Cost Performance Category Percent Score).

We invite public comments on these proposals.

In Table 32, we provide an example of cost performance category percent scores along with the determination of improvement or decline. For illustrative purposes, we are using the alternative proposal of a maximum cost improvement score of 1. This example is for group reporting where the group is measured on both the total per capita cost measure and the MSPB measure for 2 consecutive performance periods.

TABLE 32: Example of Assessing Achievement and Improvement in the Cost Performance Category

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

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

proposed revised formula, the cost performance category percent score would be (14.6/20)+0.5%=73.5%.

As discussed in section II.C.7.b.(2) of this proposed rule, in determining the MIPS final score, the cost performance category percent score is multiplied by the cost performance category weight. For the 2020 MIPS payment year, if we finalize the cost performance category weight of zero percent, then the cost performance category percent score will not contribute to the final score.

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

(a) Background

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. In the MIPS and APMs RFI (80 FR 59108), we sought comment on how we could best use this authority. We refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77127) for a summary of these comments.

As noted in the CY 2017 Quality Payment Program proposed rule (81 FR 28192), we considered an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the MIPS eligible clinician's quality score. However, we did not propose an option for the transition year of MIPS because there were several operational considerations that we believed needed to be addressed before this option could be implemented. We requested comments on the following issues: (1) whether we should attribute a facility's performance to a MIPS eligible clinician for purposes of the

quality and cost performance categories and under what conditions such attribution would be appropriate and representative of the MIPS eligible clinician's performance; (2) possible criteria for attributing a facility's performance to a MIPS eligible clinician for purposes of the quality and cost performance categories; (3) the specific measures and settings for which we can use the facility's quality and cost data as a proxy for the MIPS eligible clinician's quality and cost performance categories; and (4) if attribution should be automatic or if an individual MIPS eligible clinician or group should elect for it to be done and choose the facilities through a registration process.

As noted in the CY 2017 Quality Payment Program final rule (81 FR 77127 through 77130), the majority of the comments we received supported attributing a facility's performance to a MIPS eligible clinician for purposes of the quality and cost performance categories. Some commenters opposed using a facility's quality and cost performance as a proxy for MIPS eligible clinicians. Many of these commenters expressed the view that facility scores do not represent the individual MIPS eligible clinician's performance. In addition, we received suggestions on how we should attribute a facility's performance to a MIPS eligible clinician, as well as comments suggesting that attribution should be voluntary and that the facility's measures should be relevant to the MIPS eligible clinician. A full discussion of the comments we received and our responses can be found in the CY 2017 Quality Payment Program final rule (81 FR 77127 through 77130).

In addition, we have received ongoing feedback from various stakeholder associations and individuals regarding facility-based measurement for MIPS eligible clinicians, which included: support for MIPS eligible clinicians being able to choose to be assessed in this manner; several groups' preference that value-based purchasing and quality reporting program measure data be used for facility-based scoring; support for a "hybrid" approach where MIPS eligible clinicians could select both clinician-based measures and

facility-based measures for purposes of MIPS scoring; and a suggested 2-year pilot program before expanding facility-based scoring more broadly with an emphasis on no negative impact on those who are measured in this fashion. We took this feedback, as well as the comments discussed in the CY 2017 Quality Payment Program final rule, into consideration when developing proposals for the application of facility-based measures.

(b) Facility-Based Measurement

We believe that facility-based measurement is intended to reduce reporting burden on facility-based MIPS eligible clinicians by leveraging existing quality data sources and value-based purchasing experiences and aligning incentives between facilities and the MIPS eligible clinicians who provide services there. In addition, we believe that facility-based MIPS eligible clinicians contribute substantively to their respective facilities' performance on facility-based measures of quality and cost, and that their performance may be better reflected by their facilities' performance on such measures.

Medicare operates both pay-for-reporting programs and pay-for-performance programs. Pay-for-reporting programs incentivize the act of reporting data on quality and/or other measures and activities, typically by applying a downward payment adjustment to facilities or clinicians, as applicable, that fail to submit data as required by the Secretary. This type of program does not adjust payments based on performance. In contrast, pay-for-performance programs, such as VBP programs, score facilities or clinicians, as applicable, on their performance on specified quality and/or other measures and activities and adjust payments based on that performance. Pay-for-performance programs, such as VBP programs, are more analogous to MIPS given its focus on performance and not just reporting. For this reason, we believe that facility-based measurement under MIPS should be based on pay-for-performance programs rather than pay-for-reporting programs.

Many Medicare payment systems include a pay-for-performance program, such as the Hospital VBP Program, the Skilled Nursing Facility VBP Program (SNF VBP), the End Stage Renal Disease Quality Incentive Program (ESRD QIP), and the Home Health Value-Based Purchasing Program (HHVBP). We believe that clinicians play a role in contributing to quality performance in all of these programs. However, we believe that a larger and more diverse group of clinicians contributes to quality in the inpatient hospital setting than in other settings in which we might begin to implement this measurement option. In addition, the inpatient hospital setting has a mature value-based purchasing program, first established to adjust payment for hospitals in FY 2013 (76 FR 26489). Therefore, we believe it is appropriate to implement this scoring option in a limited fashion in the first year of incorporating additional facility-based measures under MIPS by focusing on inpatient hospital measures that are used for certain pay-for-performance programs as facility-based measures.

The inpatient hospital setting includes three distinct pay-for-performance programs: the Hospital VBP Program, the Hospital Readmissions Reduction Program (HRRP), and the Hospital-Acquired Condition Reduction Program (HACRP). We believe that the Hospital VBP Program is most analogous to the MIPS program at this time because the Hospital VBP Program compares facilities on a series of different measures that intend to capture the breadth of care provided in a facility. In contrast, the HACRP and HRRP each focus on a single type of outcome for patients treated in a hospital (safety and readmissions, respectively), though we note that these outcomes are critically important to health care improvement. The payment adjustments associated with those 2 programs are intended to provide negative adjustments for poor performance but do not similarly reward high performance. In contrast, the Hospital VBP Program compares performance among

hospitals and rewards high performers and provides negative adjustments to poor performers.

We also considered program timing when determining what Hospital VBP Program year to use for facility-based measurement for the 2020 MIPS payment year. Quality measurement for the FY 2019 Hospital VBP Program's performance period will be concluded by December 31, 2017 (we refer readers to the finalized FY 2019 performance periods in the FY 2017 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Final Rule, 81 FR 57002), and the Hospital VBP Program scoring reports (referred to as the Percentage Payment Summary Reports) will be provided to participating hospitals not later than 60 days prior to the beginning of FY 2019, pursuant to the Hospital VBP Program's statutory requirement at section 1886(o)(8) of the Act. We further note that hospitals must meet case and measure minimums during the performance period to receive a Total Performance Score under that Program. We discuss eligibility for facility-based measurement in section II.C.7.b.(4)(c) of this proposed rule, and we note that the determination of the applicable hospital will be made on the basis of a period that overlaps with the applicable Hospital VBP Program performance period. Although Hospital VBP Program measures have different measurement periods, the FY 2019 measures all overlap from January to June in 2017, which also overlaps with our first 12-month period to determine MIPS eligibility.

We believe 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, including how their attributed hospital performed in the Hospital VBP Program because an individual clinician is a part of the clinical team in the hospital, rather than the sole clinician responsible for care as tracked by quality measures. Therefore, we concluded that we should be as transparent as possible with MIPS eligible clinicians about

their potential facility-based scores before they begin data submission for the MIPS performance period since this policy option is intended to minimize reporting burdens on clinicians that are already participating in quality improvement efforts through other CMS programs. We expect that MIPS eligible clinicians that would consider facility-based scoring would generally be aware of their hospital's performance on its quality measures, but believe that providing this information directly to clinicians ensures that such clinicians are fully aware of the implications of their scoring elections under MIPS. However, we note 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. We view that compromise as a necessity to maximize transparency, and we request comment on whether this notification in advance of the conclusion of the MIPS performance period is appropriate, or if we 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 clinicians and pick the higher of the two. Since higher performance category scores may result in a higher final score and a higher MIPS payment adjustment, there is a substantial incentive for a clinician to undertake this comparison, a comparison unavailable to non-facility-based peers.

The performance periods proposed in section II.C.5. of this proposed rule for the 2020 MIPS payment year occur in 2018, with data submission for most mechanisms starting in January 2019. To provide potential facility-based scores to clinicians by the time the data submission period for the 2018 MIPS performance period begins assuming that timeframe is operationally feasible), we believe that the FY 2019 program year of the Hospital VBP

Program, as well as the corresponding performance periods, is the most appropriate program year to use for purposes of facility-based measurement under the quality and cost performance categories for the 2020 MIPS payment year. However, we note also that Hospital VBP performance periods can run for periods as long as 36 months, and for some FY 2019 Hospital VBP Program measures, the performance period begins in 2014. We request comment on whether this lengthy performance period duration should override our desire to include all Hospital VBP Program measures as discussed further below. We propose at §414.1380(e)(6)(iii) that the performance period for facility-based measurement is the performance period for the measures for the measures adopted under the value-based purchasing program of the facility of the year specified.

We considered whether we 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, we believe 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. We propose at §414.1380(e)(6)(i) that the quality and cost measures are those adopted under the value-based purchasing program of the facility program for the year specified.

Therefore, we propose for the 2020 MIPS payment year to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality measures and cost measures. Under this proposal, we consider the FY 2019 Hospital VBP Program measures to meet the definition of additional system-based measures provided in section 1848(q)(2)(C)(ii) of the Act, and we propose at §414.1380(e)(1)(i) that facility-based measures available for the 2018 MIPS performance period are the measures adopted for the FY 2019 Hospital VBP Program year authorized by section 1886(o) of the Act and codified

in our regulations at §§412.160 through 412.167. Measures in the FY 2019 Hospital VBP Program have different performance periods as noted in Table 33.

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

(c) Facility-Based Measurement Applicability

(i) General

The percentage of professional time a clinician spends working in a hospital varies considerably. Some clinicians may provide services in the hospital regularly, but also treat patients extensively in an outpatient office or another environment. Other clinicians may practice exclusively within a hospital. Recognizing the various levels of presence of different clinicians within a hospital environment, we seek to limit the potential applicability of facility-based measurement to those MIPS eligible clinicians with a significant presence in the hospital.

In the CY 2017 Quality Payment Program final rule (81 FR 77238 through 77240), we adopted a definition of "hospital-based MIPS eligible clinician" under §414.1305 for purposes of the advancing care information performance category. Section 414.1305 defines a hospital-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting, based on claims for a period prior to the performance period as specified by CMS. We considered whether we should simply use this definition to determine eligibility for facility-based measurement under MIPS. However, we are concerned that this definition could include many clinicians that have limited or no presence in the inpatient hospital setting. We have noted that hospital-based

clinicians may not have control over important aspects of the certified EHR technology that is available in the hospital setting (81 FR 77238). In that regard, there is little difference between outpatient and inpatient hospital settings. But we are proposing to determine a MIPS eligible clinician's quality performance category score and cost performance category score based on a hospital's Hospital VBP performance, which is based on inpatient services. Section 1848(q)(2)(C)(ii) of the Act limits our ability to incorporate measures used for hospital outpatient departments. Our proposal at section II.C.6.f.(7)(a)(i) of this proposed rule to expand the definition of a hospital-based MIPS eligible clinician for the advancing care information performance category to include clinicians who practice primarily in off-campus outpatient hospitals could include clinicians that practice many miles away from the hospital in practices which are owned by the hospital, but do not substantially contribute to the hospital's Hospital VBP Program performance. As we discuss further in this section, the measures used in the Hospital VBP Program are focused on care provided in the inpatient setting. We do not believe it is appropriate for a MIPS eligible clinician to use a hospital's Hospital VBP Program performance for MIPS scoring if they did not provide services in that setting.

Therefore, we believe establishing a different definition for purposes of facility-based measurement is necessary to implement this option. We also note that, since we are seeking comments above on other programs to consider including for purposes of facility-based measurement in future years, we believe establishing a separate definition that could be expanded as needed for this purpose is appropriate. We propose at §414.1380(e)(2) that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as an individual. We propose at §414.1380(e)(2)(i) that a MIPS eligible clinician is considered facility-based as an individual if the MIPS eligible clinician furnishes 75 percent or more of their covered professional services (as defined in section

1848(k)(3)(A) of the Act) 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. We understand that the services of some clinicians who practice solely in the hospital are billed using place of service codes such as code 22, reflecting an on-campus outpatient hospital for patients who are in observation status. Because there are limits on the length of time a Medicare patient may be seen under observation status, we believe that these clinicians would still furnish 75 percent or more of their covered professional services using POS code 21, but seek comment on whether a lower or higher threshold of inpatient services would be appropriate. We do 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. In contrast, we believe those who provide services in the emergency room or the inpatient hospital clearly contribute to patient care that is captured as part of the Hospital VBP Program because many patients who are admitted are admitted through the emergency room. We seek comments on whether POS 22 should be included in determining if a clinician is facility-based and how we might distinguish those clinicians who contribute to inpatient care from those who do not. We note that the inclusion of any POS code in our definition is pending technical feasibility to link a clinician to a facility under the method described in section II.C.7.b.(4)(d) of this proposed rule.

We note that this more limited definition would mean that a clinician who is determined to be facility-based likely would also be determined to be hospital-based for purposes of the advancing care information performance category, because this proposed definition of facility-based is narrower than the hospital-based definition established for that

purpose. 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 we have adopted a performance period of CY 2018 for the quality and cost performance categories, we would use the data available at the end of October 2017 to determine whether a MIPS eligible clinician is considered facility-based by our 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, we 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. We believe that this definition allows us to identify MIPS eligible clinicians who are significant contributors to facilities' care for Medicare beneficiaries and other patients for purposes of facility-based measurement.

We also recognize that in addition to the variation in the percentage of time a clinician is present in the hospital, there is also great variability in the types of services that clinicians perform. Some may be responsible for overall management of patients throughout their stay, others may perform a procedure, and others may serve a role in supporting diagnostics. We considered whether certain clinicians should be identified as eligible for this facility-based measurement option based on characteristics in addition to their percentage of covered professional services furnished in the inpatient hospital or emergency room setting, such as by requiring a certain specialty such as hospital medicine or by limiting eligibility to those who served in patient-facing roles. However, we believe that all

MIPS eligible clinicians with a significant presence in the facility play a role in the overall performance of a facility, and therefore, are not proposing at this time to further limit this option based on characteristics other than the percentage of covered professional services furnished in an inpatient hospital or emergency room setting. Additionally, we believe that allowing facility-based MIPS eligible clinicians the most flexibility possible, while still being able to accurately measure the value of care those clinicians provide, as we continue implementation of the Quality Payment Program is paramount in ensuring that clinicians understand the program and its effects on the care they provide.

We request comments on this proposal.

(ii) Facility-Based Measurement Group Participation

We are also proposing at §414.1380(e)(2) that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as part of a group. We are proposing at §414.1380(e)(2)(ii) that a facility-based group is a group in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals as defined in §414.1380(e)(2)(i). We also considered an alternative proposal in which a facility-based group would be a group where the TIN overall furnishes 75 percent or more of its covered professional services (as defined in section 1848(k)(3)(A) of the Act) 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 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 period (or if not operationally feasible to use claims from this exact time period, 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).

We request comments on our proposal and alternative proposal.

(d) Facility Attribution for Facility-Based Measurement

Many MIPS eligible clinicians provide services at more than one hospital, so we must develop a method to identify which hospital's scores should be associated with that MIPS eligible clinician under this facility-based measurement option. We considered whether a clinician should be required to identify for us the hospital with which they were affiliated, but felt that such a requirement would add unnecessary administrative burden in a process that we believe was intended to reduce burden. We also considered whether we could combine scores from multiple hospitals, but believe that such a combination would reduce the alignment between a single hospital and a clinician or group and could be confusing for participants. We believe we must establish a reasonable threshold for a MIPS eligible clinician's participation in clinical care at a given facility to allow that MIPS eligible clinician to be scored using that facility's measures. We do not believe it to be appropriate to allow MIPS eligible clinicians to claim credit for facilities' measures if the MIPS eligible clinician does not participate meaningfully in the care provided at a given facility.

Therefore, we propose at §414.1380(e)(5) that MIPS eligible clinicians who elect facility-based measurement would receive scores derived from the value-based purchasing score (using the methodology described in section II.B.7.b.4 of this proposed rule) 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 our 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, we propose to use the value-based purchasing score from the facility with the highest score.

(e) Election of Facility-Based Measurement

Stakeholders have expressed a strong preference that facility-based measurement be a voluntary process, and we agree with this preference considering our general goal in making MIPS as flexible as possible. Therefore, we propose at §414.1380(e)(3) 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. We propose that those clinicians or groups who are eligible for and wish to elect facility-based measurement would be required to submit their election during the data submission period as determined at §414.1325(f) through the attestation submission mechanism established for the improvement activities and advancing care information performance categories. If technically feasible, we 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.

We 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. Under this approach, we would calculate a MIPS eligible clinician's facility-based measurement score based on the hospital's (as identified using the process described in section II.C.6.b. of this proposed rule) performance using the methodology described in section II.C.7.a.2.b. of this proposed rule, and automatically use that facility-based measurement score for the quality and cost performance category scores if the facility-based measurement score is higher than

the quality and cost performance category scores as determined based on data submitted by the MIPS eligible clinician through any available reporting mechanism. 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, our considerations about Hospital VBP Program timing would be less applicable. That is, we explained our rationale for specifying the FY 2019 Hospital VBP Program above, in part to ensure that MIPS eligible clinicians are informed about their potential facility-based scores prior to the conclusion of the MIPS performance period. However, under an automatic process, we could consider automatically using other Hospital VBP Program years' scores. For example, we could apply FY 2020 Hospital VBP Program scores instead of FY 2019. We intend in general to align Hospital VBP and MIPS performance periods when feasible, and the timing considerations we described above led us to conclude that FY 2019 was the most appropriate Hospital VBP Program year for the first year of the facility-based measurement option under MIPS, and selecting other years would result in further divergence between the MIPS performance period and the Hospital VBP Program's performance periods. We are also concerned that a method that does not require active selection may result in MIPS eligible clinicians being scored on measures at a facility and being unaware that such scoring is taking place. We are also concerned that such a method could provide an advantage to those facility-based clinicians who do not submit quality measures in comparison to those who work in other environments. We also note that this option may not be technically feasible for us to implement for the 2018 MIPS performance period.

We invite comments on this proposal and alternate proposal.

(e) Facility-Based Measures

For the FY 2019 program year, the Hospital VBP Program has adopted 13 quality and efficiency measures. The Hospital VBP Program currently includes 4 domains: person and community engagement, clinical care, safety, and efficiency and cost reduction. These domains align with many MIPS high priority measures (outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in the quality performance category and the efficiency and cost reduction domain closely aligns with our cost performance category. We believe this set of measures covering 4 domains and composed primarily of measures that would be considered high priority under the MIPS quality performance category capture a broad picture of hospital-based care. For example, the HCAHPS survey under the Hospital VBP Program is a patient experience measure, which would make it a high-priority measure under MIPS. Additionally, the Hospital VBP Program has adopted several measures of clinical outcomes in the form of 30-day mortality measures, and clinical outcomes are a high-priority topic for MIPS. The Hospital VBP Program includes several measures in a Safety domain, which meets our definition of patient safety measures as high-priority. Therefore, we propose 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.

The Hospital VBP Program's FY 2019 measures, and their associated performance periods, have been reproduced in Table 33 (see 81 FR 56985 and 57002).

TABLE 33: FY 2019 Hospital VBP Program Measures

Short Name	Domain/Measure Name	NQF #	Performance Period
Person and Community Engagement Domain			
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (including Care Transition Measure)	0166 (0228)	CY 2017
Clinical Care Domain			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230	July 1, 2014 – June 30, 2017
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229	July 1, 2014 – June 30, 2017
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0468	July 1, 2014 – June 30, 2017
THA/TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550	January 1, 2015 – June 30, 2017
Safety Domain			
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	0138	CY 2017
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	CY 2017
Colon and Abdominal Hysterectomy SSI	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.	0753	CY 2017
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716	CY 2017
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717	CY 2017
PSI-90*	Patient Safety for Selected Indicators (Composite Measure)	0531	July 1, 2015 – June 30 2017
PC-01	Elective Delivery	0469	CY 2017
Efficiency and Cost Reduction Domain			
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158	CY 2017

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

We note 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 (82 FR 19970) due to issues with calculating the measure score. If the proposal to remove

that measure from the hospital measure set is finalized, we would remove the measure from the list of those adopted for facility-based measurement in the MIPS program.

We propose at §414.1380(e)(4) 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 as proposed in section II.C.7.a.(4)(e). We also refer readers to section II.C.7. of this proposed rule for further details on how we will incorporate scoring for facility-based measurements into MIPS.

(f) Scoring Facility-Based Measurement

(i) Hospital VBP Program Scoring

As we discuss above in subsection (b), we believe that the Hospital VBP Program represents the most appropriate value-based purchasing program with which to begin implementation of the facility-based measurement option under MIPS.

Section 1886(o) of the Act, as added by section 3001(a)(1) of the Affordable Care Act, requires the Secretary to establish a hospital value-based purchasing program (the Hospital VBP Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. These value-based incentive payments are funded through a reduction to participating hospitals' base-operating DRG payment amounts, with the amount of the reduction specified by statute. For the FY 2019 program year, that reduction will be equal to 2 percent. Participating hospitals then receive value-based incentive payments depending on their performance on measures adopted under the Program. For more detail on the statutory background and history of the Hospital VBP Program's implementation, we refer readers to 81 FR 56979.

As noted previously, the FY 2019 Hospital VBP Program will score participating hospitals on 13 measures covering 4 domains of care, although as discussed in the FY 2018 IPPS/LTCH proposed rule (82 FR 19970), we have proposed to remove the PSI 90 Patient Safety

Composite measure from the FY 2019 measure set. For each of the measures, performance standards are established for the applicable fiscal year that include levels of achievement and improvement. For the FY 2019 program year, the achievement threshold and benchmark are calculated using baseline period data with respect to that fiscal year, with the achievement threshold for each of these measures being the median of hospital performance on the measure during the baseline period and the benchmark for each of these measures being the arithmetic mean of the top decile of hospital performance during the baseline period. The achievement threshold and benchmark for the MSPB measure are calculated using the same methodology, except that we use performance period data instead of baseline period data in our calculations. We then calculate hospital performance on each measure during the performance period for which they have sufficient data and calculate a measure score based on that performance as compared with the performance standards that apply to the measure. For achievement scoring, those hospitals that perform below (or above in the case of measures for which a lower rate is better) the level of the achievement threshold are not awarded any achievement points. Those that perform between the level of the achievement threshold and the benchmark are awarded points based on the relative performance of the hospital, according to formulas specified by the Hospital VBP Program (see the Hospital Inpatient VBP Program final rule, 76 FR 26518 through 26519). Those hospitals whose performance meets or exceeds the benchmark are awarded 10 achievement points for the measure. Hospitals are also provided the opportunity to receive improvement points based on their improvement between the baseline period for the measure and the performance period. A hospital is awarded between 0 and 10 points for achievement and 0 and 9 points for improvement, and is awarded the higher of the 2 scores for each individual measure. There are no floors established for scoring and no bonus points are available in this scoring system.

Points awarded for measures within each domain are summed to reach the unweighted domain score. We note for the person and community engagement domain only, the domain score consists of a base score and a consistency score. The base score is based on the greater of improvement or achievement points for each of the 8 HCAHPS survey dimensions. Consistency points are awarded based on a hospital's lowest HCAHPS dimension score during the performance period relative to national hospital scores on that dimension during the baseline period. 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. We refer readers to 81 FR 57005 and 81 FR 79857 through 79858 for additional information on the Hospital VBP Program's performance standards, as well as the QualityNet website for certain technical updates to the performance standards.

(ii) Applying Hospital VBP Program Scoring to the MIPS Quality and Cost Performance Categories

We considered several methods to incorporate facility-based measures into scoring for the 2020 MIPS payment year, including selecting hospitals' measure scores, domain scores, and the Hospital VBP Program Total Performance Scores to form the basis for the cost and quality performance category scores for individual MIPS eligible clinicians and groups that are eligible to participate in facility-based measurement. Although each of these approaches may have merit, we have proposed the option that we believe provides the fairest comparison between performance in the 2 programs and will best allow us to expand the opportunity to other programs in the future.

Unlike MIPS, the Hospital VBP Program does not have performance categories. There are instead four domains of measures. We considered whether we should try to identify certain

domains or measures that were more closely aligned with those identified in the quality performance category or the cost performance category. We also considered whether we should limit the application of facility-based measurement to the quality performance category and calculate the cost performance category score as we do for other clinicians. However, we believe that value-based purchasing programs are generally constructed to assess an overall picture of the care provided by the facility, taking into account both the costs and the quality of care provided. Given our focus on alignment between quality and cost, we also do not believe it is appropriate to measure quality on one unit (a hospital) and cost on another (such as an individual clinician or TIN). Therefore, we propose at §414.1380(e) that facility-based scoring is available for the quality and cost performance categories and that the facility-based measurement scoring standard is the MIPS scoring methodology applicable for those who meet facility-based eligibility requirements and who elect facility-based measurement.

(iii) Benchmarking Facility-Based Measures

Measures in the MIPS quality performance category are benchmarked to historical performance on the basis of performance during the 12-month calendar year that is 2 years prior to the performance period for the MIPS payment year. If a historical benchmark cannot be established, a benchmark is calculated during the performance period. In the cost performance category, benchmarks are established during the performance period because changes in payment policies year to year can make it challenging to compare performance on cost measure year to year. Although we propose a different performance period for MIPS eligible clinicians in facility-based measurement, the baseline period used for creating MIPS benchmarks is generally consistent with this approach. We note that the Hospital VBP Program uses measures for the same fiscal year even if those measures do not have the same performance period length, but the baseline period closes well before the performance period. The MSPB is benchmarked in a manner that is similar to measures in the MIPS cost performance category. The MSPB only uses

a historical baseline period for improvement scoring and bases its achievement threshold and benchmark solely on the performance period (81 FR 57002). We propose at §414.1380(e)(6)(ii) 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.

(iv) Assigning MIPS Performance Category Scores based on Hospital VBP Performance

Performance measurement in the Hospital VBP Program and MIPS is quite different in part due to the design and the maturity of the programs. As noted above, the Hospital VBP Program only assigns achievement points to a hospital for its performance on a measure if the hospital's performance during the performance period meets or exceeds the median of hospital performance on that measure during the applicable baseline period, whereas MIPS assigns achievement points to all measures that meet the required data completeness and case minimums. In addition, the Hospital VBP Program has removed many process measures and topped out measures since its first program year (FY 2013), while both process and topped out measures are available in MIPS. With respect to the FY 2017 program year, for example, the median Total Performance Score for a hospital in Hospital VBP was 33.88 out of 100 possible points. If we were to simply assign the Hospital VBP Total Performance Score for a hospital to a clinician, the performance of those MIPS eligible clinicians electing facility-based measurement would likely be lower than most who participated in the MIPS program, particularly in the quality performance category.

We believe that we should recognize relative performance in the facility programs that reflects their different designs. Therefore, we propose at §414.1380(e)(6)(iv) that the quality performance category score for facility-based measurement is reached by determining the percentile performance of the facility determined in the value-based purchasing program for the specified year as described under §414.1380(e)(5) 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. We also propose at §414.1380(e)(6)(v) that the cost performance category 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 as described in §414.1380(e)(5) 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. For example, if the median Hospital VBP Program Total Performance Score was 35 out of 100 possible points and the median quality performance category percent score in MIPS was 75 percent and the median cost performance category score was 50 percent, then a clinician or group that is evaluated based on a hospital that received an Hospital VBP Program Total Performance Score of 35 points would receive a score of 75 percent for the quality performance category and 50 percent for the cost performance category. The percentile distribution for both the Hospital VBP Program and MIPS would be based on the distribution during the applicable performance periods for each of the programs and not on a previous benchmark year.

We believe this proposal offers a fairer comparison of the performance among participants in MIPS and the Hospital VBP Program compared to other options we considered and provides an objective means to normalize differences in measured performance between the programs. In addition, we believe this method will make it simpler to apply the concept of facility-based measurement to additional programs in the future.

We welcome public comments on this proposal.

(v) Scoring Improvement for Facility-Based Measurement

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

In this proposed rule, we have proposed to consider improvement in the quality and cost performance categories. In section II.C.7.a.(2)(i) of this proposed rule, we propose to measure improvement in the quality performance category based on improved achievement for the performance category percent score and award improvement even if, under certain circumstances, a clinician moves from one identifier to another from 1 year to the next. For those who may be measured under facility-based measurement, improvement is already captured in the scoring method used by the Hospital VBP Program, so we do not believe it is appropriate to separately measure improvement using the proposed MIPS methodology. Although the improvement methodology is not identical, a hospital that demonstrated improvement in the individual measures would in turn receive a higher score through the Hospital VBP Program methodology, so that improvement is reflected in the underlying Hospital VBP Program measurement. In addition, improvement is already captured in the distribution of MIPS performance scores that is used to translate Hospital VBP Total Performance Score into a MIPS quality performance category score. Therefore, we are not proposing any additional improvement scoring for facility-based measurement for either the quality or cost performance category.

Because we intend 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, we seek comment on how to assess improvement for those that switch from facility-based scoring to another MIPS method. We request 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.

In section II.C.7.a.(3)(a) of this proposed rule, we discuss our proposal to measure improvement in the cost performance category at the measure level. We propose that clinicians under facility-based measurement would not be eligible for a cost improvement score in the cost performance category. As in the quality performance category, we believe that a clinician participating in facility-based measurement in subsequent years would already have improvement recognized as part of the Hospital VBP Program methodology and should therefore not be given additional credit. In addition, because we propose 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 our proposed methodology because they would not be scored on the same cost measure(s) for 2 consecutive performance periods.

We invite comments on these proposals.

(vi) Bonus Points for Facility-Based Measurement

MIPS eligible clinicians that report on quality measures are eligible for bonus points for the reporting of additional outcome and high priority measures beyond the one that is required. 2 bonus points are awarded for each additional outcome or patient experience measure, and one bonus point is awarded for each additional other high priority measure. These bonus points are intended to encourage the use of measures that are more impactful on patients and better reflect the overall goals of the MIPS program. Many of the measures in the Hospital VBP Program meet the criteria that we have adopted for high-priority measures. We support measurement that takes clinicians' focus away from clinical process measures; however, our proposed scoring method described above is based on a percentile distribution of scores within the quality and cost performance categories that already accounts for bonus points. For this reason, we are not proposing to calculate additional high priority bonus points for facility-based measurement.

We note that clinicians have an additional opportunity to receive bonus points in the quality performance category score for using end-to-end electronic submission of quality measures. The Hospital VBP Program does not capture whether or not measures are reported using end-to-end electronic reporting. In addition, our proposed facility-based scoring method described above is based on a percentile distribution of scores within the quality and cost performance categories that already accounts for bonus points. For this reason, we are not proposing to calculate additional end-to-end electronic reporting bonus points for facility-based measurement.

We welcome public comments on our approach.

(vii) Special Rules for Facility-Based Measurement

Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital Inpatient Quality Reporting Program, or other reasons. In these cases, we would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method. Most hospitals which do not receive a Total Performance Score in the Hospital VBP Program are routinely excluded, such as hospitals in Maryland. In such cases, facility-based clinicians would know well in advance that the hospital would not receive a Total Performance Score, and that they would need to participate in MIPS through another method. However, we are concerned that some facility-based clinicians may provide services in hospitals which they expect will receive a Total Performance Score but do not due to various rare circumstances such as natural disasters. In section II.C.7.b.(3)(c) of this proposed rule, we propose a process for requesting a reweighting assessment for the quality, cost and improvement activities performance categories due to extreme and uncontrollable circumstances, such as natural disasters. We propose that

MIPS eligible clinicians who are facility-based and affected by extreme and uncontrollable circumstances, such as natural disasters, may apply for reweighting.

In addition, we note that 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, subject to Hospital VBP Program requirements established in prior rulemaking. We intend to use the final Hospital VBP Total Performance Score for the facility-based measurement option under MIPS. In the event that a hospital obtains a successful correction or appeal of its Total Performance Score, we 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. We welcome public comments on whether a different deadline should be considered.

Additionally, although we wish to tie the hospital and clinician performance as closely together as possible for purposes of the facility-based scoring policy, we do not wish to disadvantage those clinicians and groups that select this measurement method. In section II.C.7.a.(2) of this proposed rule, we propose to retain a policy equivalent to the 3-point floor for all measures with complete data in the quality performance category scored against a benchmark in the 2020 MIPS payment year. However, the Hospital VBP Program does not have a corresponding scoring floor. Therefore, we propose to adopt a floor on the Hospital VBP Program Total Performance Score for purposes of facility-based measurement under MIPS so that any score in the quality performance category, once translated into the percentile distribution described above, that would result in a score of below 30 percent would be reset to a score of 30 percent in the quality performance category. We believe that this adjustment is important to maintain consistency with our other policies. There is no similar floor established for measures in the cost performance category under MIPS, so we do not propose any floor for the cost performance category for facility-based measurement.

Some MIPS eligible clinicians who select facility-based measurement could have sufficient numbers of attributed patients to meet the case minimums for the cost measures established under MIPS. Although there is no additional data reporting for cost measures, we believe that, to facilitate the relationship between cost and quality measures, they should be evaluated covering the same population as opposed to comparing a hospital population and a population attributed to an individual clinician or group. In addition, we believe that including additional cost measures in the cost performance category score for MIPS eligible clinicians who elect facility-based measurement would reduce the alignment of incentives between the hospital and the clinician. Thus, we are proposing at §414.1380(e)(6)(v)(A) that MIPS eligible clinicians who elect facility-based measurement would not be scored on other cost measures specified for the cost performance category, even if they meet the case minimum for a cost measure.

If a clinician or a group elects facility-based measurement but also submits quality data through another MIPS mechanism, we propose 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. Therefore, we seek 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.

(5) Scoring the Improvement Activities Performance Category

Section 1848(q)(5)(C) of the Act specifies scoring rules for the improvement activities performance category. For more of the statutory background and description of the proposed and finalized policies, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77311 through 77319). We have also codified certain requirements for the improvement activities performance category at §414.1380(b)(3). Based on these criteria, we finalized at §414.1380(b)(3) in the CY 2017 Quality Payment Program final rule the scoring methodology for this category, which assigns points based on certified patient-centered medical home participation or comparable specialty practice participation, APM participation, and the improvement activities reported by the MIPS eligible clinician (81 FR 77312). A MIPS eligible clinician's performance will be evaluated by comparing the reported improvement activities to the highest possible score (40 points). We are not proposing any changes to the scoring of the improvement activities performance category in this proposed rule.

(a) Assigning Points to Reported Improvement Activities

We will assign points for each reported improvement activity within 2 categories: medium-weighted and high-weighted activities. Each medium-weighted activity is worth 10 points toward the total category score of 40 points, and each high-weighted activity is worth 20 points toward the total category score of 40 points. These points are doubled for small practices, practices in rural areas, or practices located in geographic HPSAs, and non-patient facing MIPS eligible clinicians. We refer readers to §414.1380(b)(3) and the CY 2017 Quality Payment Program final rule (81 FR 78312) for further detail on improvement activities scoring.

Activities will be weighted as high based on the extent to which they align with activities that support the certified patient-centered medical home, since that is consistent with the standard under section 1848(q)(5)(C)(i) of the Act for achieving the highest potential

score for the improvement activities performance category, as well as with our priorities for transforming clinical practice (81 FR 77311). Additionally, activities that require performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI), participation in a MIPS eligible clinician's state Medicaid program, or an activity identified as a public health priority (such as emphasis on anticoagulation management or utilization of prescription drug monitoring programs) are justifiably weighted as high (81 FR 77311 through 77312).

We refer readers to Table 26 of the CY 2017 Quality Payment Program final rule for a summary of the previously finalized improvement activities that are weighted as high (81 FR 77312 through 77313), and we refer readers to Table H of the same final rule, for a list of all the previously finalized improvement activities, both medium- and high-weighted (81 FR 77817 through 77831). Please refer to Table F and Table G in the appendices of this proposed rule for proposed additions and changes to the Improvement Activities Inventory for the 2020 MIPS payment year and future years. Activities included in these proposed tables would apply for the 2020 MIPS payment year and future years unless further modified via notice and comment rulemaking. Consistent with our unified scoring system principles, we finalized in the CY 2017 Quality Payment Program final rule that MIPS eligible clinicians will know in advance how many potential points they could receive for each improvement activity (81 FR 77311 through 77319).

(b) Improvement Activities Performance Category Highest Potential Score

At §414.1380(b)(3), we finalized that we will require a total of 40 points to receive the highest score for the improvement activities performance category (81 FR 77315). For more of the statutory background and description of the proposed and finalized policies, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77314 through 77315).

For small practices, practices in rural areas and geographic HPSA practices and non-patient facing MIPS eligible clinicians, the weight for any activity selected is doubled so that these practices and eligible clinicians only need to select one high- or two medium-weighted activities to achieve the highest score of 40 points (81 FR 77312).

In accordance with section 1848(q)(5)(C)(ii) of the Act, we codified at §414.1380(b)(3)(ix) that individual MIPS eligible clinicians or groups who are participating in an APM (as defined in section 1833(z)(3)(C) of the Act) for a performance period will automatically earn at least one half of the highest potential score for the improvement activities performance category for the performance period. In addition, MIPS eligible clinicians that are participating in MIPS APMs will be assigned an improvement activity score, which may be higher than one half of the highest potential score. This assignment is based on the extent to which the requirements of the specific model meet the list of activities in the Improvement Activities Inventory. For a further description of improvement activities and the APM scoring standard for MIPS, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77246). For all other individual MIPS eligible clinicians or groups, we refer readers to the scoring requirements for individual MIPS eligible clinicians and groups in the CY 2017 Quality Payment Program final rule (81 FR 77270). An individual MIPS eligible clinician or group is not required to perform activities in each improvement activities subcategory or participate in an APM to achieve the highest potential score in accordance with section 1848(q)(5)(C)(iii) of the Act (81 FR 77178).

In the CY 2017 Quality Payment Program final rule, we also finalized that individual MIPS eligible clinicians and groups that successfully participate and submit data to fulfill the requirements for the CMS Study on Improvement Activities and Measurement will receive the highest score for the improvement activities performance category (81 FR 77315). We refer readers to section II.C.6.e.(7) of this proposed rule for further detail on this study.

(c) Points for Certified Patient-Centered Medical Home or Comparable Specialty Practice

Section 1848(q)(5)(C)(i) of the Act specifies that a MIPS eligible clinician who is in a practice that is certified as a patient-centered medical home or comparable specialty practice for a performance period, as determined by the Secretary, must be given the highest potential score for the improvement activities performance category for the performance period. Accordingly, at §414.1380(b)(3)(iv), we specify that a MIPS eligible clinician who is in a practice that is certified as a patient-centered medical home, including a Medicaid Medical Home, Medical Home Model, or comparable specialty practice, will receive the highest potential score for the improvement activities performance category (81 FR 77196 through 77180).

We are not proposing any changes to the scoring of the patient-centered medical home or comparable specialty practice; although we are proposing a change to how groups qualify for this activity. We refer readers to section II.C.6.e. of this proposed rule for a discussion of the requirements for certified patient-centered medical home practices or comparable specialty practices.

(d) Calculating the Improvement Activities Performance Category Score

In the CY 2017 Quality Payment Program final rule (81 FR 77318), we finalized that individual MIPS eligible clinicians and groups must earn a total of 40 points to receive the highest score for the improvement activities performance category. To determine the improvement activities performance category score, we sum the points for all of a MIPS eligible clinician's reported activities and divide by the improvement activities performance category highest potential score of 40. A perfect score will be 40 points divided by 40 possible points, which equals 100 percent. If MIPS eligible clinicians have more than 40 improvement activities points we will cap the resulting improvement activities performance category score at 100 percent.

Section 1848(q)(2)(B)(iii) of the Act requires the Secretary to give consideration to the circumstances of small practices and practices located in rural areas and in geographic HPSAs (as designated under section 332(a)(1)(A) of the PHS Act) in defining activities. Section 1848(q)(2)(C)(iv) of the Act also requires the Secretary to give consideration to non- patient facing MIPS eligible clinicians. Further, section 1848(q)(5)(F) of the Act allows the Secretary to assign different scoring weights for measures, activities, and performance categories, if there are not sufficient measures and activities applicable and available to each type of eligible clinician.

Accordingly, we finalized that the following scoring applies to MIPS eligible clinicians who are a non-patient facing MIPS eligible clinician, a small practice (consisting of 15 or fewer professionals), a practice located in a rural area, or practice in a geographic HPSA or any combination thereof:

- Reporting of one medium-weighted activity will result in 20 points or one-half of the highest score.
- Reporting of two medium-weighted activities will result in 40 points or the highest score.
- Reporting of one high-weighted activity will result in 40 points or the highest score.

The following scoring applies to MIPS eligible clinicians who are not a non-patient facing clinician, a small practice, a practice located in a rural area, or a practice in a geographic HPSA:

- Reporting of one medium-weighted activity will result in 10 points which is one-fourth of the highest score.
- Reporting of two medium-weighted activities will result in 20 points which is one-half of the highest score.
- Reporting of three medium-weighted activities will result in 30 points which is three-fourths of the highest score.

- Reporting of four medium-weighted activities will result in 40 points which is the highest score.

- Reporting of one high-weighted activity will result in 20 points which is one-half of the highest score.

- Reporting of two high-weighted activities will result in 40 points which is the highest score.

- Reporting of a combination of medium-weighted and high-weighted activities where the total number of points achieved are calculated based on the number of activities selected and the weighting assigned to that activity (number of medium-weighted activities selected x 10 points + number of high-weighted activities selected x 20 points) (81 FR 78318).

We also finalized in the CY 2017 Quality Payment Program final rule that certain activities in the improvement activities performance category will also qualify for a bonus under the advancing care information performance category (81 FR 78318). This bonus will be calculated under the advancing care information performance category and not under the improvement activities performance category. We refer readers to section II.C.6.f.5.(d) of this proposed rule for further details. For more information about our finalized improvement activities scoring policies and for several sample scoring charts, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 78319). Finally, in that same final rule, we codified at §414.1380(b)(3)(ix) that MIPS eligible clinicians participating in APMs that are not certified patient-centered medical homes will automatically earn a minimum score of one-half of the highest potential score for the performance category, as required by section 1848(q)(5)(C)(ii) of the Act. For any other MIPS eligible clinician who does not report at least one activity, including a MIPS eligible clinician who does not identify to us that they are participating in a certified patient-centered medical home or comparable specialty practice, we will calculate a score of zero points (81 FR 77319).

(e) Self-Identification Policy for MIPS Eligible Clinicians

We also noted in the CY 2017 Quality Payment Program final rule (81 FR 77319), that individual MIPS eligible clinicians or groups participating in APMs would not be required to self-identify as participating in an APM, but that all MIPS eligible clinicians would be required to self-identify if they were part of a certified patient-centered medical home or comparable specialty practice, 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, and that we would validate these self-identifications as appropriate. However, beginning with the 2018 MIPS performance period, we are proposing to no longer require these self-identifications for a non-patient facing MIPS eligible clinician, a small practice, a practice located in a rural area, or a practice in a geographic HPSA or any combination thereof because it is technically feasible for us to identify these MIPS eligible clinicians during attestation to the performance of improvement activities following the performance period. We define these MIPS eligible clinicians in the CY 2017 Quality Payment Program final rule (81 FR 77540), and they are discussed in this proposed rule in section II.C.1. of this proposed rule. 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 we will validate these self-identifications as appropriate. We refer readers to section II.C.6.e.3.(c) of this proposed rule for the criteria for recognition as a certified patient-centered medical home or comparable specialty practice.

(6) Scoring the Advancing Care Information Performance Category

We refer readers to section II.C.6.f. of this proposed rule with comment period, where we discuss scoring the advancing care information performance category.

b. Calculating the Final Score

For a description of the statutory basis and our policies for calculating the final score for MIPS eligible clinicians, we refer readers to the discussion in the CY 2017 Quality Payment Program final rule (81 FR 77319 through 77329) and §414.1380. In this proposed rule, we propose to add a complex patient scoring bonus and add a small practice bonus to the final score. In addition, we review the final score calculation for the 2020 MIPS payment year and propose refinements to the reweighting policies.

(1) Accounting for Risk Factors

Section 1848(q)(1)(G) of the Act requires us to consider risk factors in our scoring methodology. Specifically, that section provides that the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on individuals' health status and other risk factors, assess appropriate adjustments to quality measures, cost measures, and other measures used under MIPS and assess and implement appropriate adjustments to payment adjustments, final scores, scores for performance categories, or scores for measures or activities under the MIPS. In doing this, the Secretary is required to take into account the relevant studies conducted under section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and, as appropriate, other information, including information collected before completion of such studies and recommendations. We refer readers to our discussion of risk factors for the transition year of MIPS (81 FR 77320 through 77321).

In this section, we summarize our efforts related to social risk and the relevant studies conducted under section 2(d) of the IMPACT Act of 2014. We also propose some short-term adjustments to address patient complexity.

(a) Considerations for Social Risk

We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. One of our core objectives is to improve beneficiary outcomes, including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care. In addition, we seek to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible under our programs while ensuring that beneficiaries have adequate access to excellent care.

We have been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS' value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. On December 21, 2016, ASPE submitted the first of several Reports to Congress on a study it was required to conduct under section 2(d) of the IMPACT Act of 2014. The first study analyzed the effects of certain social risk factors in Medicare beneficiaries on quality measures and measures of resource use used in one or more of nine Medicare value-based purchasing programs.[12] The report also included considerations for strategies to account for social risk factors in these programs. A second report due October 2019 will expand on these initial analyses, supplemented with non-Medicare datasets to measure social risk factors. In a January 10, 2017 report released by the National Academies of Sciences, Engineering, and Medicine, that

[12] Office of the Assistant Secretary for Planning and Evaluation. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

body provided various potential methods for accounting for social risk factors, including stratified public reporting.[13]

As noted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56974), the NQF has undertaken a 2-year trial period in which certain new measures and measures undergoing maintenance, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for selected social risk factors is appropriate for these measures. This trial entails temporarily allowing inclusion of social risk factors in the risk-adjustment approach for these measures. At the conclusion of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures, and we will closely review its findings.

As we continue to consider the analyses and recommendations from these and any future reports, and await the results of the NQF trial on risk adjustment for quality measures, we are continuing in this proposed rule to work with stakeholders in this process. As we have previously communicated, we are concerned about holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. Keeping this concern in mind, while we sought input on this topic previously, we continue to seek public comment on whether we 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

[13] National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press.

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). We are 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, we are 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. We are 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. We will take commenters' input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in MIPS. We note that any such changes would be proposed through future notice and comment rulemaking.

We look forward to working with stakeholders as we consider the issue of accounting for social risk factors and reducing health disparities in CMS programs. Of note, implementing any of the above methods would be taken into consideration in the context of how this and other CMS programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of data calculations, among others), we also welcome comment on operational considerations. CMS is committed to ensuring that its beneficiaries have access to and receive excellent care, and that the quality of care furnished by providers and suppliers is assessed fairly in CMS programs.

(b) Complex Patient Bonus

While we work with stakeholders on these issues as we have described, we are proposing, under the authority within section 1848(q)(1)(G) of the Act, which allows us to assess and implement appropriate adjustments to payment adjustments, MIPS final scores, scores for performance categories, or scores for measures or activities under MIPS, to implement a short-term strategy for the Quality Payment Program to address the impact patient complexity may have on final scores. The overall goal when considering a bonus for complex patients is two-fold: (1) to protect access to care for complex patients and provide them with excellent care; and (2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while we review the completed studies and research to address the underlying issues. We used the term "patient complexity" to take into account a multitude of factors that describe and have an impact on patient health outcomes; such factors include the health status and medical conditions of patients, as well as social risk factors. We believe that as the number and intensity of these factors increase for a single patient, the patient may require more services, more clinician focus, and more resources in order to achieve health outcomes that are similar to those who have fewer factors. In developing the policy for the complex patient bonus, we assessed whether there was a MIPS performance discrepancy by patient complexity using two well-established indicators in the Medicare program. Our proposal is intended to address any discrepancy, without masking performance. Because this bonus is intended to be a short-term strategy, we are proposing 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.

When considering approaches for a complex patient bonus, we reviewed evidence to identify how indicators of patient complexity have an impact on performance under MIPS as well as availability of data to implement the bonus. Specifically, we identified two potential indicators for complexity: medical complexity as measured through Hierarchical Condition

Category (HCC) risk scores, and social risk as measured through the proportion of patients with dual eligible status. We identified these indicators because they are common indicators of patient complexity in the Medicare program and the data is readily available. As discussed below, both of these indicators have been used in Medicare programs to account for risk and both data elements are already publicly available for individual NPIs in the Medicare Physician and Other Supplier Public Use File (referred to as the Physician and Other Supplier PUF) (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html). While we recognize that these indicators are interrelated (as dual eligible status is one of the factors included in calculation of HCC risk scores), we intend for the sake of simplicity to implement one of these indicators for the 2020 MIPS payment year.

We believe that average HCC risk scores are a valid proxy for medical complexity that have been used by other CMS programs. The HCC model was developed by CMS as a risk-adjustment model that uses hierarchical condition categories to assign risk scores to Medicare beneficiaries. Those scores estimate how Medicare beneficiaries' FFS spending will compare to the overall average for the entire Medicare population. According to the Physician and Other Supplier PUF methodological overview, published in January of 2017,[14] the average risk score is set at 1.08; beneficiaries with scores greater than that are expected to have above-average spending, and vice versa. Risk scores are based on a beneficiary's age and sex; whether the beneficiary is eligible for Medicaid, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home); and the beneficiary's diagnoses from the previous year. The HCC model was designed for risk adjustment on larger populations, such as the enrollees in an MA plan, and generates more accurate results when used to compare groups of

[14] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Medicare-Physician-and-Other-Supplier-PUF-Methodology.pdf.

beneficiaries rather than individuals. For more information on the HCC risk score, see: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html.

HCC risk scores have been used in the VM to apply an additional upward payment adjustment of +1.0x for clinicians whose attributed patient population has an average risk score that is in the top 25 percent of all beneficiary risk scores (77 FR 69325 through 69326). CMS proposes and announces changes to the HCC risk adjustment model as part of the announcement of payment policies for Medicare Advantage plans under section 1853 of the Act; the proposals and announcements are posted at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

A mean HCC risk score for a MIPS eligible clinician can be calculated by averaging the HCC risk scores for the beneficiaries cared for by the clinician. In considering options for a complex patient bonus, we explored the use of average HCC risk scores while recognizing that "complexity" is one of several drivers of that metric. We believe that using the HCC risk score as a proxy for patient complexity is a helpful starting point, and will explore methods for further distinguishing complexity from other reasons a clinician could receive a high average HCC risk score.

In addition to medical complexity, patient complexity includes social risk factors, and we considered identifying patients dually eligible for Medicare and Medicaid, which we believe is a proxy for social risk factors. A ratio of beneficiaries seen by a MIPS eligible clinician who are dual eligible can be calculated using claims data based on the proportion of unique patients who are dually eligible for Medicare and full- and partial-benefit Medicaid (referred to herein as "dual eligible status") seen by the MIPS eligible clinician during the performance year among all unique Medicare beneficiaries seen during the performance year. Dual eligible Medicare beneficiaries are qualified to receive Medicare and Medicaid benefits. In the Physician and Other Supplier PUF, beneficiaries are classified as Medicare and Medicaid entitlement if in any

month in the given calendar year they were receiving full or partial Medicaid benefits. [15] Dual eligibility has been used in the Medicare Advantage 5-star methodology[16] and stratification by proportion of dual eligibility status is proposed for the Hospital Readmissions Reduction Program (82 FR 19959 through 19961).

We evaluated both indicators (average HCC risk score and proportion dual eligible status) using the 2015 Physician and Other Supplier PUF. We incorporated these factors into our scoring model that uses historical PQRS data to simulate scores for MIPS eligible clinicians including estimates for the quality, advancing care information, and improvement activities performance categories, and the small practice bonus that is proposed in section II.C.7.b.(1)(c) of this proposed rule. The scoring model is described in more detail in the regulatory impact analysis in section V.C. of this proposed rule. For HCC, we merged the average HCC risk score by NPI with each TIN/NPI in our population. We calculated a dual eligible ratio by taking a proportion of dual eligible beneficiaries and divided by total beneficiaries for each NPI. We created group level scores by taking an average of NPI scores weighted by the number of beneficiaries. We divided clinicians and groups into quartiles based on average HCC risk score and percent of duals. To assess whether there was a difference in MIPS simulated scores by these two variables, we analyzed the effect of average HCC risk score and dual eligible ratio separately for groups and individuals. When looking at individuals, we focused on individuals that reported 6 or more measures (removing individuals who reported no measures or who reported less than 6 measures). We restricted our analysis to individuals who reported 6 or more measures because we wanted to look at differences in performance for those who reported the required 6 measures, rather than differences in scores due to incomplete reporting.

[15] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Medicare-Physician-and-Other-Supplier-PUF-Methodology.pdf.
[16] Centers for Medicare & Medicaid Services. Medicare 2017 Part C & D Star Rating Technical Notes. Available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Part-C-and-D-Medicare-Star-Ratings-Data-v04-04-2017-.zip.

We observed modest correlation between these two indicators. Using the Physician and Other Supplier PUF (after restricting to those clinicians that we estimate to be MIPS eligible in our scoring model described in section V.C of this proposed rule), the correlation coefficient for these two factors is 0.487 (some correlation is expected due to the inclusion of dual eligible status in the HCC risk model). The correlation between average HCC risk scores and proportion of patients with dual eligible status indicates that while there is overlap between these two indicators, they cannot be used interchangeably.

We also assessed the correlation of these indicators with MIPS final scores based on performance and the small practice bonus for MIPS eligible clinicians, as well as variations by practice size, submission mechanism, and specialty. Average MIPS simulated scores (prior to any complex patient bonus) varied from 82.73 (fourth HCC quartile, highest risk) to 87.14 (first HCC quartile, lowest risk) for group reporters, and from 82.36 (fourth HCC quartile, highest risk) to 86.39 (first HCC quartile, lowest risk) for individual reporters who reported 6 or more measures (see Table 34). When reviewing average HCC risk scores by practice size, we found that MIPS eligible clinicians in larger practices had slightly higher risk scores than those in small practices (average HCC risk score of 1.82 for practices with 100 or more clinicians, compared with 1.61 for practices with 1-15 clinicians) (see Table 35) and that the average HCC risk score varied by specialty, with nephrology having the highest average HCC risk score (3.05) and dermatology having the lowest (1.24). The average HCC risk score for family medicine was 1.58 (see Table 36).

We also ranked MIPS eligible clinicians by proportion of patients with dual eligibility (see Table 34). Performance for MIPS eligible clinicians ranged from 82.35 in the fourth dual quartile (highest proportion dual eligible patients) to 89.49 in the second dual quartile (second lowest proportion dual eligible patients) for group reporters. Performance for MIPS eligible clinicians reporting individually who reported 6 or more measures ranged from 83.08 in the

fourth dual quartile (highest proportion dual eligible patients) to 86.80 in the first dual quartile (lowest proportion dual eligible patients).

TABLE 34: MIPS Simulated Score* by HCC Risk Quartile and Dual Eligible Ratio Quartile

	Individuals with 6+ Measures**	Group
HCC Quartile		
Quartile 1 – Lowest Average HCC Risk Score	86.39	87.14
Quartile 2	84.89	88.41
Quartile 3	83.31	86.76
Quartile 4 – Highest Average HCC Risk Score	82.36	82.73
Dual Eligible Ratio		
Quartile 1- Lowest Proportion of Dual Status	86.80	88.03
Quartile 2	83.76	89.49
Quartile 3	82.63	85.39
Quartile 4 – Highest Proportion of Dual Status	83.08	82.35

*****The simulated score includes estimated quality, advancing care information, and improvement activities performance categories without complex patient bonus. Simulated score does include small practice bonus proposed in II.C.7.b.(1)(c) of this proposed rule.

******We restricted this column to individuals who reported 6 or more measures to assess differences in performance for those who reported the required 6 measures and to not consider changes due to incomplete reporting.

TABLE 35: Average HCC Risk Score and Dual Eligible Ratio by Practice Size

Practice Size	Average HCC Risk Score	Dual Eligible Ratio
1-15 clinicians	1.61	24.90%
16-24 clinicians	1.70	26.20%
25-99 clinicians	1.72	27.50%
100 or more clinicians	1.82	26.90%
Total	1.75	26.60%

TABLE 36: Average HCC Risk Score and Dual Eligible Ratio by Specialty

Specialty*	Average HCC Risk Score	Dual Eligible Ratio
Total	1.75	26.60%
Addiction Medicine	1.77	37.00%
Allergy/ Immunology	1.38	19.70%
Anesthesiology	1.78	26.00%
Anesthesiology Assistant	1.94	26.50%
Cardiac Electrophysiology	1.85	23.20%
Cardiac Surgery	1.93	25.10%
Cardiovascular Disease (Cardiology)	1.85	25.30%
Certified Clinical Nurse Specialist	1.78	31.20%
Certified Registered Nurse Anesthetist (CRNA)	1.77	25.50%
Chiropractic	1.27	19.10%
Clinic or Group Practice	1.57	30.60%
Colorectal Surgery (Proctology)	1.70	22.10%
Critical Care (Intensivists)	2.06	28.50%
Dermatology	1.24	11.90%

Specialty*	Average HCC Risk Score	Dual Eligible Ratio
Diagnostic Radiology	1.78	26.50%
Emergency Medicine	1.94	34.10%
Endocrinology	1.78	24.70%
Family Medicine*	1.58	25.80%
Gastroenterology	1.70	24.20%
General Practice	1.60	35.80%
General Surgery	1.83	27.10%
Geriatric Medicine	1.93	29.60%
Geriatric Psychiatry	1.92	39.30%
Gynecological Oncology	1.76	24.20%
Hand Surgery	1.39	17.80%
Hematology	1.95	25.80%
Hematology-Oncology	1.92	24.90%
Hospice and Palliative Care	1.93	26.90%
Infectious Disease	2.35	31.60%
Internal Medicine	1.84	28.10%
Interventional Cardiology	1.79	22.90%
Interventional Pain Management	1.50	26.90%
Interventional Radiology	2.18	28.80%
Maxillofacial Surgery	1.90	30.20%
Medical Oncology	1.94	23.50%
Nephrology	3.05	33.00%
Neurology	1.79	27.40%
Neuropsychiatry	1.76	30.30%
Neurosurgery	1.68	24.70%
Nuclear Medicine	1.91	26.10%
Nurse Practitioner	1.78	28.60%
Obstetrics & Gynecology	1.63	26.20%
Ophthalmology	1.37	18.70%
Optometry	1.33	24.80%
Oral Surgery (Dentist only)	1.82	29.20%
Orthopedic Surgery	1.44	20.50%
Osteopathic Manipulative Medicine	1.62	29.70%
Otolaryngology	1.50	21.10%
Pain Management	1.57	29.50%
Pathology	1.71	23.70%
Pediatric Medicine	1.95	31.10%
Peripheral Vascular Disease	1.83	23.10%
Physical Medicine and Rehabilitation	1.76	27.00%
Physician Assistant	1.69	26.40%
Physician, Sleep Medicine	1.70	23.20%
Plastic and Reconstructive Surgery	1.74	23.60%
Podiatry	1.72	27.70%
Preventive Medicine	1.80	27.60%
Psychiatry	1.80	39.50%
Pulmonary Disease	2.00	27.20%
Radiation Oncology	1.79	22.20%
Rheumatology	1.65	23.40%
Sports Medicine	1.54	22.70%
Surgical Oncology	1.92	25.10%
Thoracic Surgery	1.94	26.30%
Urology	1.56	20.30%
Vascular Surgery	2.22	26.80%

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

Based on our assessment of these two indicators, we generally see high average simulated scores[17] that are above 80 points for each quartile based on average HCC risk score or proportion of dual status patients (see Table 34). As discussed in II.C.8.d. of this proposed rule, 70 points is the proposed additional performance threshold at which MIPS eligible clinicians can receive the additional adjustment factor for exceptional performance. However, even though the simulated scores are high, we also generally see a very modest decrease in simulated scores of 4.0 points (for individuals who report 6 or more measures) and 4.4 points (for groups) from the top quartile to the bottom quartile for the average patient HCC risk score and from 3.7 (for individuals who report 6 or more measures) and 5.7 points (for groups) from the top quartile to the bottom quartile for dual eligible ratio. While we are transitioning into MIPS and evolving our scoring policies, we want to ensure safeguards and access for these vulnerable patients; therefore, we are proposing to apply a small complex patient bonus to final scores used for the 2020 MIPS payment year. As we stated earlier, we intend to start with one dimension of patient complexity for simplicity. For the 2020 MIPS payment year, we are proposing a complex patient bonus based on the average HCC risk score because this is the indicator that clinicians are familiar with from the VM.

We propose at §414.1380(c)(3) to add a complex patient bonus to the final score for the 2020 MIPS payment year for MIPS eligible clinicians that submit data (as explained below) for at least one performance category. We propose at §414.1380(c)(3)(i) to calculate an average HCC risk score, using the model adopted under section 1853 of the Act 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. We 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

[17] Scores are simulated prior to any complex patient bonus.

MIPS eligible clinician or clinicians in the group during the second 12-month segment of the eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018 for the 2018 MIPS performance period) as described in section II.C.3.c. of this proposed rule. We propose the second 12-month segment of the eligibility period to align with other MIPS policies and to ensure we have sufficient time to determine the necessary calculations. The second period 12-month segment overlaps 8-months with the MIPS performance period which means that many of the patients in our complex patient bonus would have been cared for by the clinician, group, virtual group or APM Entity during the MIPS performance period.

HCC risk scores for beneficiaries would be calculated based on the calendar year immediately prior to the performance period. For the 2018 MIPS performance period, the HCC risk scores would be calculated based on beneficiary services from the 2017 calendar year. We chose this approach because CMS uses prior year diagnoses to set Medicare Advantage rates prospectively every year and has employed this approach in the VM (77 FR 69317-8). Additionally, this approach mitigates the risk of "upcoding" to get higher expected costs, which could happen if concurrent risk adjustments were incorporated. We realize using the 2017 calendar year to assess beneficiary HCC risk scores overlaps by 4-months with the 12-month data period to identify beneficiaries (which is September 1, 2017 to August 31, 2018 for the 2018 MIPS performance period); however, we annually calculate the beneficiary HCC risk score and use it for multiple purposes (like the Physician and Other Supplier PUF).

For MIPS APMs and virtual groups, we propose at §414.1380(c)(3)(ii) 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. We 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.

We propose at §414.1380(c)(3)(iii) that the complex patient bonus cannot exceed 3 points. This value was selected because the differences in performance we observed between simulated scores between the first and fourth quartiles of average HCC risk scores was approximately 4 points for individuals and approximately 5 points for groups. We considered whether we should apply a set number of points to those in a specific quartile (for example, for the highest risk quartile only), but did not want to restrict the bonus to only certain MIPS eligible clinicians. Rather than assign points based on quartile, we believed that adding the average HCC risk score directly to the final score would achieve our goal of accounting for patient complexity without masking low performance and does provide a modest effect on the final score. The 95th percentile of HCC values for individual clinicians was 2.91 which we rounded to 3 for simplicity. We believe applying this bonus to the final score is appropriate because caring for complex and vulnerable patients can affect all aspects of a practice and not just specific performance categories. It may also create a small incentive to provide access to complex patients.

Finally, we propose 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. Under this proposal, MIPS eligible clinicians would not need to meet submissions requirements for the quality performance category in order to receive the bonus (they could instead submit improvement activities or advancing care information measures only or submit fewer than the required number of measures for the quality performance category).

Based on our data analysis, we estimate that this bonus on average would range from 1.16 points in the first quartile based on HCC risk scores to 2.49 points in the fourth quartile for individual reporters submitting 6 or more measures, and 1.26 points in the first quartile to 2.23 points in the fourth quartile for group reporters. For example, a MIPS eligible clinician with a final score of 55.11 with an average HCC risk score of 2.01 would receive a final score of 57.12. We propose in section II.C.7.b.(2) of this proposed rule that if the result of the calculation is greater than 100 points, then the final score would be capped at 100 points.

We also seek comment on an alternative complex patient bonus methodology, similarly for the 2020 MIPS payment year only. Under the alternative, we would apply a complex patient bonus based on a ratio of patients who are dual eligible, because we believe that dual eligible status is a common indicator of social risk for which we currently have data available. We believe the advantage of this option is its relative simplicity and that it creates a direct incentive to care for dual eligible patients, who are often medically complex and have concurrent social risk factors. In addition, whereas the HCC risk scores rely on the diagnoses a beneficiary receives which could be impacted by variations in coding practices among clinicians, the dual eligibility ratio is not impacted by variations in coding practices. For this alternative option, we would calculate a dual eligible ratio (including both full and partial Medicaid beneficiaries) for each MIPS eligible clinician based on the proportion of unique patients who have dual eligible status seen by the MIPS eligible clinician among all unique patients seen during the second 12-month segment of the eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period.

For MIPS APMs and virtual groups, we 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.

Under this alternative option, we would identify dual eligible status (numerator of the ratio) using data on dual-eligibility status sourced from the state Medicare Modernization Act (MMA) files, which are files each state submits to CMS with monthly Medicaid eligibility information. We would use dual-eligibility status data from the state MMA files because it is the best available data for identifying dual eligible beneficiaries. Under this alternative option, 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.

We would define the proportion of full benefit or partial dual eligible beneficiaries as the proportion of dual eligible patients among all unique Medicare patients seen by the MIPS eligible clinician or group during the second 12-month segment of the eligibility period which spans from the last 4 months of a calendar 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) as described in section II.C.3.c. of this proposed rule, to identify MIPS eligible clinicians for calculation of the complex patient bonus. This date range aligns with the second low-volume threshold determination and also represents care provided during the performance period.

We 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. We believe this approach is simple to explain and would be available to all clinicians who care for dual eligible beneficiaries. We also believe a complex patient bonus ranging from 1 to 5 points (with most MIPS eligible clinicians receiving a bonus between 1 and 3 points) is

appropriate because, in our analysis, we estimated differences in performance between the 1st and 4th quartiles of dual eligible ratios to be approximately 3 points for individuals and approximately 6 points for groups. A bonus of less than 5 points would help to mitigate the impact of caring for patients with social risk factors while not masking poor performance. Using this approach, we estimate that the bonus would range from 0.45 (first dual quartile) to 2.42 (fourth dual quartile) for individual reporters, and from 0.63 (first dual quartile) to 2.19 (fourth dual quartile) for group reporters. Under this alternative option, we would also include the complex patient bonus in the calculation of the final score. Again, we propose in section II.C.7.b.(2) of this proposed rule that if the result of the calculation is greater than 100 points, then the final score would be capped at 100 points. We seek comments on our proposed bonus for complex patients based on average HCC risk scores, and our alternative option using a ratio of dual eligible patients in lieu of average HCC risk scores. We reiterate that the complex patient bonus is intended to be a short-term solution, which we plan to revisit on an annual basis, to incentivize clinicians to care for patients with medical complexity. We may consider alternate adjustments in future years after methods that more fully account for patient complexity in MIPS have been developed. We also seek comments on alternative methods to construct a complex patient bonus.

(c) Small Practice Bonus for the 2020 MIPS payment year

Eligible clinicians and groups who work in small practices are a crucial part of the health care system. The Quality Payment Program provides options designed to make it easier for these MIPS eligible clinicians and groups to report on performance and quality and participate in advanced alternative payment models for incentives. We have heard directly from clinicians in small practices that they face unique challenges related to financial and other resources, environmental factors, and access to health information technology. We heard from many commenters that the Quality Payment Program advantages large organizations because such

organizations have more resources invested in the infrastructure required to track and report measures to MIPS. Based on our scoring model, which is described in the regulatory impact analysis in section V.C. of this proposed rule, practices with more than 100 clinicians may perform better in the Quality Payment Program, on average compared to smaller practices. We believe this trend is due primarily to two factors: participation rates and submission mechanism. Based on the most recent PQRS data available, practices with 100 or more MIPS eligible clinicians have participated in the PQRS at a higher rate than small practices (99.4 percent compared to 69.7 percent, respectively). As we indicate in our regulatory impact analysis in section V.C. of this proposed rule, we believe participation rates based only on historic 2015 quality data submitted under PQRS significantly underestimate the expected participation in MIPS particularly for small practices. Therefore, we have modeled the regulatory impact analysis using minimum participation assumptions of 80 percent and 90 percent participation for each practice size category (1-15 clinicians, 16-24 clinicians, 25-99 clinicians, and 100 or more clinicians). However, even with these enhanced participation assumptions, MIPS eligible clinicians in small practices would have lower participation than MIPS eligible clinicians in larger practices as 80 or 90 percent participation is still much lower than the 99.4 percent participation for MIPS eligible clinicians in practices with 100 or more clinicians.

In addition, practices with 100 or more MIPS eligible clinicians are more likely to report as a group, rather than individually, which reduces burden to individuals within those practices due to the unified nature of group reporting. Specifically, 63.1 percent of practices with 100 or more MIPS eligible clinicians are reporting via CMS Web Interface (either through the Shared Savings Program or as a group practice) compared to 20.5 percent of small practices (the CMS

Web Interface reporting mechanism is only available to small practices participating in the Shared Saving Program or Next Generation ACO Model.)[18]

These two factors have financial implications based on the MIPS scoring model described in section V.C. of this proposed rule. Looking at the combined impact performance, we see consistent trends for small practices in various scenarios. A combined impact of performance measurement looks at the aggregate net percent change (the combined impact of MIPS negative and positive adjustments in the final score). In analyzing the combined impact performance, we see MIPS eligible clinicians in small practices consistently have a lower combined impact performance than larger practices based on actual historical data and after we apply the 80 and 90 percent participation assumptions.

Due to these challenges, we believe an adjustment to the final score for MIPS eligible clinicians in small practices (referred to herein as the "small practice bonus") is appropriate to recognize these barriers and to incentivize MIPS eligible clinicians in small practices to participate in the Quality Payment Program and to overcome any performance discrepancy due to practice size. To receive the small practice bonus, we propose 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. Therefore, MIPS eligible clinicians would not need to meet submission requirements for the quality performance category in order to receive the bonus (they could instead submit improvement activities or advancing care information measures only or submit fewer than the required number of measures for the quality performance category). Additionally, we propose that group practices, virtual groups, or APM Entities that consist of a total of 15 or fewer clinicians may receive the small practice bonus.

[18] Groups must have at least 25 clinicians to participate in Web Interface.

We propose at §414.1380(c)(4) to add a small practice bonus of five points to the final score for MIPS eligible clinicians who participate in MIPS for the 2018 MIPS performance period and are in small practices or virtual groups or APM entities with 15 or fewer clinicians (the entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus). We believe a bonus of 5 points is appropriate to acknowledge the challenges small practices face in participating in MIPS, and to help them achieve the performance threshold proposed at section II.C.8.c. of this proposed rule at 15 points for the 2020 MIPS payment year, as this bonus represents one-third of the total points needed to meet or exceed the performance threshold and receive a neutral to positive payment adjustment. With a small practice bonus of 5 points, small practices could achieve this performance threshold by reporting 2 quality measures or 1 quality measure and 1 improvement activity. [19] We believe that a higher bonus (for example, a bonus that would meet or exceed the performance threshold) is not ideal because it might discourage small practices from actively participating in MIPS or could mask poor performance. We propose in section II.C.7.b.(2) of this proposed rule that if the result of the calculation is greater than 100 points, then the final score would be capped at 100 points.

This bonus is intended to be a short-term strategy to help small practices transition to MIPS, therefore, we are proposing 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.

[19] Assuming the small practice did not submit advancing care information and applied for the hardship exception and had the advancing care information performance category weight redistributed to quality, the small practice would have a final score with 85 percent weight from the quality performance category score and 15 percent from improvement activities. With the proposed scoring for small practices, submitting one measure one time would provide at least 3 measure achievement points out of 60 total available measure points. With 85 percent quality performance category weight, each quality measure would be worth at least 4.25 point towards the final score. ((3/60) x 85% x 100= 4.25 points). For improvement activities, each medium weighted activity is worth 20 out of 40 possible points which translates to 7.5 points to the file score. (20/40) x 15% x 100 = 7.5 points)

We are inviting public comment on our proposal to apply a small practice bonus for the 2020 MIPS payment year.

We also considered applying a bonus for MIPS eligible clinicians that practice in either a small practice or a rural area. However, on average, we saw less than a one point difference between scores for MIPS eligible clinicians who practice in rural areas and those who do not. Therefore, we are not proposing to extend the final score bonus to those who practice in a rural area, but plan to continue to monitor the Quality Payment Program's impacts on the performance of those who practice in rural areas. We also seek comment on the application of a rural bonus in the future, including available evidence demonstrating differences in clinician performance based on rural status. If we implement a bonus for practices located in rural areas, we would use the definition for rural specified in section II.C.1. of this proposed rule for individuals and groups (including virtual groups).

(2) Final Score Calculation

With the proposed addition of the complex patient and small practice bonuses, we propose to use the formula at §414.1380(c) to calculate the final score for all MIPS eligible clinicians, groups, virtual groups, and MIPS APMs starting with the 2020 MIPS payment year.

We propose to revise the final score calculation at §414.1380(c) to reflect this updated formula. We also propose to revise the policy finalized in the CY 2017 Quality Payment Program final rule to assign MIPS eligible clinicians with only 1 scored performance category a final score that is equal to the performance threshold (81 FR 77326 through 77328) (we note that we inadvertently failed to codify this policy in §414.1380(c)). We are proposing this revision to the policy to account for our proposal in section II.C.7.b.(3)(c) of this proposed rule for extreme and uncontrollable circumstances which, if finalized, could result in a scenario where a MIPS eligible clinician is not scored on any performance categories. To reflect this proposal, we

propose to add to §414.1380(c) that a MIPS eligible clinician with fewer than 2 performance category scores would receive a final score equal to the performance threshold.

With the proposed addition of the complex patient and small practice bonuses, we also propose to strike the following phrase from the final score definition at §414.1305: "The final score is the sum of each of the products of each performance category score and each performance category's assigned weight, multiplied by 100." We believe this portion of the definition would be incorrect and redundant of the proposed revised regulation at §414.1380(c).

We invite public comment on the proposed final score methodology and associated revisions to regulation text.

(3) Final Score Performance Category Weights

(a) General Weights

Section 1848(q)(5)(E)(i) of the Act specifies weights for the performance categories included in the MIPS final score: in general, 30 percent for the quality performance category, 30 percent for the cost performance category, 25 percent for the advancing care information performance category, and 15 percent for the improvement activities performance category. However, that section also specifies different weightings for the quality and cost performance categories for the first and second years for which the MIPS applies to payments. Section 1848(q)(5)(E)(i)(II)(bb) of the Act specifies that for the transition year, not more than 10 percent of the final score will be based on the cost performance category, and for the 2020 MIPS payment year, not more than 15 percent will be based on the cost performance category. Under section 1848(q)(5)(E)(i)(I)(bb) of the Act, the weight of the quality performance category for each of the first 2 years will increase by the difference of 30 percent minus the weight specified for the cost performance category for the year.

In the CY 2017 Quality Payment Program final rule, we established the weights of the cost performance category as 10 percent of the final score (81 FR 77166) and the quality

performance category as 50 percent of the final score (81 FR 77100) for the 2020 MIPS payment year. However, we are proposing in section II.C.6.d. of this proposed rule to change the weight of the cost performance category to zero percent and in section II.C.6.b. of this proposed rule to change the weight of the quality performance category to 60 percent for the 2020 MIPS payment year. We refer readers to sections II.C.6.b. and II.C.6.d. of this proposed rule for further information on the policies related to the weight of the quality and cost performance categories, including our rationale for our proposed weighting for each category.

As specified in section 1848(q)(5)(E)(i) of the Act, the weights for the other performance categories are 25 percent for the advancing care information performance category and 15 percent for the improvement activities performance category. Section 1848(q)(5)(E)(ii) of the Act 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 Act) who are meaningful EHR users (as determined in section 1848(o)(2) of the Act) is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the final score, but not below 15 percent. For more on our policies concerning section 1848(q)(5)(E)(ii) of the Act and a review of our proposal for reweighting the advancing care information performance category in the event that the proportion of MIPS eligible clinicians who are meaningful EHR users is 75 percent or greater starting with the 2019 MIPS performance period, we refer readers to section II.C.6.f.(5) of this proposed rule.

Table 37 summarizes the weights specified for each performance category under section 1848(q)(5)(E)(i) of the Act and in accordance with our policies in the CY 2017 Quality Payment Program final rule as codified at §§414.1380(c)(1), 414.1330(b), 414.1350(b), 414.1355(b), and 414.1375(a), and with our proposals in section II.C.6. of this proposed rule.

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%

***** In sections II.C.6.b. and II.C.6.c., we propose to maintain the same weights from the transition year for the 2020 MIPS payment year for quality and cost (60 percent and zero percent, respectively).
****** As described in section II.C.6.f. of this proposed rule, the weight for advancing care information could decrease (not below 15 percent) starting with the 2021 MIPS payment year if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater.

(b) Flexibility for Weighting Performance Categories

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 shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable and for each measure and activity based on the extent to which the measure or activity is applicable and available to the type of MIPS eligible clinician involved. For the 2020 MIPS payment year, we propose to assign a scoring weight of zero percent to a performance category and redistribute its weight to the other performance categories in the following scenarios.

For the quality performance category, we propose that having sufficient measures applicable and available means that we 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. Based on the volume of measures available to MIPS eligible clinicians via the multiple submission mechanisms, we generally believe there will be at least one quality measure applicable and available to every MIPS eligible clinician. Given that we generally believe there will be at least one quality measure applicable and available to every MIPS eligible clinician, if we receive 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 because the clinician submits data for a performance category other than the quality performance category).[20] However, as described in section II.C.7.a.(2)(e) of this proposed rule, there may be rare instances that we believe 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 and for whom we receive no quality performance category submission (and for whom the all-cause hospital readmission measure does not apply). In those instances, we would not be able to calculate a quality performance category percent score.

The proposed quality performance category scoring policies for the 2020 MIPS payment year continue many of the special scoring policies from the transition year which would enable us to determine a quality performance category percent score whenever a MIPS eligible clinician has submitted at least 1 quality measure. In addition, MIPS eligible clinicians that do not submit quality measures when they have them available and applicable would receive a quality performance category percent score of zero percent. It is only in the rare scenarios when we determine that a MIPS eligible clinician does not have any relevant quality measures available to report or the MIPS eligible clinician is approved for reweighting the quality performance category based on extreme and uncontrollable circumstances as proposed in section II.C.7.b.(3)(c) of this proposed rule, that we would reweight the quality performance category. Therefore, we continue to believe that we will not be able to calculate a score for the quality performance category only in the rare scenarios when a MIPS eligible clinician does not have any relevant quality measures available to report.

[20] As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77300), groups of 16 or more eligible clinicians that meet the applicable case minimum requirement are automatically scored on the all-cause readmission measure, even if they do not submit any other data under the quality performance category, provided that they submit data under one of the other performance categories. If such groups do not submit data under any performance category, the readmission measure is not scored.

For the cost performance category, we continue to believe that having sufficient measures applicable and available means that we can reliably calculate a score for the cost measures that adequately captures and reflects the performance of a MIPS eligible clinician, and that MIPS eligible clinicians who are not attributed enough cases to be reliably measured should not be scored for the cost performance category (81 FR 77322 through 77323). We established a policy that if a MIPS eligible clinician is not attributed a sufficient number of cases for a measure (in other words, has not met the required case minimum for the measure), or if a measure does not have a benchmark, then the measure will not be scored for that clinician (81 FR 77323). If we do 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. Because we have proposed in section II.C.6.d. of this proposed rule to set the weight of the cost performance category to zero percent of the final score for the 2020 MIPS payment year, we are not proposing to redistribute the weight of the cost performance category to any other performance categories for the 2020 MIPS payment year. In the event we do not finalize this proposal, we are proposing to redistribute the weight of the cost performance category as described in section II.C.7.b.(3)(d) of this proposed rule.

For the improvement activities performance category, we believe that all MIPS eligible clinicians will have sufficient activities applicable and available; however, as discussed in section II.C.7.b.(3)(c) of this proposed rule, we believe there are limited extreme and uncontrollable circumstances, such as natural disasters, where a clinician is unable to report improvement activities. Barring these circumstances, we are not proposing any changes that would affect our ability to calculate an improvement activities performance category score.

We refer readers to section II.C.6.f. of this proposed rule for a detailed discussion of our proposals and policies under which we would not score the advancing care information

performance category and would assign a weight of zero percent to that category for a MIPS eligible clinician.

We invite public comment on our interpretation of sufficient measures available and applicable in the performance categories.

(c) Extreme and Uncontrollable Circumstances

In the CY 2017 Quality Payment Program final rule (81 FR 77241 through 77243), we discussed our belief that extreme and uncontrollable circumstances, such as a natural disaster in which an EHR or practice location is destroyed, can happen at any time and are outside a MIPS eligible clinician's control. We stated that if a MIPS eligible clinician's CEHRT is unavailable as a result of such circumstances, then the measures specified for the advancing care information performance category may not be available for the MIPS eligible clinician to report. We established a policy allowing a MIPS eligible clinician affected by extreme and uncontrollable circumstances to submit an application to us to be considered for reweighting of the advancing care information performance category under section 1848(q)(5)(F) of the Act. Although we are proposing in section II.C.6.f. of this proposed rule to use the authority in the last sentence of section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, as the authority for this policy, rather than section 1848(q)(5)(F) of the Act, we continue to believe that extreme and uncontrollable circumstances could affect the availability of a MIPS eligible clinician's CEHRT and the measures specified for the advancing care information performance category.

While we did not propose or finalize a similar reweighting policy for other performance categories in the transition year, we believe 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, we propose 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." We propose that we would review both the circumstances and the timing independently to assess the availability and applicability of measures and activities independently 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.

We believe that extreme and uncontrollable circumstances, such as natural disasters, may affect a clinician's ability to access or submit quality measures via all submission mechanisms (effectively rendering the measures unavailable to the clinician) as well as the availability of numerous improvement activities. In addition, damage to a facility where care is provided due to a natural disaster, such as a hurricane, could result in practice management and clinical systems that are used for the collection or submission of data to be down, thus impacting a clinician's ability to submit necessary information via Qualified Registry, QCDR, CMS Web Interface, or claims. 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.

We also propose to use this policy for measures which we derive from claims data, such as the all-cause hospital readmission measure and the cost measures. Other programs, such as the Hospital VBP Program, allow hospitals to submit exception applications when "a hospital is able to continue to report data on measures . . . but can demonstrate that its Hospital VBP Program measure rates are negatively impacted as a result of a natural disaster or other extraordinary circumstance and, as a result, the hospital receives a lower value-based incentive payment" (78 FR 50705). For the Hospital VBP Program, we "interpret[ed] the minimum numbers of cases and measures requirement in the Act to enable us to not score . . . all applicable quality measure data from a performance period and, thus, exclude the hospital from the Hospital VBP Program for a fiscal year during which the hospital has experienced a disaster or other extraordinary circumstance" (78 FR 50705). Hospitals that request and are granted an exception are exempted from the Program entirely for the applicable year.

For the 2020 MIPS payment year, we would score quality measures and assign points even for those clinicians who do not meet the case minimums for the quality measures they submit. However, we established a policy not to score a cost measure unless a MIPS eligible clinician has met the required case minimum for the measure (81 FR 77323), and not to score administrative claims measures, such as the all-cause hospital readmission measure, if they cannot be reliably scored against a benchmark (81 FR 77288 through 77289). Even if the required case minimums have been met and we are able to reliably calculate scores for the measures that are derived from claims, we believe a MIPS eligible clinician's performance on

those measures could be adversely impacted by a natural disaster or other extraordinary circumstance, similar to the issues we identified for the Hospital VBP Program. For example, the claims data used to calculate the cost measures or the all-cause hospital readmission measure could be significantly affected if a natural disaster caused wide-spread injury or health problems for the community, which could not have been prevented by high-value healthcare. In such cases, we believe that the measures are available to the clinician, but are likely not applicable, because the extreme and uncontrollable circumstance has disrupted practice and measurement processes. Therefore, we believe an approach similar to Hospital VBP Program is warranted under MIPS, and we are proposing that we would 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.

Beginning with the 2020 MIPS payment year, we propose that we 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. We propose 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, we 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 advancing care information performance category. For example, we propose to adopt the same deadline (December 31, 2018 for the 2018 MIPS performance period) for submission of a reweighting assessment (see section II.C.6.f. of this proposed rule), and we would encourage the requests to be submitted on a rolling basis. We propose 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 we finalize the policy to allow reweighting based on extreme and uncontrollable circumstances beginning with the 2020 MIPS payment year, we 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.

For virtual groups, we propose to ask the virtual group to submit a reweighting assessment for extreme and uncontrollable circumstances similar to groups, and we would evaluate whether sufficient measures and activities are applicable and available to the majority of TINs in the virtual group. We are proposing that a majority of TINs in the virtual group would need to be impacted before we grant an exception. We still find it important to measure the performance of virtual group members unaffected by an extreme and uncontrollable circumstance even if some of the virtual group's TINs are affected.

We also seek comment on what additional factors we should consider for virtual groups. 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 the following reasons. First, all MIPS eligible clinicians scored under the APM scoring standard will automatically receive an improvement activities category score based on the terms of their participation in a MIPS APM and need not report anything for this performance category. Second, the cost performance category has no weight under the APM scoring standard. Finally, for the quality performance category, each MIPS APM has its own rules related to quality measures and we believe any decisions related to availability and

applicability of measures should reside within the model. As noted in II.C.6.g.(2)(d) of this proposed rule, MIPS APM entities would be able to request reweighting of the advancing care information performance category.

If we finalize these proposals for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances, then it would be possible that one or more of these performance categories would not be scored and would be weighted at zero percent of the final score for a MIPS eligible clinician. We propose to assign a final score equal to the performance threshold if fewer than two performance categories are scored for a MIPS eligible clinician. This is consistent with our policy finalized in the CY 2017 Quality Payment Program final rule that because the final score is a composite score, we believe the intention of section 1848(q)(5) of the Act is for MIPS eligible clinicians to be scored based on multiple performance categories (81 FR 77326 through 77328).

We request comment on our extreme and uncontrollable circumstances proposals. We also seek comment on the types of the extreme and uncontrollable circumstances we should consider for this policy given the general parameters we describe in this section.

(d) Redistributing Performance Category Weights

In the CY 2017 Quality Payment Program final rule, we codified at §414.1380(c)(2) that we will assign different scoring weights for the performance categories if we determine there are not sufficient measures and activities applicable and available to MIPS eligible clinicians (81 FR 77327). We also finalized a policy to assign MIPS eligible clinicians with only one scored performance category a final score that is equal to the performance threshold, which means the clinician would receive a MIPS payment adjustment factor of zero percent for the year (81 FR 77326 through 77328). We are proposing in section II.C.7.b.(2) of this proposed rule to refine this policy such that a MIPS eligible clinician with fewer than 2 performance category scores would receive a final score equal to the performance threshold. This refinement is to account for

our proposal in section II.C.7.b.(3)(c) of this proposed rule for extreme and uncontrollable circumstances which, if finalized, could result in a scenario where a MIPS eligible clinician is not scored on any performance categories. We refer readers to the CY 2017 Quality Payment Program final rule for a description of our policies for redistributing the weights of the performance categories (81 FR 77325 through 77329). For the 2020 MIPS payment year, we propose to redistribute the weights of the performance categories in a manner that is similar to the transition year. However, we are also proposing new scoring policies to incorporate our proposals for extreme and uncontrollable circumstances.

In section II.C.6.f. of this proposed rule, we are proposing to use the authority in the last sentence of section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, as the authority for certain policies under which we would assign a scoring weight of zero percent for the advancing care information performance category, and to amend §414.1380(c)(2) to reflect our proposals. We are not, however, proposing substantive changes to the policy established in the CY 2017 Quality Payment Program final rule to redistribute the weight of the advancing care information performance category to the other performance categories for the transition year (81 FR 77325 through 77329).

For the 2020 MIPS payment year, if we assign a weight of zero percent for the advancing care information performance category for a MIPS eligible clinician, we propose to continue our policy from the transition year and redistribute the weight of the advancing care information performance category to the quality performance category (assuming the quality performance category does not qualify for reweighting). We believe redistributing the weight of the advancing care information performance category to the quality performance category (rather than redistributing to both the quality and improvement activities performance categories) is appropriate because MIPS eligible clinicians have more experience reporting quality measures through the PQRS program, and measurement in this performance category is more mature.

If we do not finalize our proposal at section II.C.6.d. of this proposed rule to weight the cost performance category at zero percent (which means the weight of the cost performance category is greater than zero percent), then we propose to not redistribute the weight of any other performance categories to the cost performance category. We believe this is consistent with our policy of introducing cost measurement in a deliberate fashion and recognition that clinicians are more familiar with other elements of MIPS. In the rare and unlikely scenario where a MIPS eligible clinician qualifies for reweighting of the quality performance category percent score (because there are not sufficient quality measures applicable and available to the clinician or the clinician is facing extreme and uncontrollable circumstances) and the MIPS eligible clinician is eligible to have the advancing care information performance category reweighted to zero and the MIPS eligible clinician has sufficient cost measures applicable and available to have a cost performance category percent score that is not reweighted, then we would redistribute the weight of the quality and advancing care information performance categories to the improvement activities performance category and would not redistribute the weight to the cost performance category. If we finalize the cost performance category weight at zero percent for the 2020 MIPS payment year, then we would set the final score at the performance threshold because the final score would be based on improvement activities which would not be a composite of two or more performance category scores.

For the 2020 MIPS payment year, if we do not finalize the proposal to set the cost performance category a zero percent weight, and if a MIPS eligible clinician does not receive a cost performance category percent score because there are not sufficient cost measures applicable and available to the clinician or the clinician is facing extreme and uncontrollable circumstances, we propose to redistribute the weight of the cost performance category to the quality performance category. In the rare scenarios where a MIPS eligible clinician does not receive a quality performance category percent score because there are not sufficient quality

measures applicable and available to the clinician or the clinician is facing extreme and uncontrollable circumstances, we propose to redistribute the weight of the cost performance category equally to the remaining performance categories that are not reweighted.

In the rare event a MIPS eligible clinician is not scored on at least one measure in the quality performance category because there are not sufficient measures applicable and available or the clinician is facing extreme and uncontrollable circumstances, we propose for the 2020 MIPS payment year to continue our policy from the transition year and redistribute the 60 percent weight of the quality performance category so that the performance category weights are 50 percent for the advancing care information performance category and 50 percent for the improvement activities performance category (assuming these performance categories do not qualify for reweighting). While clinicians have more experience reporting advancing care information measures, we believe equal weighting to both the improvement activities and advancing care information is appropriate for simplicity. Additionally, in the absence of quality measures, we believe increasing the relative weight of the improvement activities performance category is appropriate because both improvement activities and advancing care information have elements of quality and care improvement which are important to emphasize. Should the cost performance category have available and applicable measures and the cost performance category weight is not zero, but either the improvement activities or advancing care information performance category is reweighted to zero percent, then we would redistribute the weight of the quality performance category to the remaining performance category that is not weighted at zero percent. We would not redistribute the weight to the cost performance category.

We believe that all MIPS eligible clinicians will have sufficient improvement activities applicable and available. It is possible that a MIPS eligible clinician might face extreme and uncontrollable circumstances that render the improvement activities not applicable or available to the clinician; however, in that scenario, we believe it is likely that the measures specified for

the other performance categories also would not be applicable or available to the clinician based on the circumstances. In the rare event that the improvement activities performance category would qualify for reweighting based on extreme and uncontrollable circumstances, and the other performance categories would not also qualify for reweighting, we propose to redistribute the improvement activities performance category weight to the quality performance category consistent with the redistribution policies for the cost and advancing care information performance categories. Should the cost performance category have available and applicable measures and the cost performance category weight is not finalized at zero percent, and the quality performance category is reweighted to zero percent, then we would redistribute the weight of the improvement activities performance category to the advancing care information performance category.

Table 38 summarizes the potential reweighting scenarios based on our proposals for the 2020 MIPS payment year should the cost performance category be weighted at zero percent.

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

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

In response to our final policy to redistribute the advancing care information performance category weight solely to the quality performance category in the CY 2017 Quality Payment Program final rule (81 FR 77327), we received some comments expressing concern that this would place undue emphasis on the quality performance category. Commenters expressed the

belief that this policy would particularly affect non-patient facing MIPS eligible clinicians who have limited available measures, and would limit the ability to fairly compare different specialties that are reweighted differently. One reason for the discrepancy is that MIPS eligible clinicians that submit data to the advancing care information performance category can readily achieve a base score of 50 percent if they meet the requirements for the base score measures, whereas the quality performance category does not start at the same base. Commenters also expressed the belief that specialties with few quality measures available to them will be unfairly impacted by this reweighting policy, by putting a disproportionate weight on just a few quality measures. Commenters suggested we redistribute the weight of the advancing care information performance category to the improvement activities performance category because the improvement activities performance category allows for the most flexibility. One commenter recommended redistributing the weight of the advancing care information performance category to both the quality and improvement activities performance categories.

We continue to have concerns about increasing the weight of the improvement activities performance category, given that this performance category is based on attestation only and is not connected to a predecessor CMS program like the other MIPS performance categories. However, based on the comments we received, we considered an alternative approach for the 2020 MIPS payment year to redistribute the weight of the advancing care information performance category to the quality and improvement activities performance categories, to minimize the impact of the quality performance category on the final score. For this approach, we would redistribute 15 percent to the quality performance category (60 percent + 15 percent = 75 percent) and 10 percent to the improvement activities performance category (15 percent + 10 percent = 25 percent). We considered redistributing the weight of the advancing care information performance category equally to the quality and improvement activities performance categories. However, for simplicity, we wanted to redistribute the weights in increments of 5

points. Because MIPS eligible clinicians have more experience reporting quality measures and because these measures are more mature, under this alternative option, we would redistribute slightly more to the quality performance category (15 percent vs. 10 percent). Should the cost performance category have available and applicable measures and the cost performance category weight is not finalized at zero percent and the quality performance category is reweighted to zero percent, then we would redistribute the weight of the advancing care information performance category to the improvement activities performance category. This alternative approach, assuming the cost performance category weight is zero percent is detailed in Table 39.

TABLE 39: Alternative Option for Reweighting the Advancing Care Information Performance Category for the 2020 MIPS Payment Year If the Cost Performance Category Weight is Zero Percent

Performance Category	Weighting for the 2020 MIPS payment year	Reweight Scenario If No Advancing Care Information Performance Category Score
Quality	60%	75%
Cost	0%	0%
Improvement Activities	15%	25%
Advancing Care Information	25%	0%

We invite comments on our proposal for weighting the performance categories for the 2020 MIPS payment year and our alternative option for reweighting the advancing care information performance category.

8. MIPS Payment Adjustments

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

(1) Payment Adjustment Identifier

For purposes of applying the MIPS payment adjustment under section 1848(q)(6)(E) of the Act, we finalized a policy in the CY 2017 Quality Payment Program final rule 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 (81 FR 77329 through 77330). In other

words, a TIN/NPI may receive a final score based on individual, group, or APM Entity group performance, but the MIPS payment adjustment would be applied at the TIN/NPI level.

We are not proposing any changes to the MIPS payment adjustment identifier.

(2) Final Score Used in Payment Adjustment Calculation

In CY 2017 Quality Payment Program final rule (81 FR 77330 through 77332), we finalized a policy to use a TIN/NPI's historical performance from the performance period associated with the MIPS payment adjustment. We also proposed the following policies, and, although we received public comments on them and responded to those comments, we inadvertently failed to state that we were finalizing these policies, although it was our intention to do so. Thus, we clarify that the following final policies apply beginning with the transition year. For groups submitting data using the TIN identifier, we 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, we will use the final score associated with the TIN/NPI that is used during the performance period. For eligible clinicians in MIPS APMs, we 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, we will assign a final score using either the individual or group data submission assignments.

In the case where a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, there would be no corresponding historical performance information or final score for the new TIN/NPI. In cases where there is no final score associated with a TIN/NPI from the performance period, we will use the NPI's performance for the TIN(s) the NPI was billing under during the performance period. If the MIPS eligible clinician has only one final score associated with the NPI from the performance period, then we will use that final score. In the event that an NPI bills under

multiple TINs in the performance period and bills under a new TIN in the MIPS payment year, we finalized a policy of taking the highest final score associated with that NPI in the performance period (81 FR 77332).

In some cases, a TIN/NPI could have more than one final score associated with it from the performance period, if the MIPS eligible clinician submitted duplicative data sets. In this situation, the MIPS eligible clinician has not changed practices; rather, for example, a MIPS eligible clinician has a final score for an APM Entity and a final score for a group TIN. If a MIPS eligible clinician has multiple final scores, 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, we 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, we will calculate a final score for the group and individual identifier and use the highest final score for the TIN/NPI (81 FR 77332).

For a further description of our policies, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77330 through 77332).

In addition to the above policies from the CY 2017 Quality Payment Program final rule, beginning with the 2020 MIPS payment year, we are proposing to modify the policies to address the addition of virtual groups. 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. Therefore, when identifying a final score for payment adjustments, we must prioritize a virtual group final score over other final scores such as

individual and group scores. Because we also wish to encourage movement towards APMs, we will prioritize using the APM Entity final score over any other score for a TIN/NPI, including a TIN/NPI that is in a virtual group. If a TIN/NPI is in both a virtual group and a MIPS APM, we propose to use the waiver authority for Innovation Center models under section 1115A(d)(1) of the Act and the Shared Savings Program waiver authority under section 1899(f) of the Act to waive section 1848(q)(5)(I)(i)(I) and (II) of the Act. As discussed in section II.C.4.h. of this proposed rule, the use of waiver authority is to avoid creating competing incentives between MIPS and the APM. We want MIPS eligible clinicians to focus on the requirements of the APM to ensure that the models produce valid results that are not confounded by the incentives created by MIPS.

We also propose to modify our 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. Our policies remain unchanged for TIN/NPIs who are not in an APM Entity or virtual group.

We invite public comment on our 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 40: Hierarchy for Final Score When More than One Final Score Is Associated with a TIN/NPI

Example	Final Score Used to Determine Payment Adjustments
TIN/NPI has more than one APM Entity final score	The highest of the APM Entity final scores
TIN/NPI has an APM Entity final score that is not a virtual group score and also has a group final score	APM Entity final score
TIN/NPI has an APM Entity final score and also has a virtual group score	APM Entity final score
TIN/NPI has a virtual group score and an individual final score	Virtual group score
TIN/NPI has a group final score and an individual final score, but no APM Entity final score and is not in a virtual group	The highest of the group or individual final score.

Table 41 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.

TABLE 41: No Final Score Associated with a TIN/NPI

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

b. MIPS Payment Adjustment Factors

For a description of the statutory background and further description of our policies, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77332 through 77333).

We are not proposing any changes to these policies.

c. Establishing the Performance Threshold

Under section 1848(q)(6)(D)(i) of the Act, for each year of the MIPS, the Secretary shall 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 under section 1848(q)(6)(A) of the Act for a year. 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. Section 1848(q)(6)(D)(iii) of the Act outlines a special rule for the initial 2 years of MIPS, which

requires the Secretary, prior to the performance period for such years, to establish a performance threshold for purposes of determining the MIPS payment adjustment factors under section 1848(q)(6)(A) of the Act and an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors under section 1848(q)(6)(C) of the Act, each of which shall be based on a period prior to the performance period and take into account data available for performance on measures and activities that may be used under the performance categories and other factors determined appropriate by the Secretary. We codified the term performance threshold at §414.1305 as the numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the MIPS payment adjustment factors. We codified at §414.1405(b) that a performance threshold will be specified for each MIPS payment year. We refer readers to the CY 2017 Quality Payment Program final rule for further discussion of the performance threshold (81 FR 77333 through 77338). In accordance with the special rule set forth in section 1848(q)(6)(D)(iii) of the Act, we finalized a performance threshold of 3 points for the transition year (81 FR 77334 through 77338).

Our goal was to encourage participation and provide an opportunity for MIPS eligible clinicians to become familiar with the MIPS Program. We determined that it would have been inappropriate to set a performance threshold that would result in downward adjustments to payments for many clinicians who may not have had time to prepare adequately to succeed under MIPS. By providing a pathway for many clinicians to succeed under MIPS, we believed that we would encourage early participation in the program, which may enable more robust and thorough engagement with the program over time. We set the performance threshold at a low number to provide MIPS eligible clinicians an opportunity to achieve a minimum level of success under the program, while gaining experience with reporting on the measures and activities and becoming familiar with other program policies and requirements. We believed if we set the threshold too high, using a new formula that is unfamiliar and confusing to clinicians, many could be

discouraged from participating in the first year of the program, which may lead to lower participation rates in future years. Additionally, we believed this flexibility is particularly important to reduce the burden for MIPS eligible clinicians in small or solo practices. We believed that active participation of MIPS eligible clinicians in MIPS will improve the overall quality, cost, and care coordination of services provided to Medicare beneficiaries. In accordance with section 1848(q)(6)(D)(iii) of the Act, we took into account available data regarding performance on measures and activities, as well as other factors we determined appropriate. We refer readers to 81 FR 77333 through 77338 for details on our analysis. We also stated our intent to increase the performance threshold in the 2020 MIPS payment year, and that, beginning in the 2021 MIPS payment year, we will use the mean or median final score from a prior period as required by section 1848(q)(6)(D)(i) of the Act (81 FR 77338).

For the 2020 MIPS payment year, we again want to use the flexibility provided in section 1848(q)(6)(D)(iii) to help transition MIPS eligible clinicians to the 2021 MIPS payment year, when the performance threshold will be the mean or median of the final scores for all MIPS eligible clinicians from a prior period. We want to encourage continued participation and the collection of meaningful data by MIPS eligible clinicians. A higher performance threshold would help MIPS eligible clinicians strive to achieve more complete reporting and better performance and prepare MIPS eligible clinicians for the 2021 MIPS payment year. However, a performance threshold set too high could also create a performance barrier, particularly for MIPS eligible clinicians who did not previously participate in PQRS or the EHR Incentive Programs. We have heard from stakeholders requesting that we continue a low performance threshold and from stakeholders requesting that we ramp up the performance threshold to help MIPS eligible clinicians prepare for the 2021 MIPS payment year and to meaningfully incentivize higher performance. Given our desire to provide a meaningful ramp between the transition year's 3-point performance threshold and the 2021 MIPS payment year performance threshold using the

mean or median of the final scores for all MIPS eligible clinicians for a prior period, we are proposing to set the performance threshold at 15 points for the 2020 MIPS payment year.

We propose a performance threshold of 15 points because it represents a meaningful increase in performance threshold, compared to 3 points in the transition year, while maintaining flexibility for MIPS eligible clinicians in the pathways available to achieve this performance threshold. For example, submitting the maximum number of improvement activities could qualify for a score for 15 points (40 out 40 possible points for the improvement activity which is worth 15 percent of the final score). The performance threshold could also be met by full participation in the quality performance category: by submitting all required measures with the necessary data completeness, MIPS eligible clinicians would earn at least a quality performance category percent score of 30 percent (which is 3 measure achievement points out of 10 measure points for each required measure).

If the quality performance category is weighted at 60 percent, then the quality performance category would be 30 percent x 60 percent x 100 which equals 18 points toward the final score and exceeds the performance threshold. Finally, a MIPS eligible clinician could achieve a final score of 15 points through an advancing care information performance category score of 60 percent or higher (60 percent advancing care information performance category score x 25 percent for the advancing care information performance category weight x 100 equals 15 points towards the final score). We refer readers to section II.C.8.g.(2) of this proposed rule for complete examples of how MIPS eligible clinician could exceed the performance threshold. We believe the proposed performance threshold would mitigate concerns from MIPS eligible clinicians about participating in the program for the second year. However, we remain 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.

By the 2021 MIPS payment year, MIPS eligible clinicians would likely need to submit most of the required information and perform well on the measures and activities to receive a positive MIPS payment adjustment. Therefore, we also seek comment on setting the performance threshold either lower or higher than the proposed 15 points for the 2020 MIPS payment year. A performance threshold lower than the proposed 15 points for the 2020 MIPS payment year presents the potential for a significant increase in the final score a MIPS eligible clinician must earn to meet the performance threshold in the 2021 MIPS payment year, as well as providing for a potentially smaller total amount of negative MIPS payment adjustments upon which the total amount of the positive MIPS payment adjustments would depend due to the budget neutrality requirement under section 1848(q)(6)(F)(ii) of the Act. A performance threshold higher than the proposed 15 points would increase the final score required to receive a neutral MIPS payment adjustment, which may be particularly challenging for small practices, even with the proposed addition of the small practice bonus. A higher performance threshold would also allow for potentially higher positive MIPS payment adjustments for those who exceed the performance threshold.

We 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. While this lower performance threshold may provide a sharp increase to the required performance threshold in MIPS payment year 2021 (the mean or median of the final scores for all MIPS eligible clinicians for a prior period), it would continue to reward clinicians for participation in MIPS as they transition into the program.

We 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. Such a threshold would make the step to the

required mean or median performance threshold in MIPS payment year 2021 less steep, but could present further challenges to clinicians who have not previously participated in legacy quality reporting programs.

As required by section 1848(q)(6)(D)(iii) of the Act, for the purposes of determining the performance threshold, we considered data available for performance on measures and activities that may be used under the MIPS performance categories. Specifically, we updated our scoring model using 2019 MIPS payment year eligibility data from the initial 12-month period to identify potential MIPS eligible clinicians who are physicians (doctors of medicine, doctors of osteopathy, chiropractors, dentists, optometrists, and podiatrists), nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists, and who exceeded the low-volume threshold. We estimated newly enrolled Medicare clinicians who would be excluded from MIPS by using clinicians (identified by NPI) that have Part B charges in the eligibility file, but no Part B charges in 2015. To exclude QPs from our scoring model, we used a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. We assumed that all partial QPs would participate in MIPS and included them in our scoring model.

We used 2014 and 2015 PQRS and 2015 VM data to estimate scores for the quality performance category, using the published benchmarks for the 2017 MIPS performance period. We used 2015 and 2016 Medicare and Medicaid EHR Incentive files to estimate advancing care information performance category scores. We also modeled an improvement activities performance category score using assumptions based on prior PQRS and EHR Incentive Program participation. We did not model any cost measures as we proposed in section II.C.6.d.(2) of this proposed rule to weight the cost performance category at zero percent. We

refer readers to the regulatory impact analysis in section V.C. of this proposed rule for a detailed description of our scoring model and data sources.

Using 2015 PQRS data, we determined which of these MIPS eligible clinicians participated in PQRS and estimated participation rates for the MIPS quality performance category based on PQRS participation, which is the performance category that accounts for the largest share (a minimum of 60 percent) of the 2020 MIPS payment year final score. We noted that 92.4 percent of the estimated MIPS eligible clinicians submitted data to PQRS, but the participation rate was lower for MIPS eligible clinicians in small practices at 69.7 percent. While we believe many of the policies in this proposed rule and the technical assistance for small practices would help increase participation, we believe it is important to keep the performance threshold low so that these small practices can learn to participate and perform well in MIPS for future years without excessive financial risk.

We invite public comments on the proposal to set the performance threshold at 15 points, and also seek comment on setting the performance threshold at the alternative of 6 points or at 33 points for the 2020 MIPS payment year.

We also seek 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.

d. Additional Performance Threshold for Exceptional Performance

Section 1848(q)(6)(D)(ii) of the Act requires the Secretary 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 under paragraph (C). For each such year, the Secretary shall apply either of the following methods for computing the additional performance threshold: (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 determined under section

1848(q)(6)(D)(i) of the Act; 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 the prior period described in section 1848(q)(6)(D)(i) of the Act.

We codified at §414.1305 the definition of additional performance threshold as the numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the additional MIPS payment adjustment factors for exceptional performance. We also codified at §414.1405(d) that an additional performance threshold will be specified for each of the MIPS payment years 2019 through 2024. We refer readers to the CY 2017 Quality Payment Program final rule for further discussion of the additional performance threshold (81 FR 77338 through 77339).

Based on the special rule for the initial 2 years of MIPS in section 1848(q)(6)(D)(iii) of the Act, for the transition year, we decoupled the additional performance threshold from the performance threshold and established the additional performance threshold at 70 points. We selected a 70-point numerical value for the additional performance threshold, in part, because it would require a MIPS eligible clinician to submit data for and perform well on more than one performance category (except in the event the advancing care information performance category is reweighted to zero percent and the weight is redistributed to the quality performance category making the quality performance category worth 85 percent of the final score). Under section 1848(q)(6)(C) of the Act, a MIPS eligible clinician with a final score at or above the additional performance threshold will receive an additional MIPS payment adjustment factor and may share in the $500,000,000 available for the year under section 1848(q)(6)(F)(iv) of the Act. We believed these additional incentives should only be available to those clinicians with very high performance on the MIPS measures and activities. We took into account the data available and the modeling described in section II.E.7.c.(1) of the CY 2017 Quality Payment Program final

rule in selecting the additional performance threshold for the transition year (81 FR 77338 through 77339).

As we discussed in section II.C.8.c. of this proposed rule, we are relying on the special rule under section 1848(q)(6)(D)(iii) of the Act to establish the performance threshold at 15 points for 2020 MIPS payment year. We are proposing to again decouple the additional performance threshold from the performance threshold. Because we do not have actual MIPS final scores for a prior performance period, if we do not decouple the additional performance threshold from the performance threshold, then we would have to set the additional performance threshold at the 25th percentile of possible final scores above the performance threshold. With a performance threshold set at 15 points, the range of total possible points above the performance threshold is 16 to 100 points. The 25th percentile of that range is 36.25 points, which is barely more than one third of the possible 100 points in the MIPS final score. We do not believe it would be appropriate to lower the additional performance threshold to 36.25 points, as we do not believe a final score of 36.25 points demonstrates exceptional performance by a MIPS eligible clinician. We believe these additional incentives should only be available to those clinicians with very high performance on the MIPS measures and activities. Therefore, we are relying on the special rule under section 1848(q)(6)(D)(iii) of the Act to set the additional performance threshold at 70 points for the 2020 MIPS payment year, which is higher than the 25th percentile of the range of the possible final scores above the performance threshold.

We took into account the data available and the modeling described in section II.C.8.c. of this proposed rule to estimate final scores for the 2020 MIPS payment year. We believe 70 points is appropriate because it requires a MIPS eligible clinician to submit data for and perform well on more than one performance category (except in the event the advancing care information measures are not applicable and available to a MIPS eligible clinician). Generally, a MIPS eligible clinician could receive a maximum score of 60 points for the quality performance

category, which is below the 70-point additional performance threshold. In addition, 70 points is at a high enough level that MIPS eligible clinicians must submit data for the quality performance category to achieve this target. For example, if a MIPS eligible clinician gets a perfect score for the improvement activities and advancing care information performance categories, but does not submit quality measures data, then the MIPS eligible clinician would only receive 40 points (0 points for quality + 15 points for improvement activities + 25 points for advancing care information), which is below the additional performance threshold. We believe the additional performance threshold at 70 points maintains the incentive for excellent performance while keeping the focus on quality performance. Finally, we believe keeping the additional performance threshold at 70 points maintains consistency with the 2019 MIPS payment year which helps to simplify the overall MIPS framework.

We invite public comment on these proposals. We also seek feedback on whether we 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 advancing care information performance category requirements would apply. In addition, a higher additional performance threshold would incentivize better performance and would also allow MIPS eligible clinicians to receive a higher additional MIPS payment adjustment.

We also seek public comment on which method we should use to compute the additional performance threshold beginning with the 2021 MIPS payment year. Section 1848(q)(6)(D)(ii) of the Act requires the additional performance threshold to be the score that is equal to the 25th percentile of the range of possible final scores above the performance threshold for the year, or 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 the prior period described in section 1848(q)(6)(D)(i) of the Act. For example, should we 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 we 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 under section 1848(q)(6)(F)(iv) of the Act 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.

e. Scaling/Budget Neutrality

We codified at §414.1405(b)(3) that a scaling factor not to exceed 3.0 may be applied to positive MIPS payment adjustment factors to ensure budget neutrality such that the estimated increase in aggregate allowed charges resulting from the application of the positive MIPS payment adjustment factors for the MIPS payment year equals the estimated decrease in aggregate allowed charges resulting from the application of negative MIPS payment adjustment factors for the MIPS payment year. We refer readers to the CY 2017 Quality Payment Program final rule for further discussion of budget neutrality (81 FR 77339).

We are not proposing any changes to the scaling and budget neutrality requirements as they are applied to MIPS payment adjustment factors in this proposed rule.

f. Additional Adjustment Factors

We refer readers to the CY 2017 Quality Payment Program final rule for further discussion of the additional MIPS payment adjustment factor (81 FR 77339 through 77340). We are not proposing any changes to determine the additional MIPS payment adjustment factors.

g. Application of the MIPS Payment Adjustment Factors

(1) Application to the Medicare paid amount

Section 1848(q)(6)(E) of the Act provides that for items and services furnished by a MIPS eligible clinician during a year (beginning with 2019), the amount otherwise paid under Part B for such items and services and MIPS eligible clinician for such year, shall be multiplied

by 1 plus the sum of the MIPS payment adjustment factor determined under section 1848(q)(6)(A) of the Act divided by 100, and as applicable, the additional MIPS payment adjustment factor determined under section 1848(q)(6)(C) of the Act divided by 100.

We codified at §414.1405(e) the application of the MIPS payment adjustment factors. For each MIPS payment year, the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, are applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician during the year.

We are proposing 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. This proposal is consistent with the approach taken for the value-based payment modifier (77 FR 69308 through 69310) and 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. Please refer to the CY 2017 Quality Payment Program final rule at 81 FR 77340 and section II.C.3.c. of this proposed rule for further discussion and our proposals regarding which Part B covered items and services would be subject to the MIPS payment adjustment.

(2) Example of Adjustment Factors

Figure A provides an example of how various final scores would be converted to an adjustment factor, and potentially an additional adjustment factor, using the statutory formula and based on proposed policies. In Figure A, the performance threshold is 15 points. The applicable percentage is 5 percent for 2020. The adjustment factor is determined on a linear sliding scale from zero to 100, with zero being the lowest negative applicable percentage

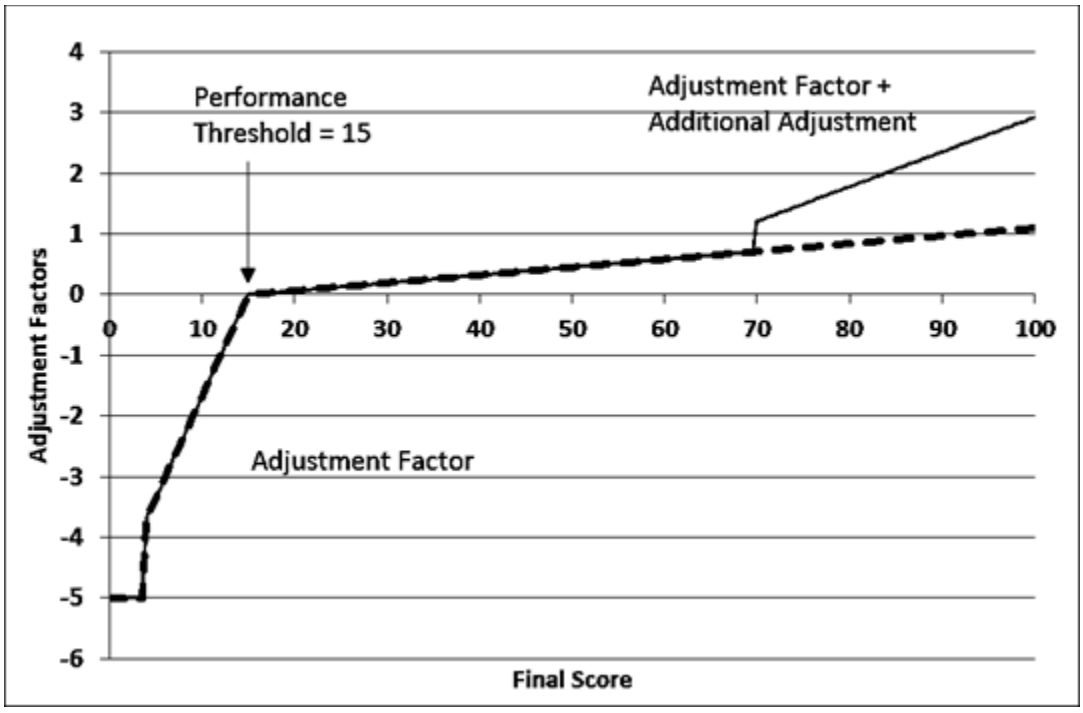
(negative 5 percent for the 2020 MIPS payment year), and 100 being the highest positive applicable percentage. However, there are two modifications to this linear sliding scale. First, there is an exception for a final score between zero and one-fourth of the performance threshold (zero and 3.75 points based on the proposed performance threshold for the 2020 MIPS payment year). All MIPS eligible clinicians with a final score in this range would receive the lowest negative applicable percentage (negative 5 percent for the 2020 MIPS payment year). Second, the linear sliding scale line for the positive MIPS adjustment factor is adjusted by the scaling factor (as discussed in section II.C.8.e. of this proposed rule). If the scaling factor is greater than zero and less than or equal to 1.0, then the adjustment factor for a final score of 100 would be less than or equal to 5 percent. If the scaling factor is above 1.0, but less than or equal to 3.0, then the adjustment factor for a final score of 100 would be higher than 5 percent. Only those MIPS eligible clinicians with a final score equal to 15 points (which is the performance threshold in this example) would receive a neutral MIPS payment adjustment. Because our proposed policies have set the performance threshold at 15 points, we anticipate that the scaling factor would be less than 1.0 and the payment adjustment for MIPS eligible clinicians with a final score of 100 points would be less than 5 percent.

Figure A of this proposed rule illustrates an example slope. In this example, the scaling factor for the adjustment factor is 0.22, which is much lower than 1.0. In this example, MIPS eligible clinicians with a final score equal to 100 would have an adjustment factor of 1.10 percent (5 percent x 0.22).

The additional performance threshold is 70 points. An additional adjustment factor of 0.5 percent starts at the additional performance threshold and increases on a linear sliding scale up to 10 percent times a scaling factor that is greater than zero and less than or equal to 1.0. The scaling factor will be determined so that the estimated aggregate increase in payments associated with the application of the additional adjustment factors is equal to $500,000,000.

In Figure A of this proposed rule, the example scaling factor for the additional adjustment factor is 0.183. Therefore, MIPS eligible clinicians with a final score of 100 would have an additional adjustment factor of 1.83 percent (10 percent x 0.183). The total adjustment for a MIPS eligible clinician with a final score equal to 100 would be 1 + 0.0110 + 0.0183 = 1.0293, for a total positive MIPS payment adjustment of 2.93 percent.

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



Note: The adjustment factor for final score values above the performance threshold is illustrative. For MIPS eligible clinicians with a final score of 100, the adjustment factor would be 5 percent times a scaling factor greater than zero and less than or equal to 3.0. The scaling factor is intended to ensure budget neutrality, but cannot be higher than 3.0. The additional adjustment factor is also illustrative. The additional adjustment factor starts at 0.5 percent and cannot exceed 10 percent. MIPS eligible clinicians at or above the additional performance threshold will receive the amount of the adjustment factor plus the additional adjustment factor.

The final MIPS payment adjustments would be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians receive positive MIPS payment adjustments.

Table 42 illustrates the changes in payment adjustments from the transition year to the 2020 MIPS payment year based on the proposals in this proposed rule as well as the statutorily-required increase in the applicable percent as required by section 1848(q)(6)(B) of the Act.

TABLE 42: Illustration of Point System and Associated Adjustments Comparison Between Transition Year and the 2020 MIPS Payment Year

Transition Year		2020 MIPS Payment Year	
Final score points	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**
0.0-0.75	Negative 4 percent	0.0-3.75	Negative 5 percent
0.76-2.99	Negative MIPS payment adjustment greater than negative 4 percent and less than 0 percent on a linear sliding scale	3.76-14.99	Negative MIPS payment adjustment greater than negative 5 percent and less than 0 percent on a linear sliding scale
3.00	0 percent adjustment	15.00	0 percent adjustment
3.01- 69.99	Positive MIPS payment adjustment greater than 0 percent on a linear sliding scale multiplied by a scaling factor to preserve budget neutrality. The linear sliding scale ranges from greater than 0 to 4 percent for scores from 3.01 to 100.00.	15.01-69.99	Positive MIPS payment adjustment greater than 0 percent on a linear sliding scale multiplied by a scaling factor to preserve budget neutrality. The linear sliding scale ranges from greater than 0 to 5 percent for scores from 15.01 to 100.00.
70.00-100	Positive MIPS payment adjustment on a linear sliding scale multiplied by a scaling factor to preserve budget neutrality AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.) The linear sliding scale ranges from greater than 0 to 4 percent for scores from 3.01 to 100.00.	70.00-100	Positive MIPS payment adjustment on a linear sliding scale multiplied by a scaling factor to preserve budget neutrality AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.) The linear sliding scale ranges from greater than 0 to 5 percent for scores from 15.01 to 100.00.

We have provided the following examples for the 2020 MIPS payment year to demonstrate scenarios in which MIPS eligible clinicians can achieve a final score at or above the performance threshold of 15 points.

Example 1: MIPS Eligible Clinician in Small Practice Submits 1 Quality Measure and 1 Improvement Activity

In the example illustrated in Table 43, a MIPS eligible clinician in a small practice reporting individually meets the performance threshold by reporting one measure one time via claims and one medium-weight improvement activity. The practice does not submit data for the advancing care information performance category, but does submit a significant hardship exception application which is approved; therefore, the weight for the advancing care information performance category is reweighted to the quality performance category due to proposed reweighting policies discussed in section II.C.7.b,(3) of this proposed rule. We also assume the small practice has a cost performance category percent score of 50 percent, although the cost performance category percent score will not contribute to the final score. Finally, we assume the average HCC score for the beneficiaries seen by the MIPS eligible clinician is 1.5.

There are several special scoring rules which affect MIPS eligible clinicians in a small practice:

- 3 measure achievement points for each quality measure even if the measure does not meet data completeness standards. We refer readers to section II.C.7.a.(2)(d) of this proposed rule for discussion of this policy. Therefore, a quality measure submitted one time would receive 3 points. Because the measure is submitted via claims, it does not qualify for the end-to-end electronic reporting bonus, nor would it qualify for the high-priority bonus because it is the only measure submitted. However, because the MIPS eligible clinician does not meet full participation requirements, the MIPS eligible clinician does not qualify for improvement scoring. We refer you to section II.C.7.a.(2)(i)(iii) of this proposed rule for a discussion on full participation requirements. Therefore, the quality performance category is (3 measure achievement points + zero measure bonus points)/60 total available measure points + zero improvement percent score which is 5 percent.
- The advancing care information performance category weight is redistributed to

quality so that the quality performance category percent score is worth 85 percent of the final score. We refer you to section II.C.7.b.(3)(d) of this proposed rule for a discussion of this proposed policy.

- MIPS eligible clinicians in small practices qualify for special scoring for improvement activities so a medium weighted activity is worth 20 points out of a total 40 possible points for the improvement activities performance category. We refer you to section II.C.6.e.(5) of this proposed rule for a discussion of this proposed policy.

- MIPS eligible clinicians in small practices qualify for the 5 point small practice bonus which is applied to the final score. We refer you to section II.C.7.b.(1)(c) of this proposed rule for a discussion of this proposed policy.

This MIPS eligible clinician exceeds the performance threshold of 15 points (but does not exceed the additional performance threshold). This score is summarized in Table 43.

TABLE 43: Scoring Example 1, MIPS Eligible Clinician in a Small Practice

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	5%	85%	4.25
Cost	50%	0%	0
Improvement Activities	20 out of 40 points - 50%	15%	7.5
Advancing Care Information	Missing	0% (reweighted to quality)	0
Subtotal (Before Bonuses)			11.75
Complex Patient Bonus			1.5
Small Practice Bonus			5
Final Score (not to exceed 100)			18.25

Example 2: Group Submission Not in a Small Group

In the example illustrated in Table 44, a MIPS eligible clinician in a medium size practice participating in MIPS as a group meets 75 percent of the quality score and 100 percent

for the advancing care information and improvement activities performance categories. There are many paths for a practice to receive a 75 percent score in the quality performance category, so for simplicity we are assuming the score has been calculated. Both the performance threshold and the additional performance threshold are exceeded. Again, for simplicity, we assume the average HCC score for the group is 1.5. In this example, the group practice does not qualify for any special scoring, yet is able to exceed the additional performance threshold and achieve the additional adjustment factor.

TABLE 44: Scoring Example 2, MIPS Eligible Clinician in a Medium Practice

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	75%	60%	45
Cost	50%	0%	0
Improvement Activities	40 out of 40 points 100%	15%	15
Advancing Care Information	100%	25%	25
Subtotal (Before Bonuses)			85
Complex Patient Bonus			1.5
Small Practice Bonus			0
Final Score (not to exceed 100)			86.5

Example 3: Non-Patient Facing MIPS Eligible Clinician

In the example illustrated in Table 45, an individual MIPS eligible clinician that is non-patient facing and not in a small practice meets 50 percent of the quality score and 50 percent for 1 medium-weighted for improvement activity. Again, there are many paths for a practice to receive a 50 percent score in the quality performance category, so for simplicity we are assuming the score has been calculated. Because the MIPS eligible clinician is non-patient facing, they qualify for special scoring for improvement activities, they receive 20 points (out of 40 possible points) for the medium weighted activity. Also, this individual did not submit

advancing care information measures and qualifies for the automatic reweighting of the advancing care information performance category to quality. The non-patient facing MIPS eligible clinician has an average HCC score of 1.5, but as the MIPS eligible clinician is not in a small practice, the MIPS eligible clinician does not qualify for the small practice bonus.

In this example, the performance threshold is exceeded while the additional performance threshold is not.

TABLE 45: Scoring Example 2, Non-Patient Facing MIPS Eligible Clinician

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	50%	60%	30
Cost	50%	0%	0
Improvement Activities	20 out of 40 points for 1 medium weight activity 50%	15%	7.5
Advancing Care Information	0%	25%	0
Subtotal (Before Bonuses)			37.5
Complex Patient Bonus			1.5
Small Practice Bonus			0
Final Score (not to exceed 100)			**39**

We note that these examples are not intended to be exhaustive of the types of participants nor the opportunities for reaching and exceeding the performance threshold.

9. Review and Correction of MIPS Final Score

a. Feedback and Information to Improve Performance

(1) Performance Feedback

As we have stated previously in the CY 2017 Quality Payment Program final rule (81 FR 77345), we will continue to engage in user research with front-line clinicians to ensure we are providing the performance feedback data in a user-friendly format, and that we are including the data most relevant to clinicians. Any suggestions from user research would be considered as we develop the systems needed for performance feedback, which would occur outside of the rulemaking process.

Over the past year, we have conducted numerous user research sessions to determine what the community most needs in performance feedback. In summary we have found the users want the following:

(1) To know as soon as possible how I am performing based on my submitted data so that I have confidence that I performed the way I thought I would.

(2) To be able to quickly understand how and why my payments will be adjusted so that I can understand how my business will be impacted.

(3) To be able to quickly understand how I can improve my performance so that I can increase my payment in future program years.

(4) To know how I am performing over time so I can improve the care I am providing patients in my practice.

(5) To know how my performance compares to my peers.

Based on that research, we have 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). By "real-time" feedback, we mean instantaneous feedback; for example, when a clinician submits their data via

our website or a third party submits data via our Application Program Interface (API), they will know immediately if their submission was successful.

We will continue to provide information for stakeholders who wish to participate in user research via our education and communication channels. Suggestions can also be sent via the "Contact Us" information on qpp.cms.gov. However, we note that suggestions provided through this channel will not be considered comments on this proposed rule. To submit comments on this proposed rule, please see the explanation of how to submit such comments and relevant deadlines explained at the beginning of this proposed rule.

(a) MIPS Eligible Clinicians

Under section 1848(q)(12)(A)(i) of the Act, we are at a minimum required to provide MIPS eligible clinicians with timely (such as quarterly) confidential feedback on their performance under the quality and cost performance categories beginning July 1, 2017, and we have discretion to provide such feedback regarding the improvement activities and advancing care information performance categories.

Beginning July 1, 2018, we are proposing 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. We propose to provide this performance feedback at least annually, and as, technically feasible, we would provide it more frequently, such as quarterly. If we are able to provide it more frequently, we would communicate the expected frequency to our stakeholders via our education and outreach communication channels.

Based on public comments summarized and responded to in the CY 2017 Quality Payment Program final rule (81 FR 77347), we 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. We request comment on these proposals.

For cost measures, since we can measure performance using any 12-month period of prior claims data, we request 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 we should make it available to clinicians and groups. In addition, as described in sections II.C.6.b. and II.C.6.d. of this proposed rule, we intend 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, we are 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. We 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.

(b) MIPS APMs

We are proposing 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. Please refer to section II.C.6.g.(5) of this proposed rule for additional information related to this proposal.

(c) Voluntary Clinician and Group Reporting

As noted in the CY 2017 Quality Payment Program final rule (81 FR 77071), eligible clinicians who are not included in the definition of a MIPS eligible clinician during the first 2 years of MIPS (or any subsequent year) may voluntarily report on measures and activities under MIPS, but will not be subject to the payment adjustment. In the final rule (81 FR 77346), we summarized public comments requesting that eligible clinicians who are not required, but who voluntarily report on measures and activities under MIPS, should receive the same access to

performance feedback as MIPS eligible clinicians, and indicated that we would take the comments into consideration in the future development of performance feedback. We propose 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. We propose that this would begin with data collected in performance period 2017, and would be available beginning July 1, 2018. Based on user and market research, we believe that making this information available would provide value in numerous ways. First, it would help clinicians who are excluded from MIPS in the 2017 performance period, but who may be considered MIPS eligible clinicians in future years, to prepare for participation in the Quality Payment Program when there are payment consequences associated with participation. Second, it would give all clinicians equal access to the CMS claims and benchmarking data available in performance feedback. And third, it would allow clinicians who may be interested in participating in an APM to make a more informed decision.

We request comments on this proposal.

(2) Mechanisms

Under section 1848(q)(12)(A)(ii) of the Act, the Secretary may use one or more mechanisms to make performance feedback available, which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. For the quality performance category, described in section 1848(q)(2)(A)(i) of the Act, the feedback shall, to the extent an eligible clinician chooses to participate in a data registry for purposes of MIPS (including registries under sections 1848(k) and (m) of the Act), be provided based on performance on quality measures reported through the use of such registries. For any other performance category (that is, cost, improvement activities, or advancing care information), the Secretary shall encourage provision of feedback through qualified clinical data registries (QCDRs) as described in section 1848(m)(3)(E) of the Act.

As previously stated in the CY 2017 Quality Payment Program final rule (81 FR 77347 through 77349), we will use a CMS-designated system as the mechanism for making performance feedback available, which we expect will be a web-based application. We expect 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 Quality Payment Program Website (qpp.cms.gov), and we intend 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.

We are also seeking 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?

We welcome public comment on these questions.

We intend to continue to leverage third party intermediaries as a mechanism to provider performance feedback. In the CY 2017 Quality Payment Program final rule (81 FR 77367 through 77386) we finalized that at least 4 times per year, qualified registries and QCDRs will provide feedback on all of the MIPS performance categories that the qualified registry or QCDR reports to us (improvement activities, advancing care information, and/or quality performance category). The feedback should be given to the individual MIPS eligible clinician or group (if participating as a group) at the individual participant level or group level, as applicable, for which the qualified registry or QCDR reports. The qualified registry or QCDR is only required to provide feedback based on the MIPS eligible clinician's data that is available at the time the performance feedback is generated. In regard to third party intermediaries, we also noted we would look to propose "real time" feedback as soon as it is technically feasible.

Per the policies finalized in the CY 2017 Quality Payment Program final rule (81 FR 77367 through 77386), we continue 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. We also understand that performance feedback is valuable to individual clinicians and groups, and seek feedback from third party intermediaries on when "real-time" feedback could be provided.

Additionally, we plan to continue to work with third party intermediaries as we continue to develop the mechanisms for performance feedback, to see where we may be able to develop and implement efficiencies for the Quality Payment Program. We are exploring options with an API, which could allow authenticated third party intermediaries to access the same data that we use to provide confidential feedback to the individual clinicians and groups on whose behalf the third party intermediary reports for purposes of MIPS, in accordance with applicable law,

including, but not limited to, the HIPAA Privacy and Security Rules. Our goal is to enable individual clinicians and groups to more easily access their feedback via the mechanisms and relationships they already have established. We are seeking comments on this approach as we continue to develop performance feedback mechanisms. We refer readers to section II.C.10. of this proposed rule for additional information on Third Party Data Submission.

(3) Receipt of Information

Section 1848(q)(12)(A)(v) of the Act, states that the Secretary may use the mechanisms established under section 1848(q)(12)(A)(ii) of the Act to receive information from professionals. This allows for expanded use of the feedback mechanism to not only provide feedback on performance to MIPS eligible clinicians, but to also receive information from professionals.

In the CY 2017 Quality Payment Program final rule (81 FR 77350), we discussed that we intended to explore the possibility of adding this feature to the CMS-designated system, such as a portal, in future years under MIPS. Although we are not making any specific proposals at this time, we are again seeking comment on the features that could be developed for the expanded use of the feedback mechanism. This could be a feature where eligible clinicians and groups can send their feedback (for example, if they are experiencing issues accessing their data, technical questions about their data, etc.) to us through the Quality Payment Program Service Center or the Quality Payment Program Website. We appreciate that eligible clinicians and groups may have questions regarding the Quality Payment Program information contained in their performance feedback. To assist eligible clinicians and groups, we intend to utilize existing resources, such as a helpdesk or offer technical assistance, to help address questions with the goal of linking these resource features to the Quality Payment Program Website and Service Center.

(4) Additional Information – Type of Information

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.

We propose, 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. We propose 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. We propose that the additional information would include historical data regarding the total, and components of, allowed charges (and other figures as determined appropriate). We propose that this information be provided on the aggregate level; with the exception of data on items and services, as we could consider providing this data at the patient level, if clinicians find that level of data to be useful, although we note it may contain personally identifiable information and protected health information. We propose the date range for making this information available would be based on what is most helpful to clinicians, such as the most recent data we have available, which as technically feasible would be provided from a 3 to 12-

month period. We propose to make this information available via the Quality Payment Program Website, and as technically feasible, as part of the performance feedback. Finally, because data on items and services furnished is generally kept confidential, we propose that access would be provided only after secure credentials are obtained. We request comment on these proposals.

(5) Performance Feedback Template

As we have previously indicated (81 FR 77352), we intend to do as much as we can of the development of the template for performance feedback by working with the stakeholder community in a transparent manner. We believe this will encourage stakeholder commentary and make sure the result is the best possible format(s) for feedback.

To continue with our collaborative goal of working with the stakeholder community, we seek comment on the structure, format, content (for example, 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, we understand the term "performance feedback" may not be meaningful to clinicians or groups to clearly denote what this data might imply. Therefore, we seek 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.

b. Targeted Review

In the CY 2017 Quality Payment Program final rule (81 FR 77546), we finalized at §414.1385 that MIPS eligible clinicians or groups may request a targeted review of the calculation of the MIPS payment adjustment factor under section 1848(q)(6)(A) of the Act and, as applicable, the calculation of the additional MIPS payment adjustment factor under section 1848(q)(6)(C) of the Act applicable to such MIPS eligible clinician or group for a year. We note MIPS eligible clinicians who are scored under the APM scoring standard described in section II.C.6.g. of this proposed rule may request this targeted review. Although we are not proposing any changes to the targeted review process, we are providing information on the process that was finalized in the CY 2017 Quality Payment Program final rule (81 FR 77353 through 77358).

(1) MIPS eligible clinicians and groups have a 60-day period to submit a request for targeted review, which begins on the day we make available the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, for the MIPS payment year and ends on September 30 of the year prior to the MIPS payment year or a later date specified by us.

(2) We will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted. Examples under which a MIPS eligible clinician or group may wish to request a targeted review include, but are not limited to:

- The MIPS eligible clinician or group believes that measures or activities submitted to us during the submission period and used in the calculations of the final score and determination of the adjustment factors have calculation errors or data quality issues. These submissions could be with or without the assistance of a third party intermediary; or
- The MIPS eligible clinician or group believes that there are certain errors made by us, such as performance category scores were wrongly assigned to the MIPS eligible clinician or

group (for example, the MIPS eligible clinician or group should have been subject to the low-volume threshold exclusion and should not have received a performance category score).

(3) The MIPS eligible clinician or group may include additional information in support of their request for targeted review at the time the request is submitted. If we request additional information from the MIPS eligible clinician or group, it must be provided and received by us within 30 days of the request. Non-responsiveness to the request for additional information may result in the closure of the targeted review request, although the MIPS eligible clinician or group may submit another request for targeted review before the deadline.

(4) Decisions based on the targeted review are final, and there is no further review or appeal.

c. Data Validation And Auditing

In the CY 2017 Quality Payment Program final rule (81 FR 77546 through 77547), we finalized at §414.1390(a) that we will selectively audit MIPS eligible clinicians and groups on a yearly basis. If a MIPS eligible clinician or group is selected for audit, the MIPS eligible clinician or group will be required to do the following in accordance with applicable law and timelines we establish:

(1) Comply with data sharing requests, providing all data as requested by us or our designated entity. All data must be shared with us or our designated entity within 45 days of the data sharing request, or an alternate timeframe that is agreed to by us and the MIPS eligible clinician or group. Data will be submitted via email, facsimile, or an electronic method via a secure website maintained by us.

(2) Provide substantive, primary source documents as requested. These documents may include: Copies of claims, medical records for applicable patients, or other resources used in the data calculations for MIPS measures, objectives, and activities. Primary source documentation

also may include verification of records for Medicare and non-Medicare beneficiaries where applicable. We are not proposing any changes to the requirements in section §414.1390(a).

We indicated in the CY 2017 Quality Payment Program final rule that all MIPS eligible clinicians and groups that submit data to us electronically must attest to the best of their knowledge that the data submitted to us is accurate and complete (81 FR 77362). We also indicated in the final rule that attestation requirements would be part of the submission process (81 FR 77360). We neglected to codify this requirement in regulation text of the CY 2017 Quality Payment Program final rule. Additionally, after further consideration since the final rule, the requirement is more in the nature of a certification, rather than an attestation. Thus, we are proposing to revise §414.1390 to add a new paragraph (b) that requires all MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS to certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. We also propose that the certification by the MIPS eligible clinician or group must accompany the submission.

We also indicated in the CY 2017 Quality Payment Program final rule that if a MIPS eligible clinician or group is found to have submitted inaccurate data for MIPS, we would reopen and revise the determination in accordance with the rules set forth at §§405.980 through 405.984 (81 FR 77362). We neglected to codify this policy in regulation text of the CY 2017 Quality Payment Program final rule and further, we did not include §405.986, which is also an applicable rule in our reopening policy. We also finalized our approach to recoup incorrect payments from the MIPS eligible clinician by the amount of any debts owed to us by the MIPS eligible clinician and likewise, we would recoup any payments from the group by the amount of any debts owed to us by the group. Thus, we are proposing to revise §414.1390 to add a new paragraph (c) that states we may reopen and revise a MIPS payment determination in accordance with the rules set forth at §§405.980 through 405.986.

In the CY 2017 Quality Payment Program, we also indicated that MIPS eligible clinicians and groups should retain copies of medical records, charts, reports and any electronic data utilized for reporting under MIPS for up to 10 years after the conclusion of the performance period (81 FR 77360). We neglected to codify this policy in regulation text of the CY 2017 Quality Payment Program final rule. Thus, we are proposing to revise §414.1390 to add a new paragraph (d) that states that 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.

Finally, we indicated in the CY 2017 Quality Payment Program final rule, that, in addition to recouping any incorrect payments, we intend to use data validation and audits as an educational opportunity for MIPS eligible clinicians and groups and we note that this process will continue to include education and support for MIPS eligible clinicians and groups selected for an audit.

10. Third Party Data Submission

In developing MIPS, our goal is to develop a program that is meaningful, understandable, and flexible for participating MIPS eligible clinicians. Flexible reporting options will provide eligible clinicians with options to accommodate different practices and make measurement meaningful. We believe that allowing eligible clinicians to participate in MIPS through the use of third party intermediaries that will collect or submit data on their behalf, will help us accomplish our goal of implementing a flexible program. We strongly encourage all third party intermediaries to work with their MIPS eligible clinicians to ensure the data submitted are representative of the individual MIPS eligible clinician's or group's overall performance for that measure or activity.

For purposes of this section, we use the term third party to refer to a qualified registry, QCDR, a health IT vendor or other third party that obtains data from a MIPS eligible clinician's Certified Electronic Health Record Technology, or a CMS approved survey vendor. In the CY 2017 Quality Payment Program final rule (81 FR 77363), we finalized at §414.1400(a)(1) that MIPS data may be submitted by third party intermediaries on behalf of a MIPS eligible clinician or group by: (1) A qualified registry; (2) a QCDR; (3) a health IT vendor; or (4) a CMS approved survey vendor. Additionally, we finalized at §414.1400(a)(3) that third party intermediaries must meet all the criteria designated by us as a condition of their qualification or approval to participate in MIPS as a third party intermediary. Lastly, as finalized at §414.1400(a)(3)(ii), all submitted data must be submitted in the form and manner specified by us.

We are proposing to revise §414.1400(a)(1) to state that MIPS data may be submitted by third party intermediaries on behalf of an individual MIPS eligible clinician, group, or virtual group. See section II.C.4. of this rule for more information related to virtual groups.

Additionally, we believe it is important that the MIPS data submitted by third party intermediaries is true, accurate, and complete. To that end, we are proposing to add a requirement at §414.1400(a)(5) 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. We also propose that this certification occur at the time of the submission and accompany the submission. We solicit comments on this proposal.

As more clinicians participate in value based payment arrangements with multiple payers, we believe third-party intermediaries will play an important role in calculating quality measures, reporting once to all payers, and sharing actionable feedback to clinicians. A robust ecosystem of third-party intermediaries would more reliably calculate measures using data across clinical practices caring for the same patients and reduce burden by streamlining reporting to all payers and offering timely feedback to clinicians that is easier to act on in addressing gaps in care. Third-party intermediaries can also take the burden off clinical practices by integrating various types of health care data, including administrative data from payers, other utilization data, cost data, and clinical data derived from health IT systems, to provide front-line clinicians and others with a comprehensive view of the cost and quality of the care they are delivering.

We are continuing to explore how we can further encourage those third-party intermediaries that provide comprehensive data services to support eligible clinicians participating in both MIPS and APMs. For instance, should we 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, for example, a virtual care team of primary and specialty physicians? Should there be a special designation for registries that would convey the availability of longitudinal clinical data for robust measurement and feedback? We seek comment on these and other ideas which can further advance the role of intermediaries and reduce clinician burden by enabling a streamlined reporting and feedback system.

a. Qualified Clinical Data Registries (QCDRs)

In the CY 2017 Quality Payment Program final rule (81 FR 77364), we finalized the definition and capabilities of a QCDR. We are not proposing any changes to the definition or the capabilities of a QCDR in this proposed rule, and refer readers to the CY 2017 Quality Payment Program final rule for a detailed discussion of the definition and capabilities of a QCDR.

(1) Establishment of an Entity Seeking To Qualify as a QCDR

In the CY 2017 Quality Payment Program final rule (81 FR 77365), we finalized the criteria to establish an entity seeking to qualify as a QCDR. We are not proposing any changes to the criteria in this proposed rule, and refer readers to the CY 2017 Quality Payment Program final rule for the criteria to qualify as a QCDR.

(2) Self-Nomination Period

In the CY 2017 Quality Payment Program final rule (81 FR 77365 through 77366), we 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. As an example, the self-nomination period for the 2018 performance period will begin on September 1, 2017, and will end on November 1, 2017. Entities that desire to qualify as a QCDR for the purposes of MIPS for a given performance period will need to self-nominate for that year and provide all information requested by us at the time of self-nomination. Having qualified as a QCDR in a prior year does not automatically

qualify the entity to participate in MIPS as a QCDR in subsequent performance periods. Furthermore, prior performance of the QCDR (when applicable) will be taken into consideration in approval of their self-nomination. For example, a QCDR may choose not to continue participation in the program in future years, or the QCDR may be precluded from participation in a future year due to multiple data or submission errors as noted below. Finally, QCDRs may want to update or change the measures or services or performance categories they intend to provide. We believe an annual self-nomination process is the best process to ensure accurate information is conveyed to MIPS eligible clinicians and accurate data is submitted to MIPS.

However, we do understand that some QCDRs have no changes to the measure and/ or activity inventory they offer to their clients and intend to participate in the MIPS for many years. Because of this, we are proposing, 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. Specifically, existing QCDRs in good standing may attest during the self-nomination period that they have no changes to their approved self-nomination application from the previous year of MIPS. 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. Minimal changes 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. We are proposing such a simplified process to reduce the burden of self-nomination for those existing QCDRs who have previously participated in MIPS, and are in good standing (not on probation or disqualified, as described below) and to allow for sufficient time for us to review data submissions and to make determinations on the standing of the QCDRs. We note 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. This proposed process will allow existing QCDRs in good standing to avoid completing the entire application annually, as is required in the existing process, and in alignment with the existing timeline. We request comments on this proposal. In the development of this proposal, we had reviewed the possibility of offering a multi-year approval, where QCDRs would be approved for a 2-year increment of time. We are concerned that utilizing a multi-year approval process in which QCDRs would be approved for 2 continuous years using the same fixed services they had for the first year, 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. Furthermore, another concern with a multi-year approval process is the concern for those QCDRs who perform poorly during the first year, and who should be placed on probation or disqualified (as described below). We request comments on this alternative.

We finalized to require other information (described below) of QCDRs at the time of self-nomination. If an entity becomes qualified as a QCDR, they will need to sign a statement confirming this information is correct prior to listing it on their web site. Once we post the QCDR on our website, including the services offered by the QCDR, we will require the QCDR

to support these services or measures for its clients as a condition of the entity's qualification as a QCDR for purposes of MIPS. Failure to do so will preclude the QCDR from participation in MIPS in the subsequent year.

For future years, beginning with the 2018 performance period, we are proposing that self-nomination information must be submitted via a web-based tool, and to eliminate the submission method of email. We will provide further information on the web-based tool at www.qpp.cms.gov. We request comments on this proposal.

(3) Information Required at the Time of Self-Nomination

In the CY 2017 Quality Payment Program final rule (81 FR 77366 through 77367), we finalized the information a QCDR must provide to us at the time of self-nomination. We are proposing to replace the term non-MIPS measures with QCDR measures for future program years, beginning with the 2018 performance period. We note that although we are proposing a change in the term referring to such measures, we are not proposing any other changes to the information a QCDR must provide to us at the time of self-nomination finalized in the CY 2017 Quality Payment Program final rule. We refer readers to the CY 2017 Quality Payment Program final rule for specific information requirements.

(4) QCDR Criteria for Data Submission

In the CY 2017 Quality Payment Program final rule (81 FR 77367 through 77374), we finalized that a QCDR must perform specific functions to meet the criteria for data submission. While we are not proposing any changes to the criteria for data submission in this proposed rule, we 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. That is, we expect that the QCDR measures, and their data elements (that is, specifications) comprising these measures be listed on the QCDR's website unless the measure is a MIPS measure, in which case the specifications will be posted by

us. QCDR measure specifications should be provided at a level of detail that is comparable to what is posted by us on the CMS website for MIPS quality 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 us. We refer readers to section II.C.9.a. of this proposed rule for additional information on third party intermediaries and performance feedback.

● For purposes of distributing performance feedback to MIPS eligible clinicians, we encourage 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 noted in the CY 2017 Quality Payment Program final rule (81 FR 77370), we 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. We would like to explain that this flexibility would only apply for MIPS measures; 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 indicate whether they will or will not be reporting on the measure, and we will review measure issues on a case-by-case basis. Any measures QCDRs wish to retire would need to be retained until the next annual self-nomination process and applicable performance period.

(5) QCDR Measure Specifications Criteria

In the CY 2017 Quality Payment Program final rule (81 FR 77374 through 77375), we specified at §414.1400(f) that the QCDR must provide specific QCDR measures specifications criteria. We generally intend to apply a process similar to the one used for MIPS measures to QCDR measures that have been identified as topped out. We are not proposing any changes to the QCDR measure specifications criteria as finalized in the CY2017 Quality Payment Program final rule. We would like to note that for QCDR quality measures, we encourage alignment with our measures development plan, but will consider all QCDR measures submitted by the QCDR. For MIPS measures, we would also like to note that CMS expects that a QCDR reporting on MIPS measures retain and use the MIPS specifications as they exist for the performance period.

We would like to clarify that we will likely not approve retired measures that were previously in one of CMS's quality programs, such as the Physician Quality Reporting System (PQRS) program, if proposed as QCDR measures. This includes measures that were retired due to being topped out (as defined in section II.C.6.c.(2) of this proposed rule) due to high-performance or measures retired due to a change in the evidence supporting the use of the measure.

We seek comment for future rulemaking, on requiring QCDRs that develop and report on QCDR measures, must fully develop and test (that is, conduct reliability and validity testing) their QCDR measures, by the time of submission of the new measure during the self-nomination

process.

Beginning with the 2018 performance period and for future program years, we propose 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 have permission from the QCDR that owns the measure that they can use the measure for the performance period. Permission must be granted at the time of self-nomination, so that the QCDR that is using the measure can include the proof of permission for CMS review and approval for the measure to be used in the performance period. The QCDR measure owner (QCDR vendor) would still own and maintain the QCDR measure, but would allow other approved QCDRs to utilize their QCDR measure with proper notification. This proposal will help to harmonize clinically similar measures and limit the use of measures that only slightly differ from another. We invite comments on this proposal.

We would like to clarify from the CY 2017 Quality Payment Program final rule (81 FR 77375) that the QCDR must publicly post the measure specifications no later than 15 calendar days following our approval of these measures specifications for each QCDR measure it intends to submit for MIPS.

We refer readers to the CY 2017 Quality Payment Program final rule for the QCDR measure specifications criteria.

(6) Identifying QCDR Quality Measures

In the CY 2017 Quality Payment Program final rule (81 FR 77375 through 77377), we finalized the definition and types of QCDR quality measures for purposes of QCDRs submitting data for the MIPS quality performance category. We are not proposing any changes to the criteria on how to identify QCDR quality measures in this proposed rule. We would like to clarify that QCDRs are not limited to reporting on QCDR measures, and may also report on MIPS measures as indicated above in the QCDR data submission criteria section.

(7) Collaboration of Entities to Become a QCDR

In the CY 2017 Quality Payment Program final rule (81 FR 77377), we finalized policy on the collaboration of entities to become a QCDR. We are not proposing any changes to this policy in this proposed rule, and would refer readers to the CY 2017 Quality Payment Program final rule for the criteria.

In response to the CY 2017 Quality Payment Program final rule, commenters recommended that we work with QCDRs to determine a more reasonable cycle for self-nomination, measure selection, and reporting because the current process is burdensome. Commenters also recommended that we not disqualify QCDRs that do not have the capability to allow MIPS eligible clinicians to report across all performance categories using only one submission mechanism, and noted that the ability for QCDRs to report their own measures allows MIPS eligible clinicians the ability to implement measures that are more clinically meaningful and up-to-date than those measures that may be available in the MIPS measure set. We would like to note that we are proposing above, a simplified self-nomination and measure selection process available to existing QCDRs that are in good standing, beginning in the third year of the Quality Payment Program. We would also like to explain that QCDRs are not required to report on all performance categories across the MIPS program, and would not be disqualified for not being able to report data across on performance categories only using one mechanism. We thank the commenters for their support with regards to allowing QCDRs to nominate and report on QCDR measures that may be specialty related. We thank the commenters for their feedback and will take their comments into consideration in future rule making.

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

In the CY 2017 Quality Payment Program final rule 81 FR 77382, we finalized definitions and criteria around health IT vendors that obtain data from MIPS eligible clinicians CEHRT. We note that, for this proposed rule, a health IT vendor that serves as a third party intermediary to collect or submit data on behalf MIPS eligible clinicians may or may not also be a "health IT developer." Under the ONC Health IT Certification Program (Program), (80 FR 62604), a health IT developer constitutes a vendor, self-developer, or other entity that presents health IT for certification or has health IT certified under the Program. The use of "health IT developer" is consistent with the use of the term "health IT" in place of "EHR" or "EHR technology" under the Program (see 80 FR 62604; and section II.C.6.f. of this proposed rule). Throughout this proposed rule, we use the term "health IT vendor" to refer to entities that support the health IT requirements of a clinician participating in the Quality Payment Program.

We are not proposing any changes to this policy in this proposed rule, and would refer readers to the CY 2017 Quality Payment Program final rule for the criteria. However we seek comment for future rulemaking regarding the potential shift to seeking alternatives which might fully replace the QRDA III format in the Quality Payment Program in future program years.

c. Qualified Registries

In the CY 2017 Quality Payment Program final rule (81 FR 77382 through 77386), we finalized the definition and capability of qualified registries. We are not proposing any changes to the definition or the capabilities of qualified registries in this final rule, and refer readers to the CY 2017 Quality Payment Program final rule for the detailed definition and capabilities of a qualified registry.

(1) Establishment of an Entity Seeking to Qualify as a Registry

In the CY 2017 Quality Payment Program final rule (81 FR 77383), we finalized the requirements for the establishment of an entity seeking to qualify as a registry. We are not proposing any changes to the criteria regarding the establishment of an entity seeking to qualify

as a registry criteria in this proposed rule, and refer readers to the final rule for the criteria for establishing an entity seeking to qualify as a registry.

(2) Self-Nomination Period

For the 2018 performance period, and for future years of the program, we finalized at §414.1400(g) a self-nomination period from September 1 of the year prior to the applicable performance period, until November 1 of the same year. For example, for the 2018 performance period, the self-nomination period would begin on September 1, 2017, and end on November 01, 2017. Entities that desire to qualify as a qualified registry for purposes of MIPS for a given performance period will need to provide all requested information to us at the time of self-nomination and would need to self-nominate for that performance period. Having previously qualified as a qualified registry does not automatically qualify the entity to participate in subsequent MIPS performance periods. Furthermore, prior performance of the qualified registry (when applicable) will be taken into consideration in approval of their self-nomination. For example, a qualified registry may choose not to continue participation in the program in future years, or the qualified registry may be precluded from participation in a future year, due to multiple data or submission errors as noted below. As such, we believe an annual self-nomination process is the best process to ensure accurate information is conveyed to MIPS eligible clinicians and accurate data is submitted to MIPS.

However, we do understand that some qualified registries have no changes to the measures and/ or activity inventory they offer to their clients and intend to participate in MIPS for many years. Because of this, we are proposing, 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 the qualified registry's 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. Specifically, existing qualified registries in good standing may attest during the self-nomination period that they have no changes to their approved self-nomination application from the previous year of MIPS. In addition, the existing qualified registry may decide to make minimal changes to their self-nomination application from the previous year, which would be submitted by the qualified registry for CMS review and approval by the close of the self-nomination period. Minimal changes may include limited changes to their performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information. By attesting that certain aspects of their approved application from the previous year have not changed, existing qualified registries will be spending less time completing the entire self-nomination form, as was previously required on a yearly basis. We are proposing such a simplified process to reduce the burden of self-nomination for those existing qualified registries who have previously participated in MIPS, and are in good standing (not on probation or disqualified , as described below) and to allow for sufficient time for us to review data submissions and to make determinations on the standing of qualified registries. This proposed process will allow existing qualified registries in good standing to avoid completing the entire application annually, as is required in the existing process, and in alignment with the existing timeline. We request comments on this proposal. In the development of this proposal, we had reviewed the possibility of offering a multi-year approval, where qualified registries would be approved for a 2-year increment of time. We are concerned that utilizing a multi-year approval process in which qualified registries would be approved for 2 continuous program years using the same fixed services they had for the first year, would not provide the qualified registry with the flexibility to add or remove services and or measures based on their capabilities for the upcoming program year. Furthermore, another concern with a multi-year approval process is the concern for those qualified registries who perform poorly during the first year, who should be placed on probation or disqualified (as

described below). We are proposing that this process 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. We believe that this annual process will provide qualified registries with the flexibility to make minor changes to their services should they wish to do so. We request comments on this proposal. We also seek comment to potentially allow for qualified registries to utilize a multi-year approval process, in which they would be approved for a continuous 2-year increment since qualified registries can only make minor changes (for example, including a performance category, or a MIPS quality measure, all of which are already considered a part of the MIPS program).

We finalized to require further information of qualified registries at the time of self-nomination. If an entity becomes qualified as a qualified registry, they would need to sign a statement confirming this information is correct prior to us listing their qualifications on their website. Once we post the qualified registry on our website, including the services offered by the qualified registry, we would require the qualified registry to support these services/measures for its clients as a condition of the entity's qualification as a qualified registry for purposes of MIPS. Failure to do so will preclude the qualified registry from participation in MIPS in the subsequent performance year.

For the 2018 performance period and beyond, we are proposing that self-nomination information must be submitted via a web-based tool, and to eliminate the submission method of email. We will provide further information on the web-based tool at www.qpp.cms.gov. We request comments on this proposal.

(3) Information Required at the Time of Self-Nomination

We finalized in the CY 2017 Quality Payment Program final rule (81 FR 77384) that a qualified registry must provide specific information to us at the time of self-nomination. We are

not proposing any changes to the information required at the time of self-nomination in this proposed rule, and refer readers to the final rule for specific information requirements.

(4) Qualified Registry Criteria for Data Submission

In the CY 2017 Quality Payment Program final rule (81 FR 77386), we finalized the criteria for qualified registry data submission. We are not proposing any changes to the data submission criteria in this proposed rule, and refer readers to the final rule for specific criteria regarding qualified registry data submission. We would like to note two clarifications to the existing criteria:

- Enter into and maintain with its participating MIPS eligible clinicians an appropriate Business Associate agreement that complies with the HIPAA Privacy and Security Rules. Ensure that the Business Associate agreement provides for the Qualified Registry's receipt of patient-specific data from an individual MIPS eligible clinician or group, as well as the Qualified Registry's disclosure of quality measure results and numerator and denominator data or patient specific data on Medicare and non-Medicare beneficiaries on behalf of individual MIPS eligible clinicians and groups.

- We had finalized that timely feedback be provided at least four times a year, on all of the MIPS performance categories that the qualified registry will report to us. We refer readers to section II.C.9.a. of this proposed rule for additional information on third party intermediaries and performance feedback.

We had received comments in response to the CY 2017 Quality Payment Program final rule from commenters who expressed concern that the 3 percent acceptable error rate for qualified registries is too low. Commenters recommended we analyze reporting for the transition year and increase the error rate to 5 percent at the minimum because qualified registries may make a small number of errors given that 2017 is the first year of MIPS and that removing qualified registries due to a low error threshold could hurt clinicians. We thank the commenters

for their feedback and will take the comments into consideration in future rulemaking.

As indicated in the CY 2017 Quality Payment Program final rule (81 FR 77370), we will on a case-by-case basis allow qualified registries to request review and approval for additional MIPS measures throughout the performance period. Any new measures that are approved by us will be added to the information related to the qualified registry on the CMS website, as technically feasible. We anticipate only being able to update this information on the website on a quarterly basis, as technically feasible.

d. CMS-Approved Survey Vendors

In the CY 2017 Quality Payment Program final rule (81 FR 77386), we finalized the definition, criteria, required forms, and vendor business requirements needed to participate in MIPS as a survey vendor. We refer readers to the CY 2017 Quality Payment Program final rule for specific details on requirements. We have heard from some groups that it would be useful to have a final list of CMS-approved survey vendors to inform their decision on whether or not to participate in the CAHPS for MIPS survey. Therefore, beginning with the 2018 performance period and for future program years, we propose to remove the April 30th survey vendor application deadline because this deadline is within the timeframe of when groups can elect to participate in the CAHPS for MIPS survey. In order to provide a final list of CMS-approved survey vendors earlier in the timeframe during which groups can elect to participate in the CAHPS for MIPS survey, an earlier vendor application deadline would be necessary. This could be accomplished by having a rolling application period, where vendors would be able to submit an application by the end of the first quarter. However, in addition to submitting a vendor application, vendors must also complete vendor training and submit a Quality Assurance Plan and we need to allow sufficient time for these requirements as well. Therefore, we propose for the Quality Payment Program 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. This

proposal would allow us to adjust the application deadline beyond January 31st on a year to year basis, based on program needs. We will notify vendors of the application deadline to become a CMS-approved survey vendor through additional communications and postings. We request comments on this proposal and other alternatives that would allow us 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.

e. Probation and Disqualification of a Third Party Intermediary

At §414.1400(k), we finalized the process for placing third party intermediaries on probation and for disqualifying such entities for failure to meet certain standards established by us (81 FR 77386). Specifically, we proposed that if at any time we determine that a third party intermediary (that is, a QCDR, health IT vendor, qualified registry, or CMS-approved survey vendor) has not met all of the applicable criteria for qualification, we may place the third party intermediary on probation for the current performance period or the following performance period, as applicable.

In addition, we finalized that we require a corrective action plan from the third party intermediary to address any deficiencies or issues and prevent them from recurring. We finalized that the corrective action plan must be received and accepted by us within 14 days of the CMS notification to the third party intermediary of the deficiencies or probation. Failure to comply with these corrective action plan requirements would lead to disqualification from MIPS for the subsequent performance period.

We finalized for probation to mean that, for the applicable performance period, the third party intermediary must meet all applicable criteria for qualification and approval and also must submit a corrective action plan for remediation or correction of any deficiencies identified by CMS that resulted in the probation (81 FR 77548).

In addition, we finalized that if the third party intermediary has data inaccuracies

including (but not limited to) TIN/NPI mismatches, formatting issues, calculation errors, data audit discrepancies affecting in excess of 3 percent (but less than 5 percent) of the total number of MIPS eligible clinicians or groups submitted by the third party intermediary, we would annotate the listing of qualified third party intermediaries on the CMS website, noting that the third party intermediary furnished data of poor quality and would place the entity on probation for the subsequent performance period.

Further, we finalized if the third party intermediary does not reduce their data error rate below 3 percent for the subsequent performance period, the third party intermediary would continue to be on probation and have their listing on the CMS website continue to note the poor quality of the data they are submitting for MIPS for one additional performance period. After 2 years on probation, the third party intermediary would be disqualified for the subsequent performance period. Data errors affecting in excess of 5 percent of the MIPS eligible clinicians or groups submitted by the third party intermediary may lead to the disqualification of the third party intermediary from participation for the following performance period. In placing the third party intermediary on probation; we would notify the third party intermediary of the identified issues, at the time of discovery of such issues.

In addition, we finalized that if the third party intermediary does not submit an acceptable corrective action plan within 14 days of notification of the deficiencies and correct the deficiencies within 30 days or before the submission deadline—whichever is sooner, we may disqualify the third party intermediary from participating in MIPS for the current performance period or the following performance period, as applicable.

We note 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. We will consider cases of vendors leaving the marketplace during the performance period on a case

by case basis, but would note that we will not consider cases prior to the performance period. We would however, need proof that the MIPS eligible clinician had an agreement in place with the vendor at the time of their withdrawal from the marketplace. We are not proposing any changes to the process of probation and disqualification of a third party intermediary in this proposed rule.

Commenters on the final rule requested that we 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. We thank the commenters for their feedback and will take the comments into consideration in future rulemaking.

f. Auditing of Third Party Intermediaries Submitting MIPS Data

In the CY 2017 Quality Payment Program final rule (81 FR 77389), we finalized at §414.1400(j) that any third party intermediary (that is, a QCDR, health IT vendor, qualified registry, or CMS-approved survey vendor) must comply with the following procedures as a condition of their qualification and approval to participate in MIPS as a third party intermediary:

(1) The entity must make available to us the contact information of each MIPS eligible clinician or group on behalf of whom it submits data. The contact information will include, at a minimum, the MIPS eligible clinician or group's practice phone number, address, and if available, email;

(2) The entity must retain all data submitted to us for MIPS for a minimum of 10 years; and

(3) For the purposes of auditing, we may request any records or data retained for the purposes of MIPS for up to 6 years and 3 months.

We are proposing to change §414.1400(j)(2) to clarify that the entity must retain all data submitted to us for purposes of MIPS for a minimum of 10 years from the end of the MIPS

performance period.

11. Public Reporting on Physician Compare

This section contains the approach for public reporting on Physician Compare for the CY 2018 Quality Payment Program final rule, including MIPS, APMs, and other information as required by the MACRA and building on the MACRA public reporting policies previously finalized (81 FR 77390 through 77399).

Physician Compare draws its operating authority from section 10331(a)(1) of the Affordable Care Act. As required by section 10331(a)(1) of the Affordable Care Act, by January 1, 2011, we developed a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Act, as well as information on other EPs who participate in the PQRS under section 1848 of the Act. More information about Physician Compare can be accessed on the Physician Compare Initiative website at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/.

The first phase of Physician Compare was launched on December 30, 2010 (http://www.medicare.gov/physiciancompare). Since the initial launch, Physician Compare has been continually improved and more information has been added. In December 2016, the site underwent a complete user-informed, evidenced-based redesign to further enhance usability and functionality on both desktop computers and mobile devices and to begin to prepare the site for the inclusion of more data as required by the MACRA.

Currently, website users can view information about approved Medicare clinicians, such as: name; Medicare primary and secondary specialties; practice locations; group affiliations; hospital affiliations that link to the hospital's profile on Hospital Compare as available; Medicare assignment status; education; residency; and, American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), and American Board of Optometry (ABO) board certification information. For groups, users can view group names, specialties, practice

locations, Medicare assignment status, and affiliated clinicians. In December 2016, we also added indicators on the results page to show those clinicians and groups that had performance scores available to view. We also included an indicator on profile pages to show those Medicare clinicians and groups that satisfactorily or successfully participated in a CMS quality program to indicate their commitment to quality.

Consistent with section 10331(a)(2) of the Affordable Care Act, Physician Compare phased in public reporting of performance scores that provide comparable information on quality and patient experience measures for reporting periods beginning January 1, 2012. To the extent that scientifically sound measures are developed and are available, Physician Compare is required to include, to the extent practicable, the following types of measures for public reporting: Measures collected under PQRS and an assessment of efficiency, patient health outcomes, and patient experience, as specified. The first set of quality measures were publicly reported on Physician Compare in February 2014. Currently, Physician Compare 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, and 90 individual clinician-level measures collected either through claims or registry for individual EPs participating in 2015 under the PQRS. In addition, 31 total individual clinician-level Qualified Clinical Data Registry (QCDR) non-PQRS measures are publicly available either through Physician Compare profile pages or 2015 QCDR websites. A complete history of public reporting on Physician Compare is detailed in the CY 2016 PFS final rule (80 FR 71117 through 71122).

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 professional (now referred to as 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), among other additions.

This expansion will continue under the MACRA. Sections 1848(q)(9)(A) and (D) of the Act facilitate the continuation of our phased approach to public reporting by requiring the Secretary 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 (quality, cost, improvement activities, and advancing care information);
- Names of eligible clinicians in Advanced APMs and, to the extent feasible, the names of such Advanced APMs and the performance of such models; and,
- Aggregate information on the MIPS, posted periodically, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians for each performance category.

Initial plans to publicly report this performance information on Physician Compare were finalized in the CY 2017 Quality Payment Program final rule (81 FR 77390). The proposals related to each of these requirements for year 2 of the Quality Payment Program are addressed below in this section.

Section 1848(q)(9)(B) of the Act also requires that this information indicate, where appropriate, that publicized information may not be representative of the eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated. The information mandated for Physician Compare under section 1848(q)(9) of the Act will generally be publicly reported consistent with sections 10331(a)(2) and 10331(b) of the Affordable Care Act, and like all measure data included on Physician Compare, will be comparable. In addition, section 10331(b) of the Affordable Care

Act requires that we include, to the extent practicable, processes to ensure that data made public are statistically valid, reliable, and accurate, including risk adjustment mechanisms used by the Secretary. In addition to the public reporting standards identified in the Affordable Care Act – statistically valid and reliable data that are accurate and comparable – we have established a policy that, as determined through user testing, the data we disclose generally should resonate with and be accurately interpreted by website users to be included on Physician Compare profile pages. Together, we refer to these conditions as the Physician Compare public reporting standards (80 FR 71118 through 71120). Section 10331(d) of the Affordable Care Act also requires us to consider input from multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Act. We continue to receive general input from stakeholders on Physician Compare through a variety of means, including rulemaking and different forms of stakeholder outreach (for example, Town Hall meetings, Open Door Forums, webinars, education and outreach, Technical Expert Panels, etc.).

In addition, section 1848(q)(9)(C) of the Act requires the Secretary to provide an opportunity for MIPS eligible clinicians to review the information that will be publicly reported prior to such information being made public. This is generally consistent with section 10331(a)(2) of the Affordable Care Act, under which we have established a 30-day preview period for all measurement performance data that allows physicians and other eligible clinicians to view their data as it will appear on the website in advance of publication on Physician Compare (80 FR 77392). Section 1848(q)(9)(C) of the Act also requires that MIPS eligible clinicians be able to submit corrections for the information to be made public. We finalized a 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 is available for public reporting in late 2018. Therefore, we finalized a 30-day preview period in advance of the publication of data on Physician Compare (81 FR 77392).

We will coordinate data review and any relevant data resubmission or correction between Physician Compare and the four performance categories of MIPS. All data available for public reporting – measure rates, scores, and attestations, etc. – are available for review and correction during the targeted review process, which will begin at least 30 days in advance of the publication of new data. Data under review is not publicly reported until the review is complete. All corrected measure rates, scores, and attestations submitted as part of this process are available for public reporting. The technical details of the process are communicated directly to affected MIPS eligible clinicians and groups and detailed outside of rulemaking with specifics made public on the Physician Compare Initiative page on www.cms.gov and communicated through Physician Compare and other CMS listservs (81 FR 77391).

In addition, section 1848(q)(9)(D) of the Act requires that aggregate information on the MIPS be periodically posted on the Physician Compare website, including the range of final scores for all MIPS eligible clinicians and the range of performance for all MIPS eligible clinicians for each performance category.

Lastly, section 104(e) of the MACRA requires the Secretary to make publicly available, on an annual basis, in an easily understandable format, information for physicians and, as appropriate, other eligible clinicians related to items and services furnished to people with Medicare, and to 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.

In accordance with section 104(e) of the MACRA, we 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 is currently available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html. This information is integrated on the Physician Compare website via the downloadable database each year using the most current data, starting with the 2016 data, targeted for initial release in late 2017 (80 FR 71130). 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. 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.

We propose to revise the public reporting regulation at §414.1395(a), to more completely and accurately reference the data available for public reporting on Physician Compare. We propose to modify §414.1395(a) to remove from the heading and text references to "MIPS" and "public website" and instead reference "Quality Payment Program" and "Physician Compare". Specifically, proposed §414.1395(a) reads as follows: "Public reporting of eligible clinician and group Quality Payment Program information. For each program year, CMS posts on Physician Compare, in an easily understandable format, information regarding the performance of eligible clinicians or groups under the Quality Payment Program." We also propose to add paragraphs (b), (c), and (d) at §414.1395, to capture previously established policies for Physician Compare relating to the public reporting standards, first year measures, and the 30-day preview

period. Specifically, at proposed §414.1395(b), we propose that, with the exception of data that must be mandatorily reported on Physician Compare, for each program year, we rely on the established public reporting standards to guide the information available for inclusion on Physician Compare. The public reporting standards require data included on Physician Compare to be statistically valid, reliable, and accurate; be comparable across reporting mechanisms; and, meet the reliability threshold. And, to be included on the public facing profile pages, the data must also resonate with website users, as determined by CMS. At proposed §414.1395(c), we propose to codify our policy regarding first year measures: "For each program year, CMS does not publicly report any first year measure, meaning any measure in its first year of use in the quality and cost performance categories. After the first year, CMS reevaluates measures to determine when and if they are suitable for public reporting." At proposed §414.1395(d), we propose to specify the 30-day preview period rule: "For each program year, CMS provides a 30-day preview period for any clinician or group with Quality Payment Program data before the data are publicly reported on Physician Compare."

We believe section 10331 of the Affordable Care Act supports the overarching goals of the MACRA by providing the public with quality information that will help them make informed decisions about their health care, while encouraging clinicians to improve the quality of care they provide to their patients. In accordance with section 10331 of the Affordable Care Act, section 1848(q)(9) of the Act, and section 104(e) of the MACRA, we plan to continue to publicly report performance information on Physician Compare. As such, we propose the inclusion of the following information on Physician Compare.

a. Final Score, Performance Categories, and Aggregate Information

Sections 1848(q)(9)(A) and (D) of the Act require that we publicly report on Physician Compare the final score for each MIPS eligible clinician, performance of each MIPS eligible clinician for each performance category, and periodically post aggregate information on the

MIPS, including the range of final scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category. We finalized such data for public reporting on Physician Compare for the transition year (81 FR 77393), and we are now proposing to add these data each year to Physician Compare for each MIPS eligible clinician or group, either on the profile pages or in the downloadable database, as technically feasible. Statistical testing and user testing, as well as consultation of the Physician Compare Technical Expert Panel, will determine how and where these data are best reported on Physician Compare. As the MACRA requires that this information be available for public reporting on Physician Compare, we are proposing to include it each year moving forward, as technically feasible. We request comment on this 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.

A detailed discussion of proposals related to each performance category of MIPS data follows.

b. Quality

As detailed in the CY 2017 Quality Payment Program final rule (81 FR 77395), and consistent with the existing policy that makes all current PQRS measures available for public reporting, we finalized a decision to make all measures under the MIPS quality performance category available for public reporting on Physician Compare in the transition year of the Quality Payment Program, as technically feasible. This included all available measures reported via all available submission methods, and applied to both MIPS eligible clinicians and groups.

Also consistent with current policy, although all measures will be available for public reporting, not all measures will be made available on the public-facing website profile pages. As

explained in the CY 2017 Quality Payment Program final rule (81 FR 77394), providing too much information can overwhelm website users and lead to poor decision making. Therefore, consistent with section 1848(q)(9)(A)(i)(II) of the Act, all measures in the quality performance category that meet the statistical public reporting standards will be included in the downloadable database, as technically feasible. We also finalized a policy that a subset of these measures will be publicly reported on the website's profile pages, as technically feasible, based on website user testing. Statistical testing and user testing will determine how and where measures are reported on Physician Compare. In addition, we adopted our existing policy of not publicly reporting first year measures, meaning new measures that have been in use for less than 1 year, regardless of submission method used, for this MIPS quality performance category. After a measure's first year in use, we will evaluate the measure to see if and when the measure is suitable for public reporting (81 FR 77395).

Currently, there is a minimum sample size requirement of 20 patients for performance data to be included on Physician Compare. We previously sought comment on moving away from this requirement and moving to a reliability threshold for public reporting. In general, commenters supported a minimum reliability threshold. As a result, we 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).

The reliability of a measure refers to the extent to which the variation in the performance rate is due to variation in quality of care as opposed to random variation due to sampling. Statistically, reliability depends on performance variation for a measure across entities, the random variation in performance for a measure within an entity's panel of attributed patients, and the number of patients attributed to the entity. High reliability for a measure suggests that comparisons of relative performance across entities, such as eligible clinicians or groups, are likely to be stable and consistent, and that the performance of one entity on the quality measure

can confidently be distinguished from another. We will conduct analyses to determine the reliability of the data collected and use this to calculate the minimum reliability threshold for the data. Once an appropriate minimum reliability threshold is determined, we will only publicly report those performance rates for any given measure that meet the minimum reliability threshold. We note that reliability standards for public reporting and reliability for scoring need not align; reliability for public reporting is unique because, for example, public reporting requires ensuring additional protections to maintain confidentiality. In addition, because publicly reported measures can be compared across clinicians and across groups, it is particularly important for the most stringent reliability standards to be in place to ensure differences in performance scores reflect true differences in quality of care to promote accurate comparisons by the public. For further information on reliability as it relates to scoring of cost measures see section II.C.7.a.(3) of this proposed rule.

In the CY 2017 Quality Payment Program final rule, we established that we will include the total number of patients reported on each measure in the downloadable database to facilitate transparency and more accurate understanding and use of the data (81 FR 77395). We will begin publishing the total number of patients reported on each measure in the downloadable database with 2017 data available for public reporting in late 2018 and for each year moving forward.

Understanding that we will continue our policies to not publicly report first year quality measures, that we will only report those measures that meet the reliability threshold and meet the public reporting standards, and include the total number of patients reported on for each measure in the downloadable database, we are again proposing to make all measures under the MIPS quality performance category available for public reporting on Physician Compare, as technically feasible. This would include all available measures reported via all available submission methods for both MIPS eligible clinicians and groups, for 2018 data available for public reporting in late 2019, and for each year moving forward, these data are required by the MACRA to be available

for public reporting on Physician Compare, continuing to publicly report these data ensures continued transparency and provides people with Medicare and their caregivers valuable information they can use to make informed health care decisions. We request comment on this proposal.

In addition, we seek comment on expanding the patient experience data available for public reporting on Physician Compare. Currently, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey is available for groups to report under the MIPS. This patient experience survey data is highly valued by patients and their caregivers as they evaluate their health care options. However, in testing with patient and caregivers, they regularly ask for more information from patients like them in their own words. Patients regularly request we include narrative reviews of clinicians and groups on the website. The Agency for Healthcare Research and Quality (AHRQ) is fielding a beta version of the CAHPS Patient Narrative Elicitation Protocol (https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html). This includes five open-ended questions designed to be added to the Clinician & Groups CAHPS survey, which CAHPS for MIPS is molded after. These five questions have been developed and tested to work to 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. More scientifically rigorous patient narrative data would not only greatly benefit patients, but it would also greatly aid clinicians and groups as they work to assess how their patients experience care. We are seeking comment on potentially public reporting these five open-ended questions for the CAHPS for MIPS survey on Physician Compare as a consideration in future rulemaking. We direct readers to the Quality Performance Criteria in section II.C.6.b.(3)(a) of this proposed rule for additional information related to seeking comment on adding these questions to the CAHPS for MIPS survey.

c. Cost

Consistent with section 1848(q)(9)(A)(i)(II) of the Act, we finalized in the CY 2017 Quality Payment Program final rule a decision to make all measures under the MIPS cost performance category available for public reporting on Physician Compare (81 FR 77396). This included all available measures reported via all available submission methods, and applied to both MIPS eligible clinicians and groups. However, as noted in the final rule, we may not have data available for public reporting in the transition year of the Quality Payment Program for the cost performance category (2017 data available for public reporting in late 2018).

As 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, we are again proposing 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. These data are required by the MACRA to be available for public reporting on Physician Compare, but we want to ensure we only share those cost measures that can help patients and caregivers make informed health care decisions on profile pages. For transparency purposes, the cost measures that meet all other public reporting standards would be included in the downloadable database. Statistical testing and website user testing would determine how and where measures are reported on Physician Compare to minimize passing the complexity of these measures on to patients and to ensure those measures included are accurately understood and correctly interpreted. Under this proposal, we note that the policies we previously mentioned regarding first year measures, the minimum reliability threshold, and all public reporting standards would apply. This proposal applies to all available measures reported via all available submission methods, and applies to both MIPS eligible clinicians and groups. We request comment on this proposal.

d. Improvement Activities

Consistent with section 1848(q)(9)(A)(i)(II) of the Act, we finalized a decision to make all activities under the MIPS improvement activities performance category available for public reporting on Physician Compare (81 FR 77396). This included all available improvement activities reported via all available submission methods, and applied to both MIPS eligible clinicians and groups.

Consistent with the policy finalized for the transition year, we are again proposing to include a subset of improvement activities data on Physician Compare that meet the public reporting standards, either on the profile pages or in the downloadable database, if technically feasible, for 2018 data available for public reporting in late 2019, and for each year moving forward. This again includes all available activities reported via all available submission methods, and applies to both MIPS eligible clinicians and groups. For those eligible clinicians or groups that successfully meet the improvement activities performance category requirements this information may be posted on Physician Compare as an indicator. This information is required by the MACRA to be available for public reporting on Physician Compare, but the improvement activities performance category is a new field of data for Physician Compare so concept and website user testing is still needed to ensure these data are understood by stakeholders. Therefore, we again propose that statistical testing and user testing would determine how and where improvement activities are reported on Physician Compare.

For the transition year, we proposed to exclude first year activities from public reporting. First year activities are any improvement activities in their first year of use. Starting with year 2 (2018 data available for public reporting in late 2019), we propose publicly reporting first year activities if all other reporting criteria are satisfied. This evolution in our Quality Payment Program public reporting plan provides an opportunity to make more valuable information public given that completion of or participation in activities the first year they are available is different

from reporting first year quality or cost measures. Clinicians and groups can learn from the first year of quality and cost data, understand why their performance rate is what it is, and take time to improve. A waiting period for indicating completion or participation in an improvement activity is unlikely to produce the same benefit. We request comments on these proposals.

e. Advancing Care Information

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. In the 2015 EHR Incentive Programs final rule (80 FR 62901), we addressed comments requesting that we not only continue this practice but also include a wider range of information on participation and performance. In that rule, we stated our intent to publish the performance and participation data on Stage 3 objectives and measures of meaningful use in alignment with quality programs which utilize publicly available performance data such as Physician Compare. At this time there is only an indicator on Physician Compare profile pages to show that an eligible clinician successfully participated in the current Medicare EHR Incentive Program.

As MIPS will include advancing care information as one of the four MIPS performance categories, we decided, consistent with section 1848(q)(9)(i)(II) of the Act, to include more information on an eligible clinician's or group's performance on the objectives and measures of meaningful use on Physician Compare for the transition year (81 FR 77387). An important consideration was that to meet the public reporting standards, the data added to Physician Compare must resonate with Medicare patients and their caregivers. Testing to date has shown that people with Medicare value the use of certified EHR technology and see EHR use as something that if used well can improve the quality of their care. In addition, we believe the inclusion of indicators for clinicians and groups who achieve high performance in key care coordination and patient engagement activities provide significant value for patients and their caregivers as they make health care decisions.

Consistent with our transition year final policy, and understanding the value of this information to website users, we are again proposing 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, we propose to include additional indicators, including but not limited to, objectives, activities, or measures specified in section II.C.6.f. of this proposed rule, such as, identifying if the eligible clinician or group scores high performance in patient access, care coordination and patient engagement, or health information exchange. These proposals would apply to 2018 data available for public reporting in late 2019, and for each year moving forward, as this information is required by the MACRA to be available for public reporting on Physician Compare. We also propose that any advancing care information objectives, activities, or measures would need to meet the public reporting standards applicable to data posted on Physician Compare, either on the profile pages or in the downloadable database. This would include all available objectives, activities, or measures reported via all available submission methods, and would apply to both MIPS eligible clinicians and groups. Statistical testing and website user testing would determine how and where objectives and measures are reported on Physician Compare. As with improvement activities, we are also proposing to allow first year advancing care information objectives, activities, and measures to be available for public reporting starting in year 2 (2018 data available for public reporting in late 2019). Again, especially if we are including an indicator over a performance rate, the benefits of waiting 1 year are not the same and thus, we believe it is more important to make more information available for public reporting as the Quality Payment Program matures. We request comment on these proposals.

f. Achievable Benchmark of Care (ABC™)

Benchmarks are important to ensuring that the quality data published on Physician Compare are accurately understood. A benchmark allows website users to more easily evaluate

the information published by providing a point of comparison between groups and between clinicians. In an effort to find the best possible methodology for Physician Compare, we embarked on a year-long information gathering and stakeholder outreach effort in advance of the CY 2016 PFS rule process. We reached out to stakeholders, including specialty societies, consumer advocacy groups, physicians and other clinicians, measure experts, and quality measure specialists, as well as other CMS Quality Programs. Based on this outreach and the recommendation of our Technical Expert Panel, we proposed and ultimately finalized (80 FR 71129) a decision to publicly report on Physician Compare an item, or measure-level, benchmark using the Achievable Benchmark of Care (ABC™)[21] methodology annually based on the PQRS performance rates most recently available by reporting mechanism. As a result, in late 2017, we expect to publicly report a benchmark based on the 2016 PQRS performance rates for each measure by each available reporting mechanism. The specific measures the benchmark will be calculated for will be determined once the data are available and analyzed. As with all data, the benchmark will only be applied to those measures deemed to meet the established public reporting standards.

We believe ABC™ is a well-tested, data-driven methodology that allows us to account for all of the data collected for a quality measure, evaluate who the top performers are, and then use that to set a point of comparison for all of those groups or clinicians who report the measure.

ABC™ starts with the pared-mean, which is the mean of the best performers on a given measure for at least 10 percent of the patient population – not the population of reporters. To find the pared-mean, we will rank order physicians or groups (as appropriate per the measure being evaluated) in order from highest to lowest performance score. We will then subset the list by taking the best performers moving down from best to worst until we have selected enough

[21] Kiefe CI, Weissman NW, Allison JJ, Farmer R, Weaver M, Williams OD. Identifying achievable benchmarks of care: concepts and methodology. International Journal of Quality Health Care. 1998 Oct; 10(5):443-7.

reporters to represent 10 percent of all patients in the denominator across all reporters for that measure.

We finalized that the benchmark would be derived by calculating the total number of patients in the highest scoring subset receiving the intervention or the desired level of care, or achieving the desired outcome, and dividing this number by the total number of patients that were measured by the top performing doctors. This would produce a benchmark that represents the best care provided to the top 10 percent of patients by measure, by reporting mechanism.

An Example: 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) We look at the total number of patients with diabetes for all clinicians who reported this diabetes measure.

(2) We 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 percent of the total number of patients with diabetes.

(3) We count how many of the patients with diabetes who were treated by the top clinicians also got a foot exam.

(4) This number is divided by the total number of patients with diabetes who were treated by the top clinicians, producing the ABC™ benchmark.

To account for low denominators, ABC™ suggests the calculation of an adjusted performance fraction (AFP) using a Bayesian Estimator or use of another statistical methodology. After analysis, we have determined that the use of a beta binomial model adjustment is most appropriate for the type of data we are working with. The beta binomial method moves extreme values toward the average for a given measure, while the Bayesian Estimator moves extreme values toward 50 percent. Using the beta binomial method is a more methodologically sophisticated approach to address the issue of extreme values based on small

sample sizes. This ensures that all clinicians are accounted for and appropriately figured in to the benchmark.

The benchmarks for Physician Compare developed using the ABC™ methodology will be based on the current year's data, so the benchmark will be appropriate regardless of the unique circumstances of data collection or the measures available in a given reporting year. We also finalized (80 FR 71129) a decision to use the ABC™ methodology to generate a benchmark which will be used to systematically assign stars for the Physician Compare 5-star rating. 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, CMS programs, measure experts, and the Physician Compare Technical Expert Panel. We expect 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.

As a result of stakeholder feedback asking that we consider one consistent approach for benchmarking and parsing the data based on the benchmark across the Quality Payment Program, we did consider an alternative approach. We reviewed the benchmark and decile breaks being used to assign points and determine payment under MIPS (see II.C.7.a.(2)(b) of this proposed rule). This approach was not considered ideal for public reporting for several reasons. A primary concern was 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. If applied to star ratings, there would need to be an equal distribution of clinicians in each of the star rating categories.

Using the ABC™ methodology for the benchmark sets the 5-star rating at the performance rate that is the best achievable rate in the current clinical climate based on the current set of measures and the current universe of reporters. The star ratings are then derived from there consistent with the raw score distribution. In this way, if the majority of clinicians

performed well on a measure, the majority would receive a high star rating. If we used the decile approach some clinicians would be reported as having a "low" star rating despite their relative performance on the measure.

It is not always ideal to use the same methodology across the program as scoring for payment purposes may be designed in a somewhat different way that may incorporate factors that are not necessarily as applicable for public reporting, while the key consideration for public reporting is that the methodology used best helps patients and caregivers easily interpret the data accurately. Testing with website users has shown that the star rating based on the ABC™ benchmark helps patients and caregivers interpret the data accurately.

ABC™ has been historically well received by the clinicians and entities it is measuring because the benchmark represents quality while being both realistic and achievable; it encourages continuous quality improvement; and, it is shown to lead to improved quality of care.[22,23,24] Appreciating this and the support this methodology received in previous rulemaking and throughout our outreach process to date, we are again proposing 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 each year of the Quality Payment Program, starting with the transition year data (2017 data available for public reporting in late 2018). We are also proposing to use this benchmark to determine a 5-star rating for each MIPS measure, as feasible and appropriate. As previously finalized, only those measures that meet the public reporting standards would be

[22] Kiefe CI, Weissman NW, Allison JJ, Farmer R, Weaver M, Williams OD. Identifying achievable benchmarks of care: concepts and methodology. International Journal of Quality Health Care. 1998 Oct; 10(5):443-7.
[23] Kiefe CI, Allison JJ, Williams O, Person SD, Weaver MT, Weissman NW. Improving Quality Improvement Using Achievable Benchmarks For Physician Feedback: A Randomized Controlled Trial. JAMA. 2001;285(22):2871-2879.
[24] Wessell AM, Liszka HA, Nietert PJ, Jenkins RG, Nemeth LS, Ornstein S. Achievable benchmarks of care for primary care quality indicators in a practice-based research network. American Journal of Medical Quality 2008 Jan-Feb;23(1):39-46.

considered and the benchmark would be based on the most recently available data. The details of how the benchmark will translate to the 5-star rating will be determined in consultation with stakeholders.

We believe that displaying the appropriate and relevant MIPS data in this user-friendly format provides more opportunities to present these data to people with Medicare in a way that is most likely to be accurately understood and interpreted. We request comment on these proposals.

g. Voluntary Reporting

In CY 2017 Quality Payment Program proposed rule (81 FR 28291), we solicited comment on the advisability and technical feasibility of including on Physician Compare data voluntarily reported by eligible clinicians and groups that are not subject to MIPS payment adjustments, such as exempt clinician types and those clinicians practicing through Rural Health Centers (RHCs), Federally Qualified Health Centers (FQHCs), etc., to be addressed through separate notice-and-comment rulemaking.

Overall, comments received were favorable. Stakeholders generally support clinicians and groups being permitted to have data available for public reporting when submitting these data voluntarily under MIPS. As a result, we are now proposing that starting with year 2 of the Quality Payment Program (2018 data available for public reporting in 2019) and for each year moving forward, 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.

If a clinician or group chooses to submit quality, cost, improvement activity, or advancing care information, these data would become available for public reporting. However, because these data would be submitted voluntarily, we propose that 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. As clinicians and groups not required to report under MIPS, particularly in the first years of the Quality Payment Program, are taking additional steps to show their commitment to quality care, we want to ensure they have the opportunity to report their data and have it included on Physician Compare. We request comment on this proposal.

h. APM Data

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. We see this as an opportunity to continue to build on the ACO reporting we are now doing on Physician Compare. At this time, if a clinician or group submitted quality data as part of an ACO, there is an indicator on the clinician's or group's profile page indicating this. In this way, it is known which clinicians and groups took part in an ACO. Also, currently, all ACOs have a dedicated page on the Physician Compare website to showcase their data. For the transition year of the Quality Payment Program, we decided to use this model as a guide as we add APM data to Physician Compare. Specifically, we finalized a policy to indicate on eligible clinician and group profile pages of Physician Compare when the eligible clinician or group is participating in an APM (81 FR 77398). We also finalized a decision to link eligible clinicians and groups to their APM's data, as technically feasible, through Physician Compare. The finalized policy provides the opportunity to publicly report data for both Advanced APMs and APMs that are not considered Advanced APMs for the transition year, as technically feasible.

At the outset, APMs will be very new concepts for Medicare patients and their caregivers. In these early years, indicating who participated in APMs and testing language to accurately explain that to website users provides useful and valuable information as we continue

to evolve Physician Compare. As we come to understand how to best explain this concept to patients and their caregivers, we can continue to assess how to most fully integrate these data on the website. Understanding this and understanding the value of adding APM data to Physician Compare, we are again proposing 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 Quality Payment Program starting with year 2 (2018 data available for public reporting in late 2019), and for each year moving forward, as technically feasible. In addition, we again propose to continue to find ways to more clearly link clinicians and groups and the APMs they participate in on Physician Compare, as technically feasible. We request comment on these proposals.

i. Stratification by Social Risk Factors

We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support play a major role in health. One of our core objectives is to improve the outcomes of people with Medicare, and we want to ensure that complex patients, as well as those with social risk factors receive excellent care. In addition, we seek to ensure that all clinicians are treated as fairly as possible within all CMS programs. In the CY 2017 Quality Payment Program final rule (81 FR 77395), we noted that we would review the first of several reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE)[25]. In addition, we have been reviewing the report of the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS programs. ASPE's first report, as required by the Improving Medicare Post-Acute Care Treatment (IMPACT) Act, was released on December 21, 2016, and analyzed the effects of social risk factors of people with Medicare on clinician performance under nine Medicare value-

[25] ASPE, "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." 21 Dec 2016. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

based purchasing programs. A second report due October 2019 will expand on these initial analyses, supplemented with non-Medicare datasets to measure social risk factors. The National Academies of Sciences, Engineers, and Medicine released its fifth and final report on January 10, 2017, and provided various potential methods for accounting for social risk factors, including stratified public reporting, as well as recommended next steps.[26]

As we continue to consider the analyses and recommendations from these and any future reports, we look forward to working with stakeholders in this process. Therefore, we seek comment only on accounting for social risk factors through public reporting on Physician Compare. Specifically, we seek comment on stratified public reporting by risk factors and ask for feedback on which social risk factors or indicators should be used and from what sources. Examples of social risk factor indicators include but are not limited to dual eligibility/low-income subsidy, race and ethnicity, social support, and geographic area of residence. We also seek comment on the process for accessing or receiving the necessary data to facilitate stratified reporting. Finally, we seek comment on whether strategies such as confidential reporting of stratified rates using social risk factor indicators should be considered in the initial years of the Quality Payment Program in lieu of publicly reporting stratified performance rates for quality and cost measures under the MIPS on Physician Compare. We seek comment only on these items for possible consideration in future rulemaking.

j. Board Certification

Finally, we propose adding additional Board Certification information to the Physician Compare website. Board Certification is the process of reviewing and certifying the qualifications of a physician or clinician by a board of specialists in the relevant field. We currently include ABMS, AOA, and ABO data as part of clinician profiles on Physician

[26] National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press.

Compare. We appreciate that there are additional, well respected boards that are not included in the ABMS, AOA, and ABO data currently available on Physician Compare that represent clinicians and specialties represented on the website. Such board certification information is of interest to users as it provides additional information to use to evaluate and distinguish between clinicians on the website, which can help in making an informed health care decision. The more data of immediate interest that is included on Physician Compare, the more users will come to the website and find quality data that can help them make informed decisions. Please note we are not endorsing any particular boards.

Another board, the American Board of Wound Medicine and Surgery (ABWMS), has shown interest in being added to Physician Compare and have demonstrated that they have the data to facilitate inclusion of this information on the website. We believe this board fills a gap for a specialty that is not currently covered by the ABMS, so we propose to add ABWMS Board Certification information to Physician Compare.

Additionally, for all years moving forward, for any board that would like to be considered to be added to the Physician Compare website, we propose to establish a process for reviewing interest from these boards as it is brought to our attention on a case-by-case basis, and selecting boards as possible sources of additional board certification information for Physician Compare. We further propose that, 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. We propose that boards 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. We request comments on these proposals.

D. Overview of the APM Incentive

1. Overview

Section 1833(z) of the Act requires that an incentive payment be made to QPs for participation in Advanced APMs. In the CY 2017 Quality Payment Program final rule (81 FR 77399 through 77491), we finalized policies relating to the following topics:

- Beginning in 2019, if an eligible clinician participated sufficiently in an Advanced APM during the QP Performance Period, that eligible clinician may become a QP for the year. Eligible clinicians who are QPs are excluded from the MIPS reporting requirements in the performance year and payment adjustment for the payment year.
- For years from 2019 through 2024, QPs receive a lump sum incentive payment equal to 5 percent of their prior year's payments for Part B covered professional services. Beginning in 2026, QPs receive a higher update under the PFS for the year than non-QPs.
- For 2019 and 2020, eligible clinicians may become QPs only through participation in Advanced APMs.
- For 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and Other Payer Advanced APMs (which we refer to as the All-Payer Combination Option).

In this proposed rule, we discuss proposals for clarifications and modifications to some of the policies that we previously finalized, and provide additional details and proposals regarding the All-Payer Combination Option.

2. Terms and Definitions

As we continue to develop the Quality Payment Program, we have identified the need to propose additions, deletions, and changes to some of the previously finalized definitions. A list of these definitions is available in the CY 2017 Quality Payment Program final rule (81 FR 77537 through 77540).

As we discuss in section II.D.6.d.(2)(a) of this proposed rule, we propose to change the timeframe of the QP Performance Period under the All-Payer Combination Option so that it would begin on January 1 and end on June 30 of the calendar year that is 2 years prior to the payment year. We propose to add the definition of All-Payer QP Performance Period using this timeframe. We also propose to add the definition of Medicare QP Performance Period, which would begin on January 1 and end on August 31 of the calendar year that is 2 years prior to the payment year. We would replace the definition we established in the CY 2017 Quality Payment Program final rule for QP Performance Period with the definitions of All-Payer QP Performance Period and Medicare QP Performance Period. To update the regulation to incorporate this proposal, we also propose to remove "QP Performance Period" each time it occurs in our regulations and replace it with either "All-Payer QP Performance Period" or "Medicare QP Performance Period" as relevant. As we discuss in section II.D.6.d.(3)(a) of this proposed rule, we propose to make QP determinations under the All-Payer Combination Option at the eligible clincian level only. In connection with our proposals to calculate Threshold Scores for QP determinations under the All-Payer Combination Option, we do not anticipate having or receiving information about attributed beneficiaries as we do under the Medicare Option. This is because, under the All-Payer Combination Option, APM Entities or eligible clinicians would only submit aggregate payment and patient data. We would not have anything similar to a Participation List or an Affiliated Practitioner List for Other Payer Advanced APMs. Therefore, we are proposing to change the definition of attributed beneficiary so that it only applies to Advanced APMs, not to Other Payer Advanced APMs. We seek comment on these proposals.

We seek comment on these terms, including how we have defined the terms, the relationship between terms, any additional terms that we should formally define to clarify the explanation and implementation of this program, and potential conflicts with other terms we use in similar contexts. We also seek comment on the naming of the terms and whether there are

ways to name or describe their relationships to one another that make the definitions more distinct and easier to understand. For instance, we would consider options for a framework of definitions that might more intuitively distinguish between APMs and Other Payer Advanced APMs and between APMs and Advanced APMs.

3. Regulation Text Changes

a. Clarifications and Corrections

We propose to revise the definition of APM Entity in the regulation at §414.1305 to clarify that a "payment arrangement with a non-Medicare payer" is an other payer arrangement as defined in §414.1305. We propose to make technical changes to the definition of Medicaid APM in §414.1305 to clarify that these arrangements must meet the Other Payer Advanced APM criteria set forth in §414.1420, and not just the criteria under §414.1420(a) as provided under the current definition.

To consolidate our regulations and avoid unnecessarily defining a term, we propose to remove the defined term for Advanced APM Entity in §414.1305 and to replace "Advanced APM Entity" where it appears throughout the regulations with "APM Entity." We also propose to make this substitution in the definitions of Affiliated Practitioner and Attributed Beneficiary in §414.1305. Similarly, we propose to replace "Advanced APM Entity group" with "APM Entity group" where it appears throughout our regulations. We note that these proposed changes are technical, and would not have a substantive effect on our policies.

We propose technical changes to correct the references in the first sentence of the regulation at §414.1415 to refer to the financial risk standard under paragraph (c)(1) or (2) and the nominal amount standard under paragraph (c)(3) or (4). Due to typographical errors, the current regulation refers to paragraphs (d)(1) through (4), and there is no paragraph (d) in this section. We also propose to correct typographical errors in §414.1420(a)(3)(i), (ii), (d) and (d)(1). In §414.1420(d), we propose to correct the reference to the "nominal risk standard" to

instead refer to the "nominal amount standard." We propose technical, non-substantive clarifications in §§414.1425(a)(1) through (3), 414.1425(b)(2), and 414.1435(d). We also propose to correct a typographical error in §414.1460(b) to refer to participation "during a Medicare QP Performance Period" instead of "during the QP Performance Periods."

b. Changes to §414.1460

We propose to reorganize and revise the monitoring and program integrity provisions at §414.1460. We propose changes to paragraphs (a), (b), and (d) in this section of the proposed rule as these policies apply to both the Medicare Option and the All-Payer Combination Option. We discuss proposed changes to paragraph (c) of §414.1460 in sections II.D.6.c.(7) and II.D.6.d.(4) of this proposed rule, and changes to paragraph (e) of §414.1460 in sections II.D.6.c.(7)(b) and II.D.6.d.(4)(c), as the policies in these paragraphs only apply to the All-Payer Combination Option.

We finalized in the CY 2017 Quality Payment Program final rule at §414.1460(d) that for any QPs who are terminated from an Advanced APM or found to be in violation of any federal, state, or tribal statute, regulation, or binding guidance during the QP Performance Period or Incentive Payment Base Period or terminated after these periods as a result of a violation occurring during either period we may rescind such eligible clinician's QP determinations and, if necessary, recoup part or all of any such eligible clinician's APM Incentive Payment or deduct such amount from future payments to such individuals. We also finalized that we may reopen and recoup any payments that were made in error (81 FR 77555). We recognize that rescinding QP determinations and reopening and recouping APM Incentive Payments are separate policies and for this reason, we propose to reorganize §414.1460 so that paragraph (b) sets forth our policy on rescinding QP determinations and paragraph (d) sets forth our policy on reopening and recouping APM Incentive Payments. We propose to revise §414.1460(b) to provide when we may rescind a QP determination. In addition, we propose to remove the last sentence of

§414.1460(d), 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 Entitles. We believe that this provision is duplicative of the immediately preceding sentence, which permits us to reopen and recoup any erroneous payments in accordance with existing procedures set forth at §§405.980 through 405.986 and 405.370 through 405.379. We propose to codify our recoupment policy at §414.1460(d)(2), which provides that we may reopen, revise, and recoup an APM Incentive Payment that was made in error in accordance with procedures similar to those set forth at §§405.980 through 405.986 and 405.370 through 405.379 or as established under the relevant APM.

In the CY 2017 Quality Payment Program final rule, we indicated at §414.1460(b) that CMS may reduce or deny an APM Incentive Payment to eligible clinicians who are terminated by APMs or whose APM Entities are terminated by APMs for non-compliance with all Medicare conditions of participation or the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. We also finalized at §414.1460(a) that for QPs who CMS determines are not in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period, there may be a reduction or denial of the APM Incentive Payment. We propose to consolidate our policy on reducing and denying APM Incentive Payments and redesignate it to §414.1460(d)(1). Thus, we propose to remove provisions regarding reducing and denying APM Incentive Payments from paragraphs (a) and (b) of §414.1460, and revise paragraph (d) to discuss when CMS may reduce or deny an APM Incentive Payment to an eligible clinician. We solicit comment on these proposals.

4. Advanced APMs

a. Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77408), we finalized the criteria that define an Advanced APM based on the requirements set forth in sections 1833(z)(3)(C) and (D) of the Act. An Advanced APM is an APM that:

- Requires its participants to use certified EHR technology (CEHRT) (See 81 FR 77409-44414);
- Provides for payment for covered professional services based on quality measures comparable to measures under the quality performance category under MIPS (See 81 FR 77414-77418); and
- Either requires its participating APM Entities to bear financial risk for monetary losses that are in excess of a nominal amount, or the APM is a Medical Home Model expanded under section 1115A(c) of the Act (See 81 FR 77418-77431).

APMs may offer multiple options or tracks with variations in CEHRT use requirements, quality-based payments, and the level of financial risk; or multiple tracks designed for different types of participant organizations, and we finalized in the CY 2017 Quality Payment Program final rule (81 FR 77406) that we will consider different tracks or options within an APM separately for purposes of making Advanced APM determinations.

b. Bearing Financial Risk for Monetary Losses

In the CY 2017 Quality Payment Program final rule (81 FR 77418), we divided the discussion of this criterion into two main elements: (1) What it means for an APM Entity to bear financial risk for monetary losses under an APM); and (2) what levels of risk we would consider to be in excess of a nominal amount. For each of these elements, we established a generally applicable standard and a Medical Home Model standard.

As we discussed in the CY 2017 Quality Payment Program final rule, we believe that it is important to maintain the distinction between Medical Home Models and other APMs because we believe that Medical Home Models are categorically different than other types of APMs, as supported by specific provisions in the statute enabling unique treatment of Medical Home Models. Also, Medical Home Model participants tend to be smaller in size and have lower Medicare revenues relative to total Medicare spending than other APM Entities, which affects their ability to bear substantial risk, especially in relation to total cost of care. We believe that the meaning of nominal financial risk varies according to context, and that smaller practices participating in Medical Home Models, as a category, experience risk differently than much larger, multispecialty focused organizations do. Historically, Medical Home Model participants have not been required to bear financial risk, which means the assumption of any new financial risk presents a new challenge for these entities (81 FR 77420-77421). For these reasons, we finalized special standards for Medical Home Models that are exceptions to the generally applicable financial risk and nominal amount standards.

(1) Medical Home Model Eligible Clinician Limit

In the CY 2017 Quality Payment Program final rule, we finalized that beginning in the 2018 Medicare QP Performance Period, the Medical Home Model financial risk standard would only apply to APM Entities that participate in Medical Home Models and that have fewer than 50 eligible clinicians in the organization through which the APM Entity is owned and operated (81 FR 77430). Under this policy, in a Medical Home Model that otherwise meets the criteria to be an Advanced APM, the Medical Home Model financial risk standard would be applicable only for those APM Entities owned and operated by organizations with fewer than 50 eligible clinicians. We note this policy does not apply to Medical Home Models expanded under section 1115A of the Act.

We are proposing to exempt from this requirement any APM Entities enrolled in Round 1 of the Comprehensive Primary Care Plus Model (CPC+).

We finalized the Medical Home Model eligible clinician limit after practices applied and signed agreements with CMS to participate in CPC+ Round 1. As such, practices applying to participate in CPC+ Round 1 were not necessarily aware of the eligible clinician limit policy and will have already participated in CPC+ for one year without this requirement applying to them by the beginning of CY 2018. Thus, to permit continued and uninterrupted testing of CPC+ in existing regions, we believe it is necessary to exempt practices participating in CPC+ Round 1 from this requirement. Additionally, since in future all APM Entities would know about this requirement prior to their enrollment and in order to ensure that large APM entities that are able to bear more risk enroll in such higher risk models, we are also proposing that CPC+ participants who enroll in the future (for example, in CPC+ Round 2) will not be exempt from this requirement. While this creates a small difference between the incentives for large APM Entities in different cohorts to participate in CPC+, we believe an APM Entity should seek to enroll in an APM, including an Advanced APM, primarily based on the framework of that APM itself, rather than the possibility of other associated payments such as the Advanced APM incentive payment. Additionally, we note that any eligible clinicians in APM Entities participating in CPC+ that do not achieve QP status for the year would be scored under MIPS using the APM scoring standard, meaning minimal additional burden would be required for such MIPS eligible clinicians.

We seek comment on these proposals.

(2) Nominal Amount of Risk

We finalized in the CY 2017 Quality Payment Program final rule (81 FR 77427) that an APM would meet the generally applicable nominal amount standard if, under the terms of the

APM, the total annual amount that an APM Entity potentially owes us or foregoes is equal to at least:

- For QP Performance Periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenue of participating APM Entities (the revenue-based standard); or
- For all QP Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard).

We also finalized in the CY 2017 Quality Payment Program final rule (81 FR 77428) that to be an Advanced APM, a Medical Home Model must require that the total annual amount that an Advanced APM potentially owes us or foregoes under the Medical Home Model be at least the following amounts in a given performance year:

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

Both the generally applicable and Medical Home Model revenue-based nominal amount standards state the standard in terms of average estimated total Medicare Parts A and B revenue of participating APM Entities. We recognize that this language may be ambiguous 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. To eliminate this potential ambiguity, we propose to amend §§414.1415(c)(3)(i)(A) and (c)(4)(i)(A) through (D) to more clearly define the generally applicable revenue-based nominal amount standard and the Medical Home Model revenue-based nominal amount standard as a percentage of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities. Under this proposed policy,

when assessing whether an APM meets the generally applicable revenue-based nominal amount standard, where total risk under the model is not expressly defined in terms of revenue, we would calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity. We would 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 percent, the APM would satisfy the generally applicable revenue-based nominal amount standard.

We request comment on this proposal.

(a) Generally Applicable Revenue-Based Nominal Amount Standard

In the CY 2017 Quality Payment Program final rule we finalized the amount of the generally applicable revenue-based nominal amount standard for the first two QP Performance Periods only, and we sought comment on what the revenue-based nominal amount standard should be for the third and subsequent QP Performance Periods. Specifically, we sought comment on: (1) Setting the revenue-based standard for 2019 and later at up to 15 percent of revenue; or (2) setting the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM Entity is responsible under an APM (81 FR 77427).

Many commenters requested that we not raise the revenue-based nominal amount standard for 2019 and beyond. Some commenters stated that maintaining the 8 percent revenue-based nominal amount standard for 2019 would allow for stability and predictability for eligible clinicians participating in certain APMs. Other commenters noted that increasing the revenue-based nominal amount standard may reduce or discourage eligible clinicians from participating in Advanced APMs and that the added complexity of requiring that a 10 percent revenue-based standard also be equivalent to at least 1.5 percent of expected expenditures would be confusing

for participants and other stakeholders. A few commenters suggested that we only consider increasing the revenue-based nominal amount standard after we review how the finalized standard affects participation in Advanced APMs.

We agree that maintaining the revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities would provide stability and clarity for eligible clinicians and APM Entities. We also continue to believe that 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities represents a reasonable standard to determine what constitutes a more than nominal amount of financial risk. We believe that the continued testing and evaluation of APMs with two-sided risk will yield critical information about the best way to structure financial incentives and financial risk, and this information may have bearing on what constitutes a more than nominal amount of risk. Therefore, we will continue to evaluate the revenue-based nominal amount standard in light of participation in Advanced APMs before considering any increase in later years.

After considering public comments submitted on the potential options for increasing the revenue-based nominal amount standard for Medicare QP Performance Periods 2019 and later, we propose to maintain the current revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the 2019 and 2020 Medicare QP Performance Periods, and to address the standard for Medicare QP Performance Periods after 2020 through subsequent rulemaking. We seek comment on whether we should consider either a lower or higher revenue-based nominal amount standard for the 2019 and 2020 Medicare QP Performance Periods, and on the amount and structure of the revenue-based nominal amount standard for Medicare QP Performance Periods 2021 and later.

We also seek comment on whether we should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural areas that are not participating in a Medical Home Model for the 2019 and 2020 Medicare QP Performance Periods. For the purposes of the Quality Payment Program, we use the definition of small practices and rural areas in §414.1305. Specifically, we seek comment on whether such a standard should apply only to small and, or rural practices that are participants in an APM, or also small and, or rural practices that join larger APM Entities in order to participate in APMs. We also seek comment on how we should decide where a practice is located in order to determine whether it is operating in a rural area as rural area is defined in §414.1305 of our regulations. We believe that a different, potentially lower, revenue-based nominal amount standard for the 2019 and 2020 Medicare QP Performance Periods specifically for small practices and those in rural areas that are not participating in a Medical Home Model may allow for their increased participation in Advanced APMs, which may help increase the quality and coordination of care beneficiaries receive as a result. We believe such a standard should not apply to small and, or rural practices participating in a Medical Home Model because participants in Medical Home Models with fewer than 50 eligible clinicians in their parent organization benefit from the lower Medical Home Model nominal amount standard. We also note that such a standard may have certain disadvantages, including reducing the likelihood that potential Advanced APMs will ultimately result in reductions in the growth of Medicare expenditures and increasing the complexity of the generally applicable nominal amount standard.

(b) Medical Home Model Nominal Amount Standard

In the CY 2017 Quality Payment Program final rule, we finalized that if the financial risk arrangement under the Medical Home Model is not based on revenue (for example, it is based on total cost of care or a per beneficiary per month dollar amount), we will make a determination for the APM based on the risk under the Medical Home Model compared to the average estimated

total Parts A and B revenue of its participating APM Entities using the most recently available data (81 FR 77428).

We received comments suggesting that few APM Entities in Medical Home Models have had experience with financial risk, and that many would be financially challenged to provide sufficient care or even remain a viable business if they were faced with the kinds of substantial disruptions in revenue that can accompany financial risk arrangements. Some commenters indicated that taking on the level of risk required under our finalized policy would still represent an increase in total risk that is too great in magnitude and premature for the many APM Entities in Medical Home Models that have little experience with financial risk.

We recognize these concerns, however, we still believe that a final Medical Home Model nominal amount standard of 5 percent is the appropriate target for the standard, and that ultimately setting the standard at 5 percent of Parts A and B revenue of providers and suppliers in participating APM Entities would strike the appropriate balance to reflect the meaning of ''nominal'' in the Medical Home Model context. We continue to believe that the meaning of the term ''nominal'' depends on the situation in which it is applied, so it is appropriate to consider the characteristics of Medical Home Models and their participating APM Entities in setting the nominal amount standard for Medical Home Models.

We have reconsidered the incremental annual increases in the nominal amount standard that we finalized to occur over several years from 2.5 percent to 5 percent. We recognize that establishing an even more gradual increase in risk for Medical Home Models with a lower risk floor for the 2018 Medicare QP Performance Period may be better suited to the circumstances of many APM Entities in Medical Home Models that have little experience with risk. We also reiterate, as we note for the generally applicable nominal amount standard, that the terms and conditions in the particular APM govern the actual risk that participants experience; the nominal amount standard merely sets a floor on the level of risk required for the APM to be considered an

Advanced APM. To that end, we believe a small reduction of risk in the Medical Home Model nominal amount standard beginning in the 2018 Medicare QP Performance Period, along with a more gradual progression toward the 5 percent nominal amount standard, would allow for greater flexibility at the APM level in setting financial risk thresholds that would encourage more participation in Medical Home Models and be more sustainable for the type of APM Entities that would potentially participate in Medical Home Models.

Therefore, we are proposing that to be an Advanced APM, a Medical Home Model must require that the total annual amount that an APM Entity potentially owes us or foregoes under the Medical Home Model be at least the following:

- For Medicare QP Performance Period 2018, 2 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.
- For Medicare QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.
- For Medicare QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.
- For Medicare QP Performance Periods 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

We seek comment on this proposal.

c. Summary of Proposals

In summary, we are making the following proposals in this section:

- We are proposing to amend our regulation at §414.1415(c)(3)(i)(A) and (c)(4)(i)(A) through (D) to more clearly define the generally applicable revenue-based nominal amount standard and the Medical Home Model revenue-based nominal amount standard as a percentage

of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

- We are proposing to amend our regulation at §414.1415(c)(2) to any APM Entities enrolled in an Advanced APM qualifying under the Medical Home Model standard as of January 1, 2017, to exempt Round 1 of the CPC+ Model from the requirement that beginning in the 2018 Medicare QP Performance Period, the Medical Home Model financial risk standard applies only to an APM Entity that is participating in a Medical Home Model if it has fewer than 50 eligible clinicians in its parent organization.

- We are proposing to amend our regulation at §414.1415(c)(3)(i)(A) to provide that the generally applicable revenue-based nominal amount standard remain at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities for the 2019 and 2020 Medicare QP Performance Periods, and to address the standard for Medicare QP Performance Periods after 2020 through subsequent rulemaking.

- We are proposing to amend our regulation at §414.1415(c)(4)(i)(A) through (D) to provide that, to be an Advanced APM, a Medical Home Model must require that the total annual amount that an APM Entity potentially owes us or foregoes under the Medical Home Model be at least the following amounts:

++ For Medicare QP Performance Period 2018, 2 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

++ For Medicare QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

++ For Medicare QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

++ For Medicare QP Performance Periods 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

5. Qualifying APM Participant (QP) and Partial QP Determination

We finalized policies relating to QP and Partial QP determinations in the CY 2017 Quality Payment Program final rule (See 81 FR 77433 through 77450).

We finalized that the QP Performance Period will run from January 1 through August 31 of the calendar year that is 2 years prior to the payment year (81 FR 77446). As we discuss in section II.D.6.(d)(2)(a)of this proposed rule, we propose to refer to this time period for the Medicare Option as the Medicare QP Performance Period.

a. Advanced APMs Starting or Ending During a Medicare QP Performance Period

We acknowledge that there may be Advanced APMs that start after January 1 of the Medicare QP Performance Period for a year. There may also be Advanced APMs that end prior to the August 31 end of the Medicare QP Performance Period for a year. By "start" and "end," in this context, we mean that the period of active testing of the model starts or ends such that there is no opportunity for any APM Entity to participate in the Advanced APM before it starts, or to participate in it after it ends. We consider the active testing period to mean the dates within the performance period specific to the model, which is also the time period for which we consider payment amounts or patient counts through the Advanced APM when we make 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. Active testing does not include, for example, the period of time after an APM Entity has stopped furnishing services to beneficiaries under the terms of the Advanced APM but is waiting for calculation or receipt of a performance-based payment. We note that we tie this policy to the timeframe during which APM Entities, rather than eligible clinicians, participate in

an Advanced APM. To the extent the participation of APM Entities and eligible clinicians is not the same, we believe it is more appropriate and consistent with other policies relating to the APM incentive, and to APMs in general, to base the active testing period for an APM on the activities of the APM Entities because they are the participants directly subject to the terms of the Advanced APM, including the specified performance period for the Advanced APM. For example, in a model like CJR, where we identify eligible clinicians for QP determinations based on the Affiliated Practitioner List, it would be possible for APM Entities to be participating in active testing of the Advanced APM without any Affiliated Practitioners for a period of time. In that case, we would consider the dates the APM Entities were able to be in active testing for CJR, as opposed to the dates when eligible clinicians began participating as Affiliated Practitioners. If a specific APM Entity joins an Advanced APM after the January 1 start and before the August 31 end of a Medicare QP Performance Period, but other APM Entities participate during the entire Medicare QP Performance Period (from January 1 through August 31), then we would consider the Advanced APM to be in active testing for the entire Medicare QP Performance Period.

For example, the performance period for an Advanced APM may start on May 1, which is after the first QP determination date (March 31) and before the second QP determination date (June 30) during the Medicare QP Performance Period. If we were to calculate Threshold Scores in such an Advanced APM using data in the denominator for all attribution-eligible beneficiaries from January through June 30, which would include data for the period before the Advanced APM is actively tested, the APM Entities, or, as applicable, individual eligible clinicians in that Advanced APM, are less likely to achieve a QP threshold on either the June 30 or the final August 31 determination date for the year. This outcome would be a direct result of our operational decisions to begin the performance period for the Advanced APM on May 1, which is outside of the control of both the participating APM Entities and eligible clinicians. As such,

participants in Advanced APMs that start or end during the Medicare QP Performance Period for the year could be disadvantaged for purposes of QP determinations. This is because the numerator of the Threshold Score calculation would include payment amounts or patient counts from only the period before the QP determination date during which the Advanced APM was actively tested, while the denominator would include payment amounts or patient counts for the entire Medicare QP performance period up to the QP determination date.

We propose to modify our policies regarding the timeframe(s) for which payment amount and patient count data are included in the QP payment amount and patient count threshold calculations for Advanced APMs that start after January 1 or end before August 31 in a given Medicare QP Performance Period. In these situations, we would 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, per the terms 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. We propose to add this policy at §414.1425(c)(6) of our regulations. The QP Threshold Score would be calculated at the APM Entity level or the Affiliated Practitioner level as set forth in §414.1425(b); this change would not affect our established policy as to which list of eligible clinicians, the Participation List or Affiliated Practitioner List, would be used.

This proposed change would not affect how we make QP and Partial QP determinations for eligible clinicians who participate in multiple Advanced APMs as set forth by §§414.1425(c)(4) and 414.1425(d)(2). We propose to make those calculations using the full Medicare QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the Medicare QP Performance Period. We believe that this policy appropriately reflects the participation of the individual eligible clinician in multiple Advanced APMs and is consistent with our general framework for making QP determinations.

For these QP determinations, we would include patients or payments through all Advanced APMs the eligible clinician participates in for a Medicare QP Performance Period, including any Advanced APMs that are in active testing for less than 60 continuous days. This policy accounts for the eligible clinician's flexibility in participating in Advanced APMs while combining that participation to potentially meet the QP threshold.

With the exception of QP determinations for individual eligible clinicians who participate in multiple Advanced APMs, we believe it is appropriate to require that an Advanced APM must be actively tested for a minimum of 60 continuous days during the Medicare QP Performance Period in order for the payment amount or patient count data to be considered for purposes of QP determinations for the year because it is important that the QP determination be based on a measure of meaningful participation in an Advanced APM. For example, if an Advanced APM started on August 30, we do not believe a QP determination made based on only 2 days of payment amount or patient count data in the numerator and denominator would reflect a meaningful assessment of participation in an Advanced APM. We have chosen a minimum of 60 continuous days because it is the shortest amount of time between two snapshot dates: June 30 and August 31. We believe this amount of time is sufficient for purposes of measuring participation in an Advanced APM. We seek comment on whether it would be more appropriate to require that the Advanced APM be in active testing for at least 90 days, since 90 days is the shortest possible length of time we would use to make a QP determination (if the QP determination is based on January 1 through March 31).

Under this proposal, we would make QP determinations for all QP determination snapshot dates that fall after the Advanced APM meets the minimum time requirement of 60 continuous days, whether the Advanced APM starts or ends during the Medicare QP Performance Period. We would not make a QP or Partial QP determination for participants in Advanced APMs that are not actively tested for a period of at least 60 continuous days during the

Medicare QP Performance Period. For example, for an Advanced APM that starts its performance period on June 1, we would not make any QP Threshold Score calculations for the June 30 snapshot date because the Advanced APM would not yet have been actively tested for 60 consecutive days. We would wait until the August 31 snapshot date because this would be the first snapshot where the Advanced APM was active for 60 or more continuous days. The QP determination would be made based on payment amounts or patient counts from the June 1 start date to August 31 in both the numerator and the denominator. For an Advanced APM that starts on or before January 1 and ends active testing on June 1, we would make QP determinations on each snapshot date, but those determinations would be made based only on payment amounts or patient counts from January 1 to June 1. Although the Advanced APM would not be actively tested between June 30 and August 31, we would still make another QP Threshold Score calculation for APM Entities or eligible clinicians who had not met the QP Threshold in case the additional time for claims run out would give us more accurate information. For an Advanced APM that started on August 30 of a year, we would not make a QP determination for that year because the APM would not be actively tested for 60 continuous days during the Medicare QP Performance Period.

We believe that this proposal allows us to properly measure performance in Advanced APMs without penalizing APM Entities or eligible clinicians for start or end dates that are wholly outside of their control. We believe this policy is needed to match the data used to assess Advanced APM participation for purposes of the APM incentive payment with the timeframe during which the Advanced APM is actively tested and to accurately reflect the participation of APM Entities and eligible clinicians. This proposed policy would not apply to Other Payer Advanced APMs because eligible clinicians have more control over the start and end dates of payment arrangements with Other Payers, such as through contract negotiations, than they do over our start and end dates, which we exclusively determine.

This proposed policy would not apply to APM Entities that had the opportunity to participate in the Advanced APM track of an APM during the entire Medicare QP Performance Period, but did not do so until partway through the Medicare QP Performance Period. For example, Oncology Care Model (OCM), has two risk tracks: one-sided and two-sided risk. Only the two-sided risk track is an Advanced APM. APM Entities participating in OCM now have the opportunity to change their risk track from one-sided to two-sided risk, to take effect on either January 1 or July 1 of the applicable calendar year. Applying this proposed policy to OCM, an APM Entity participating in OCM that requests two-sided risk to take effect beginning on July 1, 2018, would be considered a participant in and Advanced APM as of July 1, but would be subject to a QP determination based on payment and patient count data for the full Medicare QP Performance Period because that APM Entity had the opportunity to elect two-sided risk beginning on January 1, 2018. In this scenario, the APM Entity has control over its participation in an Advanced APM, and could choose to be in the Advanced APM for the full Medicare QP Performance Period.

We clarify that this proposed policy for Advanced APMs that start or end during the Medicare QP Performance Period does not apply to the CEHRT Track (Track 1) of the Comprehensive Care for Joint Replacement Model (CJR) because we have determined that Track 1 of CJR is an Advanced APM for the 2017 QP Performance Period. Therefore, we will include episodes ending on or after January 1, 2017 in QP determinations as set forth in our regulations at §414.1425.

b. Participation in Multiple Advanced APMs

We propose to edit §414.1425(c)(4) and (d)(4) to better reflect our intended policy for QP determinations and Partial QP determinations for eligible clinicians who are included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the corresponding QP or Partial QP threshold, or who are Affiliated Practitioners.

As we explained in the CY 2017 Quality Payment Program final rule (81 FR 77446-7), eligible clinicians may become QPs through any of the assessments conducted for the three snapshot dates: March 31, June 30, and August 31. If the APM Entity group meets the QP threshold under this first assessment, then all eligible clinicians in the APM Entity group will be QPs unless the APM Entity's participation in the Advanced APM is voluntarily or involuntarily terminated before the end of the Medicare QP Performance Period, or in the event of eligible clinician or APM Entity program integrity violation. We stated these same procedures apply to the QP determination made for individual eligible clinicians on an APM Entity's Affiliated Practitioner List or individual eligible clinicians in multiple Advanced APMs whose APM Entity groups did not meet the QP threshold.

We propose to amend our regulation to make clear that under §414.1425(c)(4), if an eligible clinician is a determined to be a QP based on participation in multiple Advanced APMs, but any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP. We propose to make the same clarification for Partial QP determinations under §414.1425(d)(4). These clarifying edits specify that this policy applies within the context of QP and Partial QP determinations based on participation in multiple Advanced APMs, not all QP determinations. Accordingly, for example, if an eligible clinician is a QP through participation in both of two Advanced APMs under §414.1425(b)(1), and one APM Entity voluntarily or involuntarily terminates from one of those Advanced APMs, the eligible clinician is still a QP. However, if the eligible clinician is a QP through participation in multiple Advanced APMs under §414.1425(c)(4), and any APM Entity that eligible clinician participates in that counts towards the QP determination voluntarily or involuntarily terminates, the eligible clinician is no longer a QP. We seek comment on these proposals.

c. Summary of Proposals

In summary, we are making the following proposals in this section:

- We propose to calculate QP Threshold Scores for Advanced APMs that are actively tested continuously for a minimum of 60 days during the Medicare QP Performance Period and start or end during the Medicare QP Performance Period using only the dates that APM Entities were able to participate in the Advanced APM per the terms of the Advanced APM, not the full Medicare QP Performance Period.

- We propose to make QP determinations under §414.1425(c)(4), for eligible clinicians participating in multiple Advanced APMs using the full Medicare QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the Medicare QP Performance Period.

- We propose to amend our regulation to make clear that under §414.1425(c)(4), if an eligible clinician is determined to be a QP based on participation in multiple Advanced APMs, but any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP.

6. All-Payer Combination Option

a. Overview

Section 1833(z)(2)(B)(ii) of the Act requires that beginning in payment year 2021, in addition to the Medicare Option, eligible clinicians may become QPs through the Combination All-Payer and Medicare Payment Threshold Option, which we refer to as the All-Payer Combination Option. In the CY 2017 Quality Payment Program final rule (81 FR 77459), we finalized our overall approach to the All-Payer Combination Option. The Medicare Option focuses on participation in Advanced APMs, and we make determinations under this option based on Medicare Part B covered professional services attributable to services furnished through an APM Entity. The All-Payer Combination Option does not replace or supersede the Medicare Option; instead, it would allow eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess Medicare Part B covered professional services furnished through Advanced APMs, and a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs. We finalized that beginning in payment year 2021, we will conduct QP determinations sequentially so that the Medicare Option is applied before the All-Payer Combination Option (81 FR 77438). An eligible clinician only needs to be a QP under either the Medicare Option or the All-Payer Combination Option to be a QP for the payment year. The All-Payer Combination Option encourages eligible clinicians to participate in payment arrangements with payers other than Medicare that have payment designs that satisfy the Other Payer Advanced APM criteria. It also encourages sustained participation in Advanced APMs across multiple payers.

We finalized that the QP determinations under the All-Payer Combination Option are based on payment amounts or patient counts as illustrated in Tables 46, 47, and Figures K1 and K2 (See 81 FR 77460 through 77461). We also finalized that, in making QP determinations, we

will use the Threshold Score that is most advantageous to the eligible clinician toward achieving QP status for the year, or if QP status is not achieved, Partial QP status for the year (81 FR 77475).

TABLE 46: QP Payment Amount Thresholds – All-Payer Combination Option

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

TABLE 47: QP Patient Count Thresholds – All-Payer Combination Option

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

FIGURE 1: QP Determination Tree, Payment Years 2021-2022

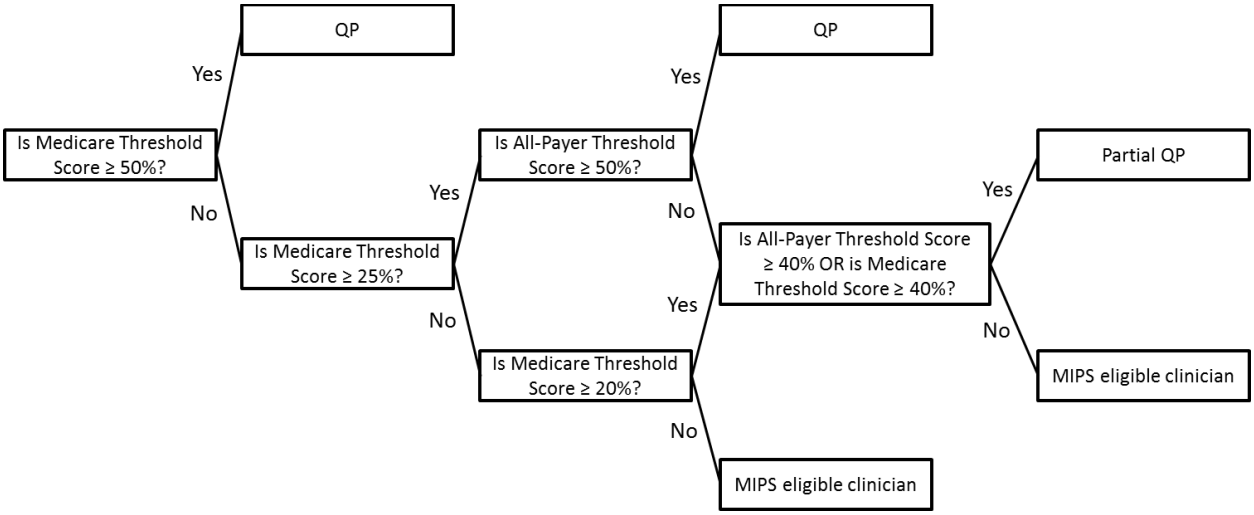
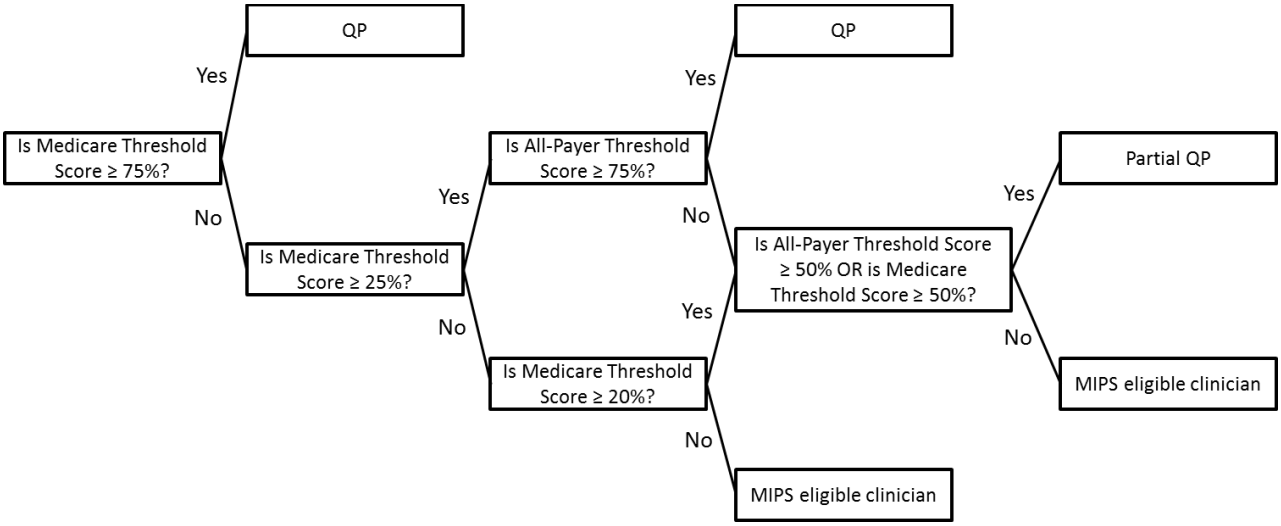


FIGURE 2: QP Determination Tree, Payment Years 2023 and Later



Unlike the Medicare Option, where we have access to all of the information necessary to determine whether an APM meets the criteria to be an Advanced APM, we cannot identify whether an other payer arrangement meets the criteria to be an Other Payer Advanced APM without receiving the required information from an external source. Similarly, we do not have the necessary payment amount and patient count information to determine under the All-Payer Combination Option whether an eligible clinician meets the payment amount or patient count threshold to be a QP without receiving the required information from an external source.

We finalized the process that eligible clinicians can use to seek a QP determination under the All-Payer Combination Option (81 FR 77478 through 77480):

- The eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers;
- Based upon that information CMS determines that at least one of those payment arrangements 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 Other Payer Advanced APMs and Advanced APMs.

We address the following topics in this section of the proposed rule: (1) Other Payer Advanced APM Criteria; (2) Determination of Other Payer Advanced APMs; and (3) Calculation of All-Payer Combination Option Threshold Scores and QP Determinations.

b. Other Payer Advanced APM Criteria

(1) In General

Our goal is to align the Advanced APM criteria under the Medicare Option and the Other Payer Advanced APM criteria under the All-Payer Combination Option as permitted by statute and as feasible and appropriate. We believe this alignment will help simplify the Quality Payment Program and encourage participation in Other Payer Advanced APMs.

In the CY 2017 Quality Payment Program final rule, we finalized that, in general, an other payer arrangement with any payer other than traditional Medicare, including Medicare Health Plans, which include Medicare Advantage, Medicaid-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans, will be an Other Payer Advanced APM if it meets all three of the following criteria:

- The other payer arrangement requires at least 50 percent of participating eligible clinicians in each APM Entity (or each hospital if hospitals are the APM participants) to use

Certified EHR Technology (CEHRT) to document and communicate clinical care (81 FR 77464 through 77465);

- 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 measure must be an outcome measure (81 FR 77466); and

- 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 (81 FR 77466 through 77467).

(2) Other Payer Medical Home Models

In the CY 2017 Quality Payment Program final rule we finalized definitions of Medical Home Model and Medicaid Medical Home Model at §414.1305. The statute does not define "medical homes," but sections 1848(q)(5)(C)(i), 1833(z)(2)(B)(iii)(II)(cc)(BB), 1833(z)(2)(C)(iii)(II)(cc)(BB), and 1833(z)(3)(D)(ii)(II) of the Act make medical homes an instrumental piece of the Quality Payment Program.

We recognize that there may be medical homes that are operated by other payers that may be appropriately considered medical home models under the All-Payer Combination Option. Examples of these arrangements may include those aligned with the Comprehensive Primary Care Plus (CPC+) model. Therefore, we seek comment on whether we should define the term Other Payer Medical Home Model as an other payer arrangement that is determined by CMS to have the following characteristics:

- The other payer arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, 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).

Similar to Medical Home Models and Medicaid Medical Home Models, we believe that Other Payer Medical Home Models could be considered unique types of other payer arrangements for purposes of the Quality Payment Program. We anticipate that participants in these arrangements may generally be more limited in their ability to bear financial risk than other entities because they may be smaller and predominantly include primary care practitioners, whose revenues are a smaller fraction of the patients' total cost of care than those of other eligible clinicians. Because of these factors, we believe 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 be different from the generally applicable Other Payer Advanced APM standards and would be identical to the Medicaid Medical Home Model financial risk and nominal amount standards.

We are particularly interested in, and seek comment on, whether there are payment arrangements that currently exist that would meet this definition. We encourage commenters to note whether such payment arrangements would meet the existing generally applicable Other Payer Advanced APM financial risk and nominal amount standards. We also request comments on any special considerations that might be relevant 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, including how the 50 clinician cap discussed in section II.D.4.b.(1) of this proposed rule for the Medical Home Model nominal amount standard would apply.

(3) Financial Risk for Monetary Losses

In the CY 2017 Quality Payment Program final rule we finalized policies to assess whether an other payer arrangement requires participating APM Entities to bear more than nominal financial risk if aggregate expenditures exceed expected aggregated expenditures (more than nominal financial risk for monetary losses). This Other Payer Advanced APM criterion has two components: a financial risk standard and a nominal amount standard. The financial risk standard defines what it means for an APM Entity to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures under an other payer arrangement. We finalized a generally applicable financial risk standard and a Medicaid Medical Home Model financial risk standard for Other Payer Advanced APMs. (See 81 FR 77466 through 77474).

We finalized that for an other payer arrangement to meet the generally applicable financial risk standard for Other Payer Advanced APMs, if an APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period, the payer must:

- Withhold payment of services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to APM Entity and/or the APM Entity's eligible clinicians; or
- Require direct payments by the APM Entity to the payer (81 FR 77467).

We also finalized that for a Medicaid Medical Home Model to be an Other Payer Advanced APM, if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period, the Medicaid Medical Home Model must:

- Withhold payment of services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to APM Entity and/or the APM Entity's eligible clinicians;
- Require direct payments by the APM Entity to the payer; or
- Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments (81 FR 77468 through 77469).

(a) Generally Applicable Nominal Amount Standard

(i) Marginal Risk and Minimum Loss Rate

The generally applicable nominal amount standard that we finalized in the CY 2017 Quality Payment Program final rule (81 FR 77471) for Other Payer Advanced APMs differs from the generally applicable nominal amount standard for Advanced APMs in two ways.

First, the finalized generally applicable Advanced APM nominal amount standard only requires an APM to meet one measure of risk – total risk (81 FR 77424). The finalized generally

applicable Other Payer Advanced APM nominal amount standard involves assessment of the following three measures of risk:

- Marginal risk – the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the payment arrangement.
- Minimum loss rate – a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk.
- Total risk – the maximum potential payment for which an APM Entity could be liable under a payment arrangement.

We note that as described in the CY 2017 Quality Payment Program final rule (81 FR 77426), although we did not formally adopt marginal risk or minimum loss rate criteria for Advanced APMs, we pointed out that all current Advanced APMs would meet these standards, and that we intend that all future Advanced APMs would meet the three measures of risk as well. Therefore, we do not expect the application of the different criteria between Advanced APMs and Other Payer Advanced APMs to produce meaningfully different results in terms of actual risk faced by participants.

Second, the finalized generally applicable Advanced APM nominal amount standard allows for total risk to be defined in one of two ways, based on expected expenditures (the benchmark-based standard) or based on revenue (the revenue-based standard) (81 FR 77427). In contrast, the finalized Other Payer Advanced APM generally applicable nominal amount standard is only based on expected expenditures (81 FR 77471).

In the CY 2017 Quality Payment program final rule, we sought comments on using the expected expenditures approach for the generally applicable Other Payer Advanced APM nominal amount standard.

Table 48 lists the requirements of the generally applicable nominal amount standards as finalized in the CY 2017 Quality Payment Program final rule (81 FR 77427 and 77471).

TABLE 48: Generally Applicable Nominal Amount Standards for Advanced APMs and Other Payer Advanced APMs finalized in the CY 2017 Quality Payment Program Final Rule

	Advanced APMs	Other Payer Advanced APMs
Generally Applicable Nominal Amount Standard	For 2017 and 2018, nominal amount of risk must be at least equal to either: • 8 percent of average estimated total of Medicare Part A and Part B revenues of all providers and suppliers in participating APM Entities; or • 3 percent of expected expenditures for which the APM entity is responsible.	Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum Loss Rate of no more than 4 percent; and • Total Risk of at least 3 percent of the expected expenditures for which the APM Entity is responsible.

We do not propose to modify the marginal risk and minimum loss rate requirements as we finalized in the CY 2017 Quality Payment Program final rule as part of the generally applicable nominal amount standard for Other Payer Advanced APMs. We continue to believe that using these measures of risk will ensure that payment arrangements involving other payers and APM Entities or eligible clinicians cannot be engineered in such a way as to provide eligible clinicians an avenue to QP status through an Other Payer Advanced APM that technically meets the financial risk criterion but carries a very low risk of losses based on performance. Because we do not have direct control over the design of Other Payer Advanced APMs, we believe the use of a multi-factor nominal amount standard to assess financial risk provides greater assurance that Other Payer Advanced APMs will involve true financial risk in accordance with statutory requirements. Including marginal risk and a minimal loss rate as components of the nominal amount standard assures that the payment arrangements that we could determine are Other Payer Advanced APMs and could contribute to the attainment of QP status are similarly rigorous to Advanced APMs. We request additional comments on this approach, and on whether there are potential alternative approaches to achieving these goals.

(ii) Revenue-Based Generally Applicable Nominal Amount Standard

We propose to add a revenue-based nominal amount standard to the generally applicable nominal amount standard for Other Payer Advanced APMs that is parallel to the revenue-based

nominal amount standard for Advanced APMs. Specifically, we propose that an other payer arrangement would meet the revenue-based nominal amount standard we are proposing if, under the terms of the other payer arrangement, the total amount that an APM Entity potentially owes the payer or foregoes is equal to at least: for the 2019 and 2020 All-Payer QP Performance Periods, 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM Entities. We would use this standard for other payer arrangements where financial risk is expressly defined in terms of revenue in the payment arrangement. We seek comment on this proposal.

For Advanced APMs, we may determine that an APM still meets the revenue-based generally applicable nominal amount standard, even if risk is not explicitly defined in terms of revenue, by comparing model downside risk to the estimated average Medicare revenue of model participants. Because we have direct access to Medicare claims data, we can estimate such an average. For other payers, we do not have similar direct access to claims data. As such, there are significant operational challenges to identifying whether an other payer arrangement would satisfy the revenue-based nominal amount standard when the other payer arrangement does not define risk explicitly in terms of revenue. 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.

We propose that under the generally applicable nominal amount standard for Other Payer Advanced APMs, an other payer arrangement would need to meet either the benchmark-based nominal amount standard or the revenue-based nominal amount standard, and need not meet both. We believe this proposed approach to the nominal amount standard would expand the opportunities for other payer arrangements to meet the generally applicable nominal amount

standard, and would allow closer alignment between Medicare and other payers as new payment arrangements are introduced and evolve. As with the revenue-based nominal amount standard for Advanced APMs, which we discuss in section II.D.4.b.(2)(a) of this proposed rule, we seek comment on whether we should consider either a lower or higher revenue-based nominal amount standard for the 2019 and 2020 All-Payer QP Performance Periods, and on the amount and structure of the revenue-based nominal amount standard for All-Payer QP Performance Periods 2021 and later.

We also seek comment on whether we should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural areas that are not participating in a Medicaid Medical Home Model for the 2019 and 2020 All-Payer QP Performance Periods. For the purposes of the Quality Payment Program, we use the definition of small practices and rural areas in §414.1305. We believe that a different, potentially lower, revenue-based nominal amount standard for the 2019 and 2020 All-Payer QP Performance Periods specifically for small and rural organizations may allow for their increased participation in Advanced APMs, which may help increase the quality and coordination of care beneficiaries receive as a result. Specifically, we seek comment on whether such a standard should apply only to small and, or, rural practices that are participants in an APM, or also to small and/or rural practices that join larger APM Entities to participate in APMs. We also seek comment on how we should decide where a practice is located to determine whether it is operating in a rural area is defined in §414.1305.

(b) Medicaid Medical Home Model Nominal Amount Standard

In the CY 2017 Quality Payment Program final rule (81 FR 77472), in addition to the financial risk standard for Medicaid Medical Home Models, we finalized that to be an Other Payer Advanced APM, a Medicaid Medical Home Model must require that the total annual

amount that an APM Entity potentially owes or foregoes be at least the following amounts in a given performance year:

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

Table 49 lists the requirements of the Medicaid Medical Home Model nominal amount standards as finalized in the CY 2017 Quality Payment Program final rule (81 FR 77428 and 77472).

TABLE 49: Medicaid Medical Home Model Nominal Amount Standards for Advanced APMs and Other Payer Advanced APMs finalized in the CY 2017 Quality Payment Program Final Rule

	Medical Home Model	Medicaid Medical Home Model
Nominal Amount Standard	Nominal amount of risk must be: • In 2017, 2.5 percent • In 2018, 3 percent • In 2019, 4 percent • In 2020 and later, 5 percent	Nominal amount of risk must be: • In 2019, 4 percent • In 2020 and later, 5 percent

As we have discussed in section II.D.4.b.(2)(b) of this proposed rule regarding APM Entities in Medical Home Models, we have also received comments that few APM Entities in Medical Home Models and Medicaid Medical Home Models have had experience with financial risk, and that many would be financially challenged to provide sufficient care or even remain a viable business in the event of substantial disruptions in revenue. We understand these concerns that the gradual increase in risk over time may be unmanageable for some APM Entities; however, we still believe that a final Medicaid Medical Home Model nominal amount standard of 5 percent is appropriate and that setting the standard at 5 percent of the APM Entity's total revenue under the payer appropriately reflects the meaning of nominal in the Medicaid Medical Home Model context.

We have reconsidered the incremental annual increases in the standard over several years. Our policy finalized in the CY 2017 Quality Payment Program final rule set forth what we envisioned was a gradually increasing but achievable amount of risk that would apply over time. In general, we still believe this to be true, but recognize that establishing an even more gradual

increase in risk for Medicaid Medical Home Models may better suit many APM Entities in Medicaid Medical Home Models that have little experience with risk. To that end, we believe a small reduction of risk in the Medicaid Medical Home Model nominal amount standard beginning in the 2019 All-Payer QP Performance Period may allow for greater flexibility in setting financial risk thresholds that would encourage more participation in Medicaid Medical Home Models and be more sustainable for the type of APM Entities that would potentially participate in Medicaid Medical Home Models.

Therefore, we are proposing that, to be an Other Payer Advanced APM, a Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes or foregoes under the Medicaid Medical Home Model must be at least:

- For All-Payer QP Performance Period 2019, 3 percent of the APM Entity's total revenue under the payer.
- For All-Payer QP Performance Period 2020, 4 percent of the APM Entity's total revenue under the payer.
- For All-Payer QP Performance Period 2021 and later, 5 percent of the APM Entity's total revenue under the payer.

We seek comment on this proposal.

(4) Summary of Proposals

In summary, we are proposing the following:

- We propose that an other payer arrangement would meet the revenue-based nominal amount standard we are proposing if, under the terms of the other payer arrangement, the total amount that an APM Entity potentially owes the payer or foregoes is equal to at least: for the 2019 and 2020 All-Payer QP Performance Periods, 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM Entities.

- We are proposing that to be an Other Payer Advanced APM, a Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes or foregoes under the Medicaid Medical Home Model must be at least:

++ For All-Payer QP Performance Period 2019, 3 percent of the APM Entity's total revenue under the payer.

++ For All-Payer QP Performance Period 2020, 4 percent of the APM Entity's total revenue under the payer.

++ For All-Payer QP Performance Period 2021 and later, 5 percent of the APM Entity's total revenue under the payer.

c. Determination of Other Payer Advanced APMs

(1) Overview

In the CY 2017 Quality Payment Program final rule, we established a prospective Advanced APM determination process (81 FR 77408). This prospective approach was implemented to ensure that APM Entities and eligible clinicians were aware of which APMs met the Advanced APM criteria prior to the first QP Performance Period, and because we have a general goal of providing notice, when possible, of which models are Advanced APMs prior to the beginning of the Medicare QP Performance Period. We were able to perform Advanced APM determinations within the time period between the effective date of the CY 2017 Quality Payment Program final rule and the beginning of the first QP Performance Period because we already possessed all of the information necessary.

For other payer arrangements, we specified that an APM Entity or eligible clinician must submit, by a date and in a manner determined by us, information necessary to identify whether a given payment arrangement satisfies the Other Payer Advanced APM criteria (81 FR 77480). We finalized that we will identify Medicaid APMs and Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria before the beginning of the QP Performance Period (81

FR 77478 through 77480). We also sought comment on the overall process for reviewing payment arrangements to determine whether they are Other Payer Advanced APMs, and we also sought comment on whether we should create a separate pathway to identify whether other payer arrangements with Medicaid as a payer meet the Other Payer Advanced APM criteria (81 FR 77463).

(a) Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process)

We propose to allow certain other payers, including payers with payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS Multi-Payer Models to request that we determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter. We propose to generally refer to this process as the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). We believe that establishing this Payer Initiated Process would be beneficial to APM Entities and eligible clinicians because it would help reduce their reporting burden, and it would provide us with the most complete information on payment arrangements. In addition, we believe the Other Payer Advanced APM determinations made via the Payer Initiated Process could be completed prior to the All-Payer QP Performance Period, and we could therefore provide APM Entities and eligible clinicians with information that may help them plan their participation in Other Payer Advanced APMs.

When referring to Medicare Health Plans in the context of the Payer Initiated Process, we include in the term Medicare Advantage and certain types of plans including Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.

If a payer requests that we determine whether a payment arrangement authorized under Title XIX, a Medicare Health Plan payment arrangement, or a payment arrangement in a CMS

Multi-Payer Model is an Other Payer Advanced APM, and the payer uses the same other payer arrangement in other commercial lines of business, we propose to allow the payer to concurrently request that we determine whether those other payer arrangements are Other Payer Advanced APMs as well. We will make Other Payer Advanced APM determinations for each individual payment arrangement.

We propose that these Other Payer Advanced APM determinations would be in effect for only one year at a time. Payers would need to submit payment arrangement information each year in order for us to make an Other Payer Advanced APM determination in each year. We believe this approach is appropriate since payment arrangements can change from year to year, and also since we may modify aspects of the Other Payer Advanced APM criteria from one year to the next. We seek comment on this approach, and we are exploring ways to streamline this process over time.

We propose to allow remaining other payers, including commercial and other private payers, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 prior to the 2020 All-Payer QP Performance Period and annually each year thereafter. We believe that phasing in the Payer Initiated Process would allow us to gain experience with the determination process on a limited basis with payers where we have the strongest relationships and existing processes that we believe can help facilitate submitting this information. We anticipate making improvements and refinements to this process, which we believe will help us facilitate receiving this information from the remaining other payers.

We propose that the Payer Initiated Process would be voluntary for all payers. We propose that the Payer Initiated Process would generally involve the same steps for each payer type as listed below for each All-Payer QP Performance Period, and we elaborate on details within this framework that are specific to payer type in the following subsections:

Guidance and Submission Form: We intend to make guidance available regarding the Payer Initiated Process for each payer type prior to the first Submission Period, which would occur during 2018. We intend to develop a submission form (which we refer to as the Payer Initiated Submission Form) that would be used by payers to request Other Payer Advanced APM determinations, and we intend to make this Payer Initiated Submission Form available to payers prior to the first Submission Period. We propose that payers would be required to use the Payer Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Payer Initiated Submission Form to include questions that are applicable to all payment arrangements and some that are specific to a particular type of payment arrangements, and we intend for it to include a way for payers to attach supporting documentation. We propose that payers may submit requests for review of multiple other payer arrangements through the Payer Initiated Process, though we would make separate determinations as to each other payer arrangement and a payer would be required to use a separate Payer Initiated Submission Form for each other payer arrangement. Payers may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.

Submission Period: We propose 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. We are proposing these dates based on operational timelines that take into account the time necessary to review submitted information, to align with other relevant deadlines in the Quality Payment Program to the extent possible, and to provide payers with as much notice of what is required in the Payer Initiated Process and as much time to complete any Payer Initiated Submission Form as possible.

CMS Determination: Upon the timely receipt of a Payer Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the payer has submitted incomplete or inadequate information, we would inform the payer and allow the payer to submit additional information no later than 10 business days from the date we inform the payer. For each other payer arrangement for which the payer does not submit sufficient information, we would not make a determination in response to that request submitted via the Payer Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We intend to notify payers of our determinations for each request as soon as practicable after the relevant Submission Deadline. APM Entities or eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

We believe that this proposed Payer Initiated Process would encourage greater participation in Other Payer Advanced APMs, particularly because it would allow us to post a

list of at least some of the Other Payer Advanced APMs before the start of the All-Payer QP Performance Period as discussed in section II.D.6.d.(2)(a) of this proposed rule. We also believe that payers are well positioned to compile and submit to us the information we require to make Other Payer Advanced APM determinations because they develop other payer arrangements. We seek comment on these proposals.

We note that we will seek OMB approval for the proposed Payer Initiated Submission Form separately from this rulemaking process. In accordance with the Paperwork Reduction Act (PRA), we will publish the required 60-day public notice and 30-day public notice. In addition, the entire information collection request and all associated forms will be made available for public review prior to OMB submission.

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

In the CY 2017 Quality Payment Program final rule, we finalized that APM Entities and eligible clinicians in payment arrangements with other payers would have an opportunity to request determinations of whether an other payer arrangement(s) is an Other Payer Advanced APM after the QP Performance Period (81 FR 77480). At that time, APM Entities and eligible clinicians would know which payment arrangements they participated in during the preceding QP Performance Period. We clarify that both APM Entities and eligible clinicians may request Other Payer Advanced APM determinations through this process, and we refer to this process as the Eligible Clinician Initiated Process.

We propose that through the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements would have an opportunity to request that we determine for the year whether those other payer arrangements are Other Payer Advanced APMs. The Eligible Clinician Initiated Process could also be used to request determinations before the beginning of an All-Payer QP Performance Period for other payer

arrangements authorized under Title XIX, as we discuss in section II.D.6.(c)(2)(b) of this proposed rule. The Eligible Clinician Initiated Process would not be necessary for, or applicable to, other payer arrangements that are already determined to be Other Payer Advanced APMs through the Payer Initiated Process.

Guidance and Submission Form: We intend to make guidance available regarding the Eligible Clinician Initiated Process for each payer type prior to the first Submission Period, which would occur during 2018. We intend to develop a submission form (which we refer to as the Eligible Clinician Initiated Submission Form) that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations, and we intend to make this Eligible Clinician Initiated Submission Form available to APM Entities and eligible clinicians prior to the first Submission Period. We propose that APM Entities and eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Eligible Clinician Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to a particular type of other payer arrangements, and we intend for it to include a way for APM Entities or eligible clinicians to attach supporting documentation. We propose that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process, though we would make separate determinations as to each other payer arrangement, and 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.

Submission Period: In general, we 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. We discuss our proposal to establish the All-Payer QP Performance Period in section II.D.6.d.(2)(a) of this proposed rule. We propose 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.

CMS Determination: Upon timely receipt of an Eligible Clinician Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that, if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we 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 we inform the APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify APM Entities and eligible clinicians of our determinations for each other payer arrangement for which a determination was requested as soon as practicable after the Submission Deadline.

We note 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 us 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 Deadline. If we determine that an other payer arrangement is not an Other Payer Advanced APM, notifying APM Entities or eligible clinicians

of such a determination may help them avoid the burden of submitting payment amount and patient count information for that payment arrangement. We intend to make these early notifications to the extent possible. We propose that APM Entities or eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all of the other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

We seek comment on these proposals.

We note that we will seek OMB approval for the proposed Eligible Clinician Initiated Submission Form separately from this rulemaking process. In accordance with the Paperwork Reduction Act (PRA), we will publish the required 60-day public notice and 30-day public notice. In addition, the entire information collection request and all associated forms will be made available for public review prior to OMB submission.

(2) Medicaid APMs and Medicaid Medical Home Models

In this section, we discuss how payers, APM Entities, and eligible clinicians may request that we determine whether payment arrangements authorized under Title XIX of the Act are Medicaid APMs or Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria. There are some differences between the determination process for other payer

arrangements where Medicaid is the payer and the process for other payer arrangements with other types of payers. These differences stem in part from the requirements specified in sections 1833(z)(2)(B)(ii)(bb) and 1833(z)(2)(C)(ii)(bb) of the Act for the All-Payer Combination Option for QP determinations. We interpret those statutory provisions to direct us, when making QP determinations under the All-Payer Combination Option, to exclude from the calculation of "all other payments" any payments made (or patients under the patient count method) under Title XIX in a state in which there is no available Medicaid APM (which by definition at §414.1305 meets the Other Payer Advanced APM criteria) or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria. We believe that our interpretation of the statute to exclude, when appropriate as discussed in section II.D.6.(d)(3)(c) of this proposed rule, Medicaid APMs or Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria, is appropriate to carry out the terms of the statute while avoiding circumstances that could unfairly impact the ability of eligible clinicians to plan ahead and position themselves to attain QP status. Our interpretation leads us to exclude Title XIX payments or patients from the denominator of QP calculations when eligible clinicians had no opportunity to participate in a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria.

To implement this requirement, we need 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 as described in section II.D.6.c.(2)(b) of the proposed rule. We believe that it is important for us to make this determination prior to the All-Payer QP Performance Period, and to announce the Medicaid APMs and Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria and the locations where they are available, so that eligible clinicians can assess whether their Title XIX payments and patients would be excluded under the All-Payer Combination Option for that particular performance year. If, for a given state, we receive no requests to make determinations 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 Clinician Initiated Process, we would assume that 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. Accordingly, we would exclude Title XIX payments and patients from the All-Payer Combination Option calculations for eligible clinicians in that state.

(a) Payer Initiated Process

We propose that any states and territories (which we refer to as states) that have in place a state plan under Title XIX may request that we determine 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 Payer Advanced APM criteria, in other words, are Other Payer Advanced APMs, under the Payer Initiated Process. States include the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

We propose to allow states to request determinations for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements. States often use managed care plan contracts to implement payment arrangements, and a substantial portion of the Medicaid beneficiary population receives their health care services through Medicaid managed care plans. We expect that states would work closely with their managed care plans to identify and collect relevant information. However, we propose to accept requests regarding payment arrangements authorized under Title XIX under the Payer Initiated Process only from the state, not from a Medicaid managed care plan, as states are responsible ultimately for the administration of their Medicaid programs. Details specific to the Payer Initiated Process for payment arrangements authorized under Title XIX are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Payer Initiated Process for each payer type prior to the first Submission Period, which would occur during 2018. We intend to develop a submission form (which we refer to as the Payer Initiated Submission Form) that would be used by payers to request Other Payer Advanced APM determinations, and we intend to send this Payer Initiated Submission Form to states prior to the first Submission Period. We propose that payers would be required to use the Payer Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Payer Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to payment arrangements authorized under Title XIX, and we intend for it to include a way for payers to attach supporting documentation. We propose that payers may submit requests for review of multiple other payer arrangements through the Payer Initiated Process, though we would make separate determinations as to each other payer arrangement, and a payer would be required to use a separate Payer Initiated Submission Form for each other payer arrangement. Payers may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.

We intend to work with states as they prepare and submit Payer Initiated Submission Forms for our review. In completing the Payer Initiated Submission Form, states could refer to information we already possess on their payment arrangements to support their request for a determination. This information could include, for example, submissions that states typically make to us to obtain 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.

Submission Period: We propose that the Submission Period for the Payer Initiated Process for use by states to request Other Payer Advanced APM determinations for other payer arrangements authorized under Title XIX will open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period for which we would make the determination for a Medicaid APM or a Medicaid Medical Home Model that is an Other Payer Advanced APM. We propose that the Submission Deadline for these submissions is April 1 of the year prior to the All-Payer QP Performance Period for which we would make the determination. As we discuss in section II.D.6.c.(2) of this proposed rule, we need to determine Medicaid APMs and Medicaid Medical Home Models that are Other Payer Advanced APMs prior to the start of the All-Payer QP Performance Period in order to apply the Title XIX exclusions where appropriate. We propose these dates for this reason, as well as to provide time for APM Entities and eligible clinicians to review the Medicaid APMs and Medicaid Medical Home Models that are Other Payer Advanced APMs on the Other Payer Advanced APM list.

CMS Determination: Upon the timely receipt of a Payer Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that, if we determine that the state has submitted incomplete or inadequate information, we 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. For each other payer arrangement for which the state does not submit sufficient information, we would not make a determination in response to that request submitted via the Payer Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify states of our determinations for each request as soon as practicable after the relevant Submission Deadline. We propose that states may submit

information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

We intend 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 us regarding the development of other payer arrangements through the different legal authorities available under Title XIX or Title XI of the Act, we would help states consider and address the Other Payer Advanced APM criteria.

(b) Eligible Clinician Initiated Process

We believe that, to appropriately implement the Title XIX exclusions, it is not feasible to allow APM Entities and eligible clinicians to request determinations for Title XIX payment arrangements after the conclusion of the All-Payer QP Performance Period for the year, as we are allowing APM Entities and eligible clinicians to do for other payers. To do so would mean that a single clinician requesting a determination for a previously unknown Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria could unexpectedly affect QP threshold calculations for every other clinician in that state (or county) as

described in section II.D.6.d.(3) of this proposed rule. Thus, we would be unable to provide timely notice of the presence of a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria to all other eligible clinicians in the state whose QP determinations under the All-Payer Combination Option could be affected. To avoid this scenario, we propose to require that APM Entities and eligible clinicians may request determinations for any Medicaid payment arrangements in which they are participating at an earlier point, prior to the All-Payer QP Performance Period. This would allow all clinicians in a given state or county to know before the beginning of the performance period whether their Title XIX payments and patients would be excluded from the all-payer calculations that are used for QP determinations for the year under the All-Payer Combination Option. Details specific to the Eligible Clinician Initiated Process for payment arrangements authorized under Title XIX are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Eligible Clinician Initiated Process for payment arrangements authorized under Title XIX prior to the first Submission Period, which would occur during 2018. We intend to develop a submission form (which we refer to as the Eligible Clinician Initiated Submission Form) that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations, and we intend to make this Eligible Clinician Initiated Submission Form available to APM Entities and eligible clinicians prior to the first Submission Period. We propose that APM Entities and eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Eligible Clinician Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to payment arrangements made under Title XIX, and we intend for it to include a way for APM Entities or eligible clinicians to attach supporting documentation. We propose that APM Entities or eligible

clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process, though we would make separate determinations as to each other payer arrangement and 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.

Submission Period: We propose 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. We also propose that the Submission Deadline is November 1 of the calendar year prior to the All-Payer QP Performance Period.

CMS Determination: Upon the timely receipt of an Eligible Clinician Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we 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 we inform the APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify APM Entities and eligible clinicians of our determinations for each other payer arrangement for which a determination was requested as soon as practicable after the relevant Submission Deadline. We propose that APM Entities or

eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all of the other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

(c) Summary

The proposed timeline for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements authorized under Title XIX are summarized in Table 50.

TABLE 50: Other Payer Advanced APM Determination Process for Payment Arrangements Authorized Under Title XIX for All-Payer QP Performance Period 2019

	Payer Initiated Process	**Date**	**Eligible Clinician (EC) Initiated Process***	**Date**
Medicaid	Guidance sent to states, then Submission Period Opens	**Jan. 2018**	Guidance made available to ECs– Submission Period Opens	**Sept. 2018**
	Submission Period Closes	**April 2018**	Submission Period Closes	**Nov. 2018**
	CMS contacts states and Posts Other Payer Advanced APM List	**Sept. 2018**	CMS contacts ECs and states and Posts Other Payer Advanced APM List	**Dec. 2018**

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

(3) CMS Multi-Payer Models

For purposes of carrying out the Quality Payment Program, we propose to define the term CMS-Multi Payer Model at §414.1305 of our regulations 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. Examples of CMS Multi-Payer Models include the Comprehensive Primary Care Plus (CPC+) Model, the Oncology Care Model (OCM) (2-sided risk arrangement), and the Vermont All-Payer ACO Model.

Other payer arrangements that are in a CMS Multi-Payer Model, by definition, are not APMs and thus cannot be Advanced APMs under the Medicare Option. We recognize, though, that these other payer arrangements could be Other Payer Advanced APMs. We therefore propose that beginning in the first All-Payer QP Performance Period, payers with other payer arrangements in a CMS Multi-Payer Model may request that we determine whether those aligned other payer arrangements are Other Payer Advanced APMs.

Because there may be differences among the other payer arrangements that are aligned with an Advanced APM in a CMS Multi-Payer Model, we propose to make separate determinations about each of those other payer arrangements on an individual basis. In other words, an other payer arrangement aligned with an Advanced APM in a CMS Multi-Payer Model is not automatically an Other Payer Advanced APM by virtue of its alignment.

We acknowledge that there can be payment arrangements authorized under Title XIX or Medicare Health Plan payment arrangements that are aligned with a CMS Multi-Payer Model. We propose that payers, APM Entities, or eligible clinicians who want to request that we determine whether those arrangements are Other Payer Advanced APMs would use the processes specified for payment arrangements authorized under Title XIX and Medicare Health Plan payment arrangements discussed in sections II.D.6.c.(2) and II.D.6.c.(4) of this proposed rule.

(a) Payer Initiated Process

Details specific to the Payer Initiated Process for payment arrangements in CMS Multi-Payer Models are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Payer Initiated Process for other payer arrangements in CMS Multi-Payer Models prior to the

first Submission Period, which would occur during 2018. We intend to develop a submission form (which we refer to as the Payer Initiated Submission Form) that would be used by payers to request Other Payer Advanced APM determinations, and we intend to make this Payer Initiated Submission Form available to payers prior to the first Submission Period. We propose that payers would be required to use the Payer Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Payer Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to other payer arrangements in CMS Multi-Payer Models, and we intend for it to include a way for payers to attach supporting documentation. We propose that payers may submit requests for review of multiple other payer arrangements through the Payer Initiated Process, though we would make separate determinations as to each other payer arrangement and a payer would be required to use a separate Payer Initiated Submission Form for each other payer arrangement. Payers may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.

Submission Period: We propose that the submission period would open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period. We also propose that the submission period would close on June 30 of the calendar year prior to the relevant All-Payer QP Performance Period.

CMS Determination: Upon the timely receipt of a Payer Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the payer has submitted incomplete or inadequate information, we would inform the payer and allow the payer to submit additional information no later than 10 business days from the date we inform the payer. For each other payer arrangement for which the payer does not submit sufficient information, we would not make a determination in response to that request submitted via the

Payer Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify payers of our determinations for each request as soon as practicable after the relevant Submission Deadline. We propose that payers may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

(b) Eligible Clinician Initiated Process

Details specific to the Eligible Clinician Initiated Process for payment arrangements in CMS Multi-Payer Models are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Eligible Clinician Initiated Process for payment arrangements in CMS Multi-Payer Models prior to the first Submission Period, which would occur during 2019. We intend to develop a submission form (which we refer to as the Eligible Clinician Initiated Submission Form) that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations, and we intend to make this Eligible Clinician Initiated Submission Form

available to APM Entities and eligible clinicians prior to the first Submission Period. We propose that APM Entities and eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Eligible Clinician Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to other payer arrangements in CMS Multi-Payer Models, and we intend for it to include a way for APM Entities or eligible clinicians to attach supporting documentation. We propose that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process, though we 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.

Submission Period: We 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. We discuss our proposal to establish the All-Payer QP Performance Period in section II.D.6.(d)(2)(a) of this proposed rule. We propose 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.

CMS Determination: Upon the timely receipt of an Eligible Clinician Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we 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 we inform the APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify APM Entities and eligible clinicians of our determinations for each other payer arrangement for which a determination was requested as soon as practicable after the relevant Submission Deadline. We note 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 us 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 Deadline. If we determine that an other payer arrangement is not an Other Payer Advanced APM, notifying APM Entities or eligible clinicians of such a determination may help them avoid the burden of submitting payment amount and patient count information for that payment arrangement. We intend to make these early notifications to the extent possible. We propose that APM Entities or eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all of the other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under

Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

(c) State All-Payer Models

Some CMS Multi-Payer Models involve an agreement with a state to test an APM and one or more associated other payer arrangements in that state where the state prescribes uniform payment arrangements across state-based payers. As such, we believe it may be appropriate and efficient for states, rather than any other payer, to submit information to us on these payment arrangements for purposes of an Other Payer Advanced APM determination.

We propose that, in CMS Multi-Payer Models where a state prescribes uniform payment arrangements across all payers statewide, the state would submit on behalf of payers in the Payer Initiated Process for Other Payer Advanced APMs; we would seek information for the determination from the state, rather than individual payers. The same Payer Initiated Process and timeline described above for CMS Multi-Payer Models would apply. We seek comment on this proposal. Additionally, we seek comment regarding the effectiveness of taking a similar approach in cases where the state does not require uniform payment arrangements across payers.

(d) Summary

The proposed timelines for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements in CMS Multi-Payer Models are summarized in Table 51.

TABLE 51: Other Payer Advanced APM Determination Process for CMS Multi-Payer Models for All-Payer QP Performance Period 2019

	Payer Initiated Process	Date	Eligible Clinician (EC)* Initiated Process	Date
CMS Multi-Payer Models	Guidance made available to payers– Submission Period Opens	**Jan. 2018**	Guidance made available to ECs– Submission Period Opens	**Aug. 2019**
	Submission Period Closes	**June 2018**	Submission Period Closes	**Dec. 2019**
	CMS contacts payers and Posts Other Payer Advanced APM Lists	**Sept. 2018**	CMS contacts ECs and Posts Other Payer Advanced APM List	**Dec. 2019**

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

(4) Medicare Health Plans

The Medicare Option for QP determinations under sections 1833(z)(2)(A), (2)(B)(i), and (2)(C)(i) of the Act, is based only on the percentage of Part B payments for covered professional services, or patients, that is attributable to payments through an Advanced APM. As such, payment amounts or patient counts under Medicare Health Plans, including Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans, cannot be included in the QP determination calculations under the Medicare Option. (See 81 FR 77473 through 77474). Instead, eligible clinicians who participate in Other Payer Advanced APMs, including those with Medicare Advantage as a payer, could begin receiving credit for that participation through the All-Payer Combination Option in 2021 based on the performance in the 2019 All-Payer QP Performance Period.

In light of these statutory limitations, we have received feedback in support of creating a way for those participating or who could participate in Advanced APMs that include Medicare Advantage to receive credit for that participation in QP determinations under the Medicare Option. We are considering opportunities to address this issue. We seek comment on such opportunities, including potential models and uses of our waiver and demonstration authorities.

Under the All-Payer Combination Option, eligible clinicians can become QPs based in part on payment amounts or patient counts associated with payer arrangements through Medicare

Health Plans, provided that such arrangements meet the criteria to be Other Payer Advanced APMs. We note that the financial relationship between the Medicare Health Plan and CMS is not relevant to the Other Payer Advanced APM determination. Rather, because QP determinations are made for eligible clinicians, only the payment arrangement between a Medicare Health Plan and an eligible clinician is relevant when determining whether a payment arrangement is an Other Payer Advanced APM.

(a) Payer Initiated Process

We propose that Medicare Health Plans may request that we determine whether their payment arrangements are Other Payer Advanced APMs prior to the All-Payer QP Performance Period, by submitting information contemporaneously with the annual bidding process for Medicare Advantage contracts (that is., submitted by the first Monday in June of the year prior to the payment and coverage year). Because this is a process in which many Medicare Health Plans currently participate, we believe it will be the least burdensome approach for Medicare Health Plans.

Details specific to the Payer Initiated Process for Medicare Health Plan payment arrangements are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Payer Initiated Process for Medicare Health Plan payment arrangements prior to the first Submission Period, which would occur during 2018. We intend to 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. We intend to develop a submission form (which we refer to as the Payer Initiated Submission Form) that would be used by payers to request Other Payer Advanced APM determinations, and we intend to make this Payer Initiated Submission Form available to payers prior to the first Submission Period. This form would be built into the Health Plan Management System (HPMS), which payers currently use for the

annual bidding process. We propose that payers would be required to use the Payer Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Payer Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to Medicare Health Plan payment arrangements, and we intend for it to include a way for payers to attach supporting documentation. We propose that payers may submit requests for review of multiple other payer arrangements through the Payer Initiated Process, though we would make separate determinations as to each other payer arrangement and a payer would be required to use a separate Payer Initiated Submission Form for each other payer arrangement. Payers may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.

Submission Period: We propose that the Submission Period would begin and end at the same time as the annual bid timeframe. We propose 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. We also propose 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.

CMS Determination: Upon the timely receipt of a Payer Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the payer has submitted incomplete or inadequate information, we would inform the payer and allow the payer to submit additional information no later than 10 business days from the date we inform the payer. For each other payer arrangement for which the payer does not submit sufficient information, we would not make a determination in response to that request submitted via the Payer Initiated Submission Form. As a result, the other payer arrangement would not be

considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify payers of our determinations for each request as soon as practicable after the relevant Submission Deadline. We propose that payers may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

(b) Eligible Clinician Initiated Process

Details specific to the Payer Initiated Process for Medicare Health Plan payment arrangements are explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Eligible Clinician Initiated Process for Medicare Health Plan payment arrangements prior to the first Submission Period, which would occur during 2019. We intend to develop a submission form (which we refer to as the Eligible Clinician Initiated Submission Form) that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations, and we intend to make this Eligible Clinician Initiated Submission Form available to APM Entities and eligible clinicians prior to the first Submission Period. We propose that APM

Entities and eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Eligible Clinician Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to Medicare Health Plan payment arrangements, and we intend for it to include a way for APM Entities or eligible clinicians to attach supporting documentation. We propose that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process, though we would make separate determinations as to each other payer arrangement and 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.

Submission Period: We 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. We discuss our proposal to establish the All-Payer QP Performance Period in section II.D.6.(d)(2)(a) of this proposed rule. We propose 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.

CMS Determination: Upon the timely receipt of an Eligible Clinician Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we 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 we inform the

APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify APM Entities and eligible clinicians of our determinations for each other payer arrangement for which a determination was requested as soon as practicable after the relevant Submission Deadline. We note 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 us 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 Deadline. If we determine that an other payer arrangement is not an Other Payer Advanced APM, notifying APM Entities or eligible clinicians of such a determination may help them avoid the burden of submitting payment amount and patient count information for that payment arrangement. We intend to make these early notifications to the extent possible. We propose that APM Entities or eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all of the other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer

QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

(c) Summary

The proposed timeline for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for Medicare Health Plan payment arrangements are summarized in Table 52.

TABLE 52: Other Payer Advanced APM Determination Process for Medicare Health Plan Payment Arrangements for All-Payer QP Performance Period 2019

	Payer Initiated Process	**Date**	**Eligible Clinician (EC)* Initiated Process**	**Date**
Medicare Health Plans	Guidance sent to Medicare Health Plans– Submission Period Opens	**April 2018**	Guidance made available to ECs– Submission Period Opens	**Aug. 2019**
	Submission Period Closes	**June 2018**	Submission Period Closes	**Dec. 2019**
	CMS contacts Medicare Health Plans and Posts Other Payer Advanced APM List	**Sept. 2018**	CMS contacts ECs and Posts Other Payer Advanced APM List	**Dec. 2019**

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

(5) Remaining Other Payers

(a) Payer Initiated Process

We propose to allow the remaining other payers not specifically addressed in proposals above, including commercial and other private payers that are not states, Medicare Health Plans or payers with arrangements that are aligned with a CMS Multi-Payer Model, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting prior to the 2020 All-Payer QP Performance Period and each year thereafter. We seek comment on this proposal, and we also seek comment on potential challenges to these other payers submitting information to us for Other Payer Advanced APM determinations. We intend to discuss this process in more detail in future rulemaking.

(b) Eligible Clinician Initiated Process

We propose that APM Entities and eligible clinicians may request that we determine whether an other payer arrangement with one of these other payers is an Other Payer Advanced APM beginning 2019 All-Payer QP Performance Period as explained below.

Guidance and Submission Form: We intend to make guidance available regarding the Eligible Clinician Initiated Process for remaining other payer arrangements prior to the first Submission Period, which would occur during 2019. We intend to develop a submission form (which we refer to as the Payer Initiated Submission Form) that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations, and we intend to make this Eligible Clinician Initiated Submission Form available to APM Entities and eligible clinicians prior to the first Submission Period. We propose that APM Entities and eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We intend for the Eligible Clinician Initiated Submission Form to include questions that are applicable to all other payer arrangements and some that are specific to remaining other payer arrangements, and we intend for it to include a way for APM Entities or eligible clinicians to attach supporting documentation. We propose that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process, though we would make separate determinations as to each other payer arrangement and 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.

Submission Period: We 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. We discuss our proposal to establish the All-Payer

QP Performance Period in section II.D.6.(d)(2)(a) of this proposed rule. We propose 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.

CMS Determination: Upon the timely receipt of an Eligible Clinician Initiated Submission Form, we would use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. We propose that if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we 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 we inform the APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. As a result, the other payer arrangement would not be considered an Other Payer Advanced APM for the year. These determinations are final and not subject to reconsideration.

CMS Notification: We propose to notify APM Entities and eligible clinicians of our determinations for each other payer arrangement for which a determination was requested as soon as practicable after the relevant Submission Deadline. We note 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 us 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 Deadline. If we determine that an other payer arrangement is not an Other Payer Advanced APM, notifying APM Entities or eligible clinicians of such a determination may help them avoid the burden of submitting payment amount and patient count information for that payment

arrangement. We intend to make these early notifications to the extent possible. We propose that APM Entities or eligible clinicians may submit information regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if we have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.

CMS Posting of Other Payer Advanced APMs: We intend to post on the CMS Website a list (which we refer to as the Other Payer Advanced APM List) of all of the other payer arrangements that we determine to be Other Payer Advanced APMs. Prior to the start of the relevant All-Payer QP Performance Period, we intend to post the Other Payer Advanced APMs that we determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that we determine through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, we would update this list to include Other Payer Advanced APMs that we determine based on other requests through the Eligible Clinician Initiated Process.

We seek comments on these proposals.

(c) Summary

The proposed timeline for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements for remaining other payers are summarized in Table 53.

TABLE 53: Other Payer Advanced APM Determination Process for Remaining Other Payer Payment Arrangements for All-Payer QP Performance Period 2019

	Eligible Clinician (EC) Initiated Process*	**Date**
Remaining Other Payers	Guidance made available to ECs– Submission Period Opens	**Aug. 2019**
	Submission Period Closes	**Dec. 2019**
	CMS contacts ECs and Posts Other Payer Advanced APM List	**Dec. 2019**

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

(6) Timeline for the Proposed Other Payer Advanced APM Determination Processes

The proposed timeline for both the proposed Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for all payer types is presented in Table 54.

TABLE 54: Timeline for Other Payer Advanced APM Determination Process for the 2019 QP Performance Period by Payer Type*

Year	Date	Payment Arrangements Authorized Under Title XIX	Payment Arrangements in CMS Multi-Payer Models	Medicare Health Plan Payment Arrangements	Remaining Other Payer Payment Arrangements
2018	January	Guidance sent to states – Submission Period Opens	Guidance made available to payers – Submission Period Opens		
	April	Submission Period Closes for states		Guidance sent to Medicare Health Plans – Submission Period Opens	
	June	Guidance made available to ECs – Submission Period Opens for ECs	Submission Period Closes for Payers	Submission Period Closes for Medicare Health Plans	
	July - August	CMS makes Other Payer Advanced APM Determinations for states	CMS makes Other Payer Advanced APM Determinations for payers	CMS makes Other Payer Advanced APM Determinations for Medicare Health Plans	
	September	CMS posts Other Payer Advanced APM List	CMS posts Other Payer Advanced APM List	CMS posts Other Payer Advanced APM List	
	November	Submission Period Closes for ECs			
	December	CMS posts Other Payer Advanced APM List			
2019	August	Submission Period Opens for ECs	Submission Period Opens for ECs	Submission Period Opens for ECs	Submission Period Opens for ECs
	September		Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period for QP determination data opens	Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period for QP determination data opens	Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period for QP determination data opens

Year	Date	Payment Arrangements Authorized Under Title XIX	Payment Arrangements in CMS Multi-Payer Models	Medicare Health Plan Payment Arrangements	Remaining Other Payer Payment Arrangements
	December		Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List	Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List	Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List

*The process repeats beginning in 2019 for the 2020 QP Performance Period.

(7) Submission of Information for Other Payer Advanced APM Determinations

In the CY 2017 Quality Payment Program final rule, we finalized that to be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians must submit, in a manner and by a date that we specify, payment arrangement information necessary to assess whether the other payer arrangement meets the Other Payer Advanced APM criteria (81 FR 77480).

(a) Required Information

As we discuss in sections II.D.6.c.(1) through II.D.6.c.(5) of this proposed rule, we propose to allow for certain types of payers as well as APM Entities or eligible clinicians to request that we determine whether certain other payer arrangements are Other Payer Advanced APMs.

(i) Payer Initiated Process

We intend to create a Payer Initiated Submission Form that would allow payers to submit the information necessary for us to determine whether a payment arrangement is an Other Payer

Advanced APM. We propose that, for each other payer arrangement a payer requests us to determine whether it is an Other Payer Advanced APM, the payer must use, complete, and submit the Payer Initiated Submission Form by the relevant deadline.

For us to make these determinations, we propose 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 criteria;
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence that the CEHRT criterion set forth in §414.1420(b) is satisfied;
- Evidence that the quality measure criterion set forth in §414.1420(c) is satisfied; including an outcome measure;
- Evidence that the financial risk criterion set forth in §414.1420(d) is satisfied; and
- Other documentation as may be necessary for us to determine that the other payer arrangement is an Other Payer Advanced APM.

We propose that the Payer Initiated Submission Form would allow payers to include descriptive language for each of the required information elements. We are proposing to require the name and description of the arrangement, nature of the arrangement, term of the arrangement, eligibility criteria, and location(s) where the arrangement will be available so that we can verify whether eligible clinicians who may tell us that they participate in such arrangements are eligible to do so. We require evidence that all of the Other Payer Advanced APM criteria are met in order for us to determine whether the arrangement is an Other Payer Advanced APM. We propose that a submission for an Other Payer Advanced APM

determination submitted by the payer is complete only if all of these information elements are submitted to us.

We propose to require that payers submit documentation that supports the information they provided in the Payer Initiated Submission Form and that is sufficient to enable us to determine whether the other payer arrangement is an Other Payer Advanced APM. Examples of such documentation would include contracts and other relevant documents that govern the other payer arrangement that verify each required information element, copies of their full contracts governing the arrangement, or some other documents that detail and govern the payment arrangement.

(ii) Eligible Clinician Initiated Process

We intend to create an Eligible Clinician Initiated Submission Form that would allow for APM Entities or eligible clinicians to submit the information necessary for us to determine whether a payment arrangement is an Other Payer Advanced APM. We propose that, for each other payer arrangement an APM Entity or eligible clinician requests us to determine whether it is an Other Payer Advanced APM, the APM Entity or eligible clinician must use, complete, and submit the Eligible Clinician Initiated Submission Form by the relevant deadline.

For us to make these determinations, we propose to require that the APM Entity or eligible clinician 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);
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence that the CEHRT criterion set forth in §414.1420(b) is satisfied;

- Evidence that the quality measure criterion set forth in §414.1420(c) is satisfied, including an outcome measure;
- Evidence that the financial risk criterion set forth in §414.1420(d) is satisfied; and
- Other documentation as may be necessary for us to determine whether the other payer arrangement is an Other Payer Advanced APM.

We propose that the Eligible Clinician Initiated Submission Form would allow APM Entities and eligible clinicians to include descriptive language for each of the required information elements. We are proposing to require the name and description of the arrangement, nature of the arrangement, term of the arrangement, eligibility criteria, and, in the case of Title XIX arrangements only, location(s) where the arrangement will be available. We require evidence that all of the Other Payer Advanced APM criteria are met in order for us to determine that the arrangement is an Other Payer Advanced APM. We propose that a submission for an Other Payer Advanced APM determination submitted by the APM Entity or eligible clinician is complete only if all of these information elements are submitted to us.

We propose to require that APM Entities or eligible clinicians submit documentation that supports the information they provided in the Eligible Clinician Initiated Submission Form and that is sufficient to enable us to determine whether the other payer arrangement is an Other Payer Advanced APM. Examples of such documentation would include contracts and other relevant documents that govern the other payer arrangement that verify each required information element, copies of their full contracts governing the arrangement, or some other documents that detail and govern the payment arrangement. In addition to requesting that we determine whether one or more other payer arrangements are Other Payer Advanced APMs for the year, APM Entities or eligible clinicians may also inform us that they are participating in an other payer arrangement that we determine to be an Other Payer Advanced APM for the year. To do so, we propose that an APM Entity or eligible clinician would indicate, upon submission of Other Payer

Advanced APM participation data for purposes of QP determination, 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 arrangements.

We acknowledge that there is some burden associated with requesting Other Payer Advanced APM determinations. We seek comment on ways to reduce burden on states, payers, APM Entities, and eligible clinicians while still allowing us to receive the information necessary to make such determinations.

(b) Certification and Program Integrity

(i) Payer Initiated Process

We believe that it is important that the information submitted by payers through the Payer Initiated Process is true, accurate, and complete. To that end, we propose to add a new requirement at §414.1445(d) stating that a payer that submits information pursuant to §414.1445(c) must certify to the best of its knowledge that the information it submitted to us through the Payer Initiated Process is true, accurate, and complete. Additionally, we propose that this certification must accompany the Payer Initiated Submission Form and any supporting documentation that payers submit to us through this process.

We propose to revise and clarify the monitoring and program integrity provisions at §414.1460. First, we propose to modify §414.1460(c) to specify that information submitted by payers for purposes of the All-Payer Combination Option may be subject to audit by us. We anticipate that the purpose of any such audit would be to verify the accuracy of an Other Payer Advanced APM determination. We seek comment on how this might be done with minimal burden to payers. Second, we propose at §414.1460(e)(1) to require payers who choose to submit information through the Payer Initiated Process to such books, contracts, records, documents, and other evidence as necessary to audit an Other Payer Advanced APM determination. We

propose that such information must be maintained for 10 years after submission. We also propose at §414.1460(e)(3) that such information and supporting documentation must be provided to us upon request. We request comments on this proposal, including comment on the length of time payers typically maintain such information. We also seek comment on how this might be done with minimal burden to payers.

(ii) Eligible Clinician Initiated Process

In the CY 2017 Quality Payment Program final rule, we finalized a requirement at §414.1445(b)(3) that payers must attest to the accuracy of information submitted by eligible clinicians (81 FR 77480). After publication of the final rule, we received comments from stakeholders opposing this requirement. Commenters noted that payers may not have any existing relationship with us, that payers do not have any direct stake in the QP status of eligible clinicians, and that there may be operational and legal barriers to payers attesting to this information. In consideration of these comments, we propose to eliminate the requirement at §414.1445(b)(3) that payers attest that the information submitted by eligible clinicians is accurate. Instead, as discussed in section II.D.6.c.(7)(b)(i) of this rule, we are proposing that payers must certify only the information they submit directly to us.

In the CY 2017 Quality Payment Program final rule, we finalized a requirement at §414.1460(c) 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. We believe 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, we are proposing to remove this requirement at §414.1460(c) and proposing at §414.1445(d) that an APM Entity or eligible clinician that submits information pursuant to §414.1445(c) 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 the APM Entity, we propose that the certification be made by a person with the authority to bind the APM Entity. We also propose that this certification accompany the Eligible Clinician Initiated Submission Form and any supporting documentation that eligible clinicians submit to us through this process. We note that under §414.1460(c), APM Entities or eligible clinicians may be subject to audit of the information and supporting documentation provided under the certification. In section II.D.6.c.(7)(b) of this rule, we discuss our proposal to add a similar certification requirement at §414.1440(f)(2) for QP determinations. We note that we propose to remove the last sentence of §414.1460(c) regarding record retention and address the record retention issue only in the maintenance of records provision at §414.1460(e).

Finally, we are proposing to clarify the nature of the information subject to the record retention requirements at §414.1460(e). Specifically, we propose 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.

(iii) Outcome Measure

For both Advanced APMs and Other Payer Advanced APMs, we want to encourage the use of outcome measures for quality performance assessment. We also recognize there is a lack of appropriate outcome measures for use by certain specialties and take that into consideration when interpreting the requirement that an Other Payer Advanced APM is one under which MIPS-comparable quality measures apply. Therefore, in the CY 2017 Quality Payment Program final rule, we finalized at §414.1420(c)(3) that to meet the quality measure use criterion to be an Other Payer Advanced APM, the other payer arrangement must use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list; but if there is no outcome measure available for use in the other payer arrangement, the APM Entity must attest that there is no applicable measure on the MIPS quality measure list. While we are not proposing

substantive changes to this policy, we are making technical revisions to our regulations to codify this policy at §414.1445(c)(3) and we clarify that a payer, APM entity, or eligible clinician must certify that there is no applicable measure on the MIPS quality measure list if the payment arrangement does not use an outcome measure.

(c) Use of Information Submitted

We intend to post, on a CMS website, only the following information about other payer arrangements that we determine are Other Payer Advanced APMs: the names of payers with Other Payer Advanced APMs as specified in either the Payer Initiated or Eligible Clinician Initiated 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.

We believe that making this information publicly available is particularly important for Medicaid APMs and Medicaid Medical Home Models so that eligible clinicians can assess whether their Medicaid payments and patients would be excluded in calculations under the All-Payer Combination Option. More generally, we believe that making this information publicly available would help eligible clinicians to identify which of their other payer arrangements are Other Payer Advanced APMs so they can include information on those Other Payer Advanced APMs in their requests for QP determinations; and to learn about, and potentially join, Other Payer Advanced APMs that may be available to them. We seek comment on whether posting this information would be helpful to APM Entities or eligible clinicians.

In the CY 2017 Quality Payment Program final rule, we finalized that, to the extent permitted by federal law, we 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 (81 FR 77478 through 77480).

We propose that, with the exception of the specific information we propose to make publicly available as stated above, the information a payer submits to us through the Payer Initiated Process and the information an APM Entity or eligible clinician submits to us 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.

We seek comment on this proposal.

(d) Use of Certified EHR Technology (CEHRT)

In the CY 2017 Quality Payment Program final rule, we finalized that to be an Other Payer Advanced APM, the other payer arrangement must require at least 50 percent of participating eligible clinicians in each APM Entity to use Certified EHR Technology (CEHRT) to document and communicate clinical care (81 FR 77465).

We believe that some other payer arrangements, particularly those for which eligible clinicians may request determinations as Other Payer Advanced APMs, may only require CEHRT use at the individual eligible clinician level in the contract the eligible clinician has with the payer. We also believe that it may be challenging for eligible clinicians to submit information sufficient for us to determine that at least 50 percent of eligible clinicians under the other payer arrangement are required to use CEHRT to document and communicate clinical care.

To address this issue, we propose that we would presume that an other payer arrangement would satisfy the 50 percent CEHRT use criterion if we receive information and documentation from the eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinician information. We seek comment on this proposal. We also seek 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.

(8) Summary of Proposals

In summary, we are proposing the following:

Payer Initiated Process

- We propose to allow certain other payers, including payers with payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS Multi-Payer Models to request that we determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter. We propose to allow remaining other payers, including commercial and other private payers, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 prior to the 2020 All-Payer QP Performance Period, and annually each year thereafter. We propose to generally refer to this process as the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process), and we propose that the Payer Initiated Process would generally involve the same steps for each payer type for each All-Payer QP Performance Period. If a payer uses the same other payer arrangement in other commercial lines of business, we propose to allow the payer to concurrently request that we determine whether those other payer arrangements are Other Payer Advanced APMs as well.

- We propose that these Other Payer Advanced APM determinations would be in effect for only one year at a time.

- We propose that the Payer Initiated Process would be voluntary for all payers..

- We propose that payers would be required to use the Payer Initiated Submission Form to request that we make an Other Payer Advanced APM determination. We propose 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.

- We propose that if we determine that the payer has submitted incomplete or inadequate information, we would inform the payer and allow the payer to submit additional information no later than 10 business days from the date we inform the payer. For each other payer arrangement for which the payer does not submit sufficient information, we would not make a determination in response to that request submitted via the Payer Initiated Submission Form.

- Title XIX (Medicaid): We propose that any states and territories ("states") that have in place a state plan under Title XIX may request that we determine prior to the All-Payer QP Performance Period whether other payer arrangements authorized under Title XIX are Other Payer Advanced APMs under the Payer Initiated Process. We propose to allow states to request determinations for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements. We propose that the Submission Period for the Payer Initiated Process for use by states to request Other Payer Advanced APM determinations for other payer arrangements authorized under Title XIX will open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period for which we would make the determination for a Medicaid APM or a Medicaid Medical Home Model that is an Other Payer Advanced APM. We propose that the Submission Deadline for these submissions is April 1 of the year prior to the All-Payer QP Performance Period for which we would make the determination.

- CMS Multi-Payer Models: We propose that payers with other payer arrangements aligned with a CMS Multi-Payer Model may request that we determine whether their aligned other payer arrangements are Other Payer Advanced APMs. We propose that payers with other payer arrangements in a CMS Multi-Payer Model may request that we determine prior to the All-Payer QP Performance Period whether those other payer arrangements are Other Payer

Advanced APMs. We propose that payers that want to request that we determine whether those arrangements are Other Payer Advanced APMs would use the processes specified for payment arrangements authorized under Title XIX and Medicare Health Plan payment arrangements. We propose that the submission period would open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period. We also propose that the submission period would close on June 30 of the calendar year prior to the relevant All-Payer QP Performance Period. We propose that, in CMS Multi-Payer Models where a state prescribes uniform payment arrangements across all payers statewide, the state would submit on behalf of payers in the Payer Initiated Process for Other Payer Advanced APMs; we would seek information for the determination from the state, rather than individual payers. The same Payer Initiated Process and timeline described above for CMS Multi-Payer Models would apply.

- Medicare Health Plans: We propose that the Submission Period would begin and end at the same time as the annual bid timeframe. We propose 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. We also propose 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.

- Remaining Other Payers: We propose to allow the remaining other payers not specifically addressed in proposals above, including commercial and other private payers that are not states, Medicare Health Plans, or payers with arrangements that are aligned with a CMS Multi-Payer Model, to request that we determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2020 All-Payer QP Performance Period and each year thereafter.

Eligible Clinician Initiated Process

- We propose that through the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements would have an opportunity to request that we determine for the year whether those other payer arrangements are Other Payer Advanced APMs. The Eligible Clinician Initiated Process could also be used to request determinations before the beginning of an All-Payer Payer QP Performance Period for other payer arrangements authorized under Title XIX.

- We propose that APM Entities or eligible clinicians would be required to use the Eligible Clinician Initiated Submission Form to request that we make an Other Payer Advanced APM determination.

- We propose that if we determine that the APM Entity or eligible clinician has submitted incomplete or inadequate information, we would inform the payer and allow the payer to submit additional information no later than 10 business days from the date we inform the APM Entity or eligible clinician. For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, we would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form.

- Title XIX (Medicaid): We propose that for the first All-Payer QP Performance Period, APM Entities and eligible clinicians may submit information on payment arrangements authorized under Title XIX to request that we determine whether those arrangements are Medicaid APMs or Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria prior to the All-Payer QP Performance Period. We propose 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. We also propose that the Submission Deadline is November 1 of the calendar year prior to the All-Payer QP Performance Period.

- CMS Multi-Payer Models: We propose that through the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements in CMS Multi-Payer Models may request that we determine whether those other payer arrangements are Other Payer Advanced APMs. We 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. We propose 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.

- Medicare Health Plans: We propose that through the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements in Medicare Health Plans would have an opportunity to request that we determine whether those other payer arrangements that are not already determined to be Other Payer Advanced APMs through the Payer Initiated Process are Other Payer Advanced APMs. We 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. We propose 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.

- Remaining Other Payers: We propose that through the Eligible Clinician Initiated Process APM Entities and eligible clinicians participating in other payer arrangements through one of these other payers is an Other Payer Advanced APM. We 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. We propose 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.

Submission of Information for Other Payer Advanced APM Determinations

- We propose that, for each other payer arrangement a payer requests us to determine whether it is an Other Payer Advanced APM, all payers must complete and submit the Payer Initiated Submission Form by the relevant Submission Deadline. We propose that the Payer Initiated Submission Form would allow payers to include descriptive language for each of the required information elements. We are proposing to require the name and description of the arrangement, nature of the arrangement, term of the arrangement, eligibility criteria, and location(s) where the arrangement will be available so that we can verify whether eligible clinicians who may tell us that they participate in such arrangements are eligible to do so. We propose to require that payers submit documentation that supports the information they provided in the Payer Initiated Submission Form and that is sufficient to enable us to determine whether the other payer arrangement is an Other Payer Advanced APM.

- We propose that, for each other payer arrangement an APM Entity or eligible clinician requests us to determine whether it is an Other Payer Advanced APM, all payers must complete and submit the Eligible Clinician Initiated Submission Form by the relevant deadline. We propose that the Eligible Clinician Initiated Submission Form would allow APM Entities or eligible clinicians to include descriptive language for each of the required information elements. We are proposing to require the name and description of the arrangement, nature of the arrangement, term of the arrangement, eligibility criteria, and location(s) where the arrangement will be available so that we can verify whether eligible clinicians who may tell us that they participate in such arrangements are eligible to do so. We propose to require that APM Entities or eligible clinicians submit documentation that supports the information they provided in the

Eligible Clinician Initiated Submission Form and that is sufficient to enable us to determine whether the other payer arrangement is an Other Payer Advanced APM.

- We propose that, for each other payer arrangement a payer requests us to determine whether it is an Other Payer Advanced APM, the payer must complete and submit the Payer Initiated Submission Form by the relevant deadline.

- We propose that, for each other payer arrangement an APM Entity or eligible clinician requests us to determine whether it is an Other Payer Advanced APM, the APM Entity or eligible clinician must complete and submit the Eligible Clinician Initiated Submission Form by the relevant deadline.

- We propose to add a new requirement at §414.1445(d) stating that a payer that submits information pursuant to §414.1445(c) must certify to the best of its knowledge that the information submitted to us through the Payer Initiated Process is true, accurate, and complete. Additionally, we propose that this certification must accompany the Payer Initiated Submission Form and any supporting documentation that payers submit to us through this process.

- We also propose to revise the monitoring and program integrity provisions at §414.1460 to ensure the integrity of the Payer Initiated Process. Specifically, we are proposing to require payers that choose to submit information through the Payer Initiated Process to maintain such books, contracts, records, documents, and other evidence as necessary to audit an Other Payer Advanced APM determination and that such information and supporting documentation must be maintained for 10 years after submission and must be provided to CMS upon request. We also propose to specify that information submitted by payers for purposes of the All-Payer Combination Option may be subject to audit by CMS.

- We are proposing to remove the requirement at §414.1445(b)(3) that payers must attest to the accuracy of information submitted by eligible clinicians. We are also proposing to remove the attestation requirement at §414.1460(c) and add a requirement at §414.1445(d) that

an APM Entity or eligible clinician that submits information pursuant to §414.1445(c) must certify to the best of its knowledge that the information it submitted to us is true, accurate, and complete. We also propose that this certification must accompany the submission.

- We propose to remove the record retention requirement at §414.1445(c) and only address the record retention issue at §414.1445(e) stating that APM Entities and eligible clinicians 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.

- We propose that, with the exception of the specific information we propose to make publicly available as stated above, the information a payer submits to us through the Payer Initiated Process and the information an APM Entity or eligible clinician submits to us 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.

- We propose that we would initially presume that an other payer arrangement would satisfy the 50 percent CEHRT use criterion if we receive information and documentation from the APM Entity or eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinical information.

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

(1) Overview

In the CY 2017 Quality Payment Program final rule, we finalized our overall approach to the All-Payer Combination Option (81 FR 77463). Beginning in 2021, in addition to the Medicare Option, an eligible clinician may alternatively become a QP through the All-Payer

Combination Option, and an eligible clinician need only meet the QP threshold under one of the two options to be a QP for the payment year (81 FR 77459). We finalized that we will conduct the QP determination sequentially so that the Medicare Option is applied before the All-Payer Combination Option (81 FR 77439).

We finalized that we will calculate Threshold Scores under the Medicare Option through both the payment amount and patient count methods, compare each Threshold Score to the relevant QP and Partial QP thresholds, and use the most advantageous score to make QP determinations (81 FR 77457). We finalized the same approach for the All-Payer Combination Option (81 FR 77475).

Sections 1833(z)(2)(B)(ii)(I) and (C)(ii)(I) of the Act specify that the all payer portion of the Threshold Score calculations under the All-Payer Combination Option is based on the sum of payments for Medicare Part B covered professional services furnished by the eligible clinician and, with certain exceptions, all other payments regardless of payer. We finalized that we would include such payments in the numerator and denominator, and we would exclude the following excepted categories of payments made to the eligible clinician and associated patients from the calculations:

- By the Secretary of Defense;
- By the Secretary of Veterans Affairs; and
- Under Title XIX in a state in which no Medicaid Medical Home Model or APM is available under the state plan.

We finalized this exclusion of payments under Title XIX to mean that Medicaid payments and patients should be excluded from the all-payer calculation under the All-Payer Combination Option, unless:

++ A state has in operation at least one Medicaid APM or Medicaid Medical Home Model that is determined to be an Other Payer Advanced APM; and

++ The relevant 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 APM Entity actually participates in such Other Payer Advanced APMs.

(2) Timing of QP Determinations Under the All-Payer Combination Option

In the CY 2017 Quality Payment Program final rule, we 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 is2 years prior to the payment year (81 FR 77446-77447).

(a) All-Payer QP Performance Period and Medicare QP Performance Period

Upon further consideration, we propose to establish a separate QP Performance Period for the All-Payer Combination Option, which would begin on January 1 and end on June 30 of the calendar year that is 2 years prior to the payment year. We propose to define this term in §414.1305 as the All-Payer QP Performance Period. The QP Performance Period for the Medicare Option will remain the same as previously finalized, so it would begin on January 1 and end on August 31 of the calendar year that is 2 years to the payment year. We propose to define this term in §414.1305 as the Medicare QP Performance Period.

We are proposing to establish the All-Payer QP Performance Period because, to make QP determinations under the All-Payer Combination Option, we first need to collect information on eligible clinicians' payments and patients with all other payers. In order to provide eligible clinicians with timely QP determination that would enable them to make their own timely decisions for purposes of MIPS based on their QP status for the year, we need to collect this information by December 1 of the QP performance year. We are concerned that eligible clinicians would not be able to submit the necessary payment and patient information from all of their other payers for the period from January 1 through August 31 before the December 1 Information Submission Deadline. For the Medicare Option, we allow for a 90 day claims run

out period before gathering the necessary payment amount and patient count information. We believe the same claims run out timeframe should be adopted for other payers. If we were to maintain the current QP Performance Period through August 31 eligible clinicians would be required to submit their other payer payment and patient information to us on or very near the end of the 90 day claims run out period leaving them with little or no time to prepare the submission. We also believe that an additional 60 days after the claims run out is a reasonable amount of time for the eligible clinician to collect and submit the payment and patient data. We seek comment on this proposal, specifically as to an appropriate claims run out standard for other payers.

If we retained the current QP Performance Period and instead delayed the submission deadline to allow eligible clinicians time comparable to the time provided under the Medicare Option to fully collect and submit this information, QP determinations under the All-Payer Combination Option would likely not be complete before the end of the MIPS reporting period, which would undermine our goal of giving eligible clinicians information about their QP status prior to the end of the MIPS reporting period.

Alternatively, we are considering 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. We believe this option would provide the most ample time possible for eligible clinicians to prepare and submit information to enable us to make a QP determination under the All-Payer Combination Option. In the CY 2017 Quality Payment Program final rule, we finalized a snapshot approach that allows an eligible clinician to attain QP status based on Advanced APM participation from January 1 through March 31 under the Medicare Option. Since QP determinations under the Medicare Option can be based on participation information for January 1 through March 31 of a year, we believe this alternative performance period under the All-Payer Combination Option would not be inconsistent with the policy that we finalized last year, and

seek comment on this alternative approach. We seek comments on the establishment of a January 1 through March 31 All-Payer QP Performance Period and whether additional requirements may be needed to ensure the appropriate inplementation of this proposal.

We seek comment on the proposed All-Payer QP Peformance Period from January 1 through June 30 of the year that is 2 years prior to the payment year, and a possible alternative All-Payer QP Performance Period that would be from January 1 through March 31. If we do not finalize the proposed or alternative All-Payer QP Performance Period, we would retain the QP Performance Period that we finalized in the CY 2017 Quality Payment Program final rule, which is from January 1 through August 31 of the calendar year that is 2 years prior to the payment year. We are particularly concerned about the potential delay or run out from other payers that may affect the ability of APM entities or eligible clinicians to gather and submit the necessary payment amount and patient count information for the applicable All-Payer QP Performance Period by the December 1 All-Payer QP Determination Submission Deadline. At the same time, we recognize the need to balance this concern with the benefit of collecting Other Payer Advanced APM participation information over a meaningful period of time. We seek comment on the feasibility or difficulty in gathering and submitting this information for each of the potential performance period time frames.

(b) Alignment of Time Periods Assessed Under the Medicare Option and the All-Payer Combination Option

In the CY 2017 Quality Payment Program final rule, we finalized that we will make QP determinations under the Medicare Option using three snapshot dates during the QP Performance Period on March 31, June 30, and August 31 (81 FR 77446 through 77447).

Consistent with our proposal to make the All-Payer QP Performance Period from January 1 through June 30 of the calendar year that is 2 years prior to the payment year, we propose to make QP determinations based on eligible clinicians' 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.

We also propose that an eligible clinician would need to meet the relevant QP or Partial QP Threshold under the All-Payer Combination Option, and we would use data for the same time periods for Medicare payments or patients and that of other payers. For example, we would not assess an eligible clinician under the All-Payer Combination Option using their Advanced APM payment amount and patient count information from January 1 through March 31 and their Other Payer Advanced APM payment amount and patient count information from January 1 through June 30. We are proposing to align the time period assessed for the for the Medicare and other payer portions of the calculations under the All-Payer Combination Option because we believe that would support the principle that QP determinations should be based on an eligible clinician's performance over a single period of time, and that lack of alignment, comingling participation information from multiple time periods for the purposes of making QP determinations, would not appropriately reflect the structure of QP assessment using the All-Payer Combination Option. We seek comment on this proposal.

(c) Notification of QP Determinations Under the All-Payer Combination Option

Our goal, under both the Medicare Option and the All-Payer Combination Option, is to notify eligible clinicians of their QP status at a time that gives any Partial QPs time to decide whether to report to MIPS and gives those eligible clinicians who are not QPs or Partial QPs sufficient notice of the need to report to MIPS. For the All-Payer Combination Option, we also believe it is important to provide eligible clinicians as much information as possible about their QP status under the Medicare Option prior to the proposed All-Payer Information Submission Deadline, as subsequently discussed in section II.D.6.d.(4)(b) of this proposed rule. We therefore propose 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.

(3) QP Determinations Under the All-Payer Combination Option

In the CY 2017 Quality Payment Program final rule, we finalized that, similar to the Medicare Option, we will calculate the Threshold Scores used to make QP determinations under the All-Payer Combination Option at the APM Entity group level unless certain exceptions apply (81 FR 77478).

(a) QP Determinations at the Individual Eligible Clinician Level

Upon further consideration, we propose to make QP determinations under the All-Payer Combination Option at the individual eligible clinician level only. We believe that there will likely be significant challenges associated with making QP determinations under the All-Payer Combination Option at the APM Entity group level as we finalized through rulemaking last year.

As we explained in the CY 2017 Quality Payment Program final rule, an APM Entity faces the risks and rewards of participation in an Advanced APM as a single unit and is responsible for performance metrics that are aggregated to the APM Entity group level as determined by the Advanced APM unless that APM Entity falls under the exception specified in §414.1425(b)(1) for eligible clinicians on Affiliated Practitioner Lists. Because of this, we believe it is generally preferable to make QP determinations at the APM Entity level unless we are making QP determinations for eligible clinicians identified on Affiliated Practitioner Lists as specified at §414.1425(b)(1); or we are making QP determinations for eligible clinicians participating in multiple APM Entities, none of which reach the QP Threshold as a group as specified at §414.1425(c)(4) (81 FR 77439). However, under the All-Payer Combination Option, we believe in many instances that the eligible clinicians in the APM Entity group we would identify and use to make QP determinations under the Medicare Option would likely have little, if any, common group-level participation in Other Payer Advanced APMs. The eligible clinicians in the same APM Entity group would not necessarily have agreed to share risks and rewards for Other Payer Advanced APM participation as an APM Entity group, particularly

when eligible clinicians may participate in Other Payer Advanced APMs at different rates within an APM Entity group (or not at all).

Eligible clinicians may participate in Other Payer Advanced APMs whose participants do not completely overlap, or do not overlap at all, with the APM Entity the eligible clinician is part of. Therefore, we believe that looking at participation in Other Payer Advanced APMs at the individual eligible clinician level may be a more meaningful way to assess their participation across multiple payers. In addition, those risks and rewards associated with participation in Other Payer Advanced APMs may vary significantly among eligible clinicians depending on the Other Payer Advanced APMs in which they participate. Specifically, we are concerned that if we were to make All-Payer Combination Option QP determinations at the APM Entity level, the denominator in QP threshold calculations could include all other payments and patients from eligible clinicians who had no, or limited, Other Payer Advanced APM participation, thereby disadvantaging those eligible clinicians who did have significant Other Payer Advanced APM participation. By contrast, this scenario is unlikely to occur when making QP determinations at the APM Entity level under the Medicare Option because all eligible clinicians in the APM Entity group would be contributing to the APM Entity's performance under the Advanced APM. For these reasons, we believe it would be most appropriate to make all QP determinations under the All-Payer Combination Option at the individual eligible clinician level.

We seek comment on this proposal, specifically on the possible extent to which APM Entity groups in Advanced APMs could agree to be assessed collectively for performance in Other Payer Advanced APMs. We also seek comment on whether there is variation, and the extent of that variation, among eligible clinicians within an APM Entity group in their participation in other payer arrangements that we may determine to be Other Payer Advanced APMs We seek comment on whether there are circumstances in which QP determinations should be made at a group level under the All-Payer Combination Option.

If we were to establish a mechanism for making QP determinations at the APM Entity group level, we anticipate that there could be significant challenges in obtaining the information necessary at the APM Entity group level under the All-Payer Combination Option. When we make QP determinations at the APM Entity group level under the Medicare Option, we can do so more easily because we receive Participation Lists and we also have the claims data necessary to identify the payment or patient data that belong in the numerator and denominator of the Threshold Score calculations for QP Determinations.

To make QP determinations at the APM Entity group level under the All-Payer Combination Option, we would need to collect for each APM Entity group all of the payment amount and patient count information for all eligible clinicians as discussed in section II.D.6.d.(4)(a) of this proposed rule. We anticipate also needing Participation Lists or similar documentation to identify eligible clinicians within each APM Entity group that participate in an Other Payer Advanced APM. We seek comment on whether APM Entities in Other Payer Advanced APMs could report this information at the APM Entity group level to facilitate our ability to make QP determinations at the group level.

We note that when an Affiliated Practitioner List defines the eligible clinicians to be assessed for QP determination in the Advanced APM, we make QP determinations under the Medicare Option at the individual level only. To promote consistency with the Medicare Option where possible, if in response to comments on this proposed rule we adopt a mechanism to make QP determinations under the All-Payer Combination Option at the APM Entity group level, we propose that eligible clinicians who meet the criteria to be assessed individually under the Medicare Option would still be assessed at the individual level only under the All-Payer Combination Option. We seek comment on whether there are alternative approaches to making QP determinations under the All-Payer Combination Option for eligible clinicians who meet the criteria to be assessed individually under the Medicare Option.

(b) Use of Individual or APM Entity Group Information for Medicare Payment Amounts and Patient Count Calculations under the All-Payer Combination Option

Because we are proposing to make QP determinations at the individual eligible clinician level only, we are proposing to use the individual eligible clinician payment amounts and patient counts for the Medicare calculations in the All-Payer Combination Option. We believe that matching the information we use at the same level for all payment amounts and patient counts for both the Medicare and all-payer calculations under the All-Payer Combination Option is most consistent with sections 1833(z)(2)(B)(ii) and (C)(ii) of the Act because these provisions require calculations that add together the payments or patients from Medicare and all other payers (except those excluded). We note however that we would use the APM Entity group level payment amounts and patient counts for all Medicare Option Threshold Scores, unless we are making QP determinations for Affiliated Practitioner Lists as specified at §414.1425(b)(1) or we are making QP determinations for eligible clinicians participating in multiple APM Entities, none of which reach the QP Threshold as a group as specified at §414.1425(c)(4) (81 FR 77439).

If we were to use the APM Entity group level payment amounts and patient counts for Medicare and individual eligible clinician payment amounts and patient counts for other payers, we would combine APM Entity group level Medicare information with individual eligible clinician level other payer information. In most instances this would disproportionately underweight the eligible clinicians' activities in Other Payer Advanced APMs relative to their activities in Advanced APMs when calculating Threshold Scores under the All-Payer Combination Option. We do not believe that this underweighting would be consistent with sections 1833(z)(2)(B)(ii) and (c)(11) of the Act.

We recognize that in many cases an individual eligible clinician's Medicare Threshold Scores would likely differ from Threshold Scores calculated at the APM Entity group level, which would benefit those eligible clinicians whose individual Threshold Scores would be higher

than the group Threshold Scores and disadvantage those eligible clinicians whose individual Threshold Scores are equal to or lower than the group Threshold Scores. In situations where eligible clinicians are assessed under the Medicare Option as an APM Entity group, and receive a Medicare Threshold Score at the group level, we believe that the Medicare portion of their All-Payer Combination Option should not be lower than the Medicare Threshold Score that they received by participating in an APM Entity group.

To accomplish this outcome, we propose a modified methodology. When the eligible clinician's Medicare Threshold Score calculated at the individual level would be a lower percentage than the one that is calculated at the APM Entity group level we would apply a weighted methodology. This methodology would allow us to apply the APM Entity group level Medicare Threshold Score (if higher than the individual eligible clinician level Medicare Threshold Score), to the eligible clinician, under either the payment amount or patient count method, but weighted to reflect the individual eligible clinician's Medicare volume.

We would multiply the eligible clinician's APM Entity group Medicare Threshold Score by the total Medicare payments or patients made to that eligible clinician as follows:

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

As an example of how this weighting methodology would apply under the payment amount method for payment year 2021, consider the following APM Entity group with two clinicians, one of whom participates in Other Payer Advanced APMs and one who does not.

TABLE 55: Weighting Methodology Example – Payment Amount Method

	Medicare – Advanced APM Payments	Medicare – Total Payments	Other Payer – Advanced APM Payments	Other Payer – Total Payments
Clinician A	$150	$200	$0	$500
Clinician B	$150	$800	$760	$1,200
APM Entity	$300	$1,000	--	--

In this example, the APM Entity group Medicare Threshold Score is $300 / $1000, or 30 percent. Eligible Clinicians A and B would not be QPs under the Medicare Option, but Clinician B could request that we make a QP determination under the All-Payer Combination Option since the APM Entity group exceeded the 25 percent minimum Medicare payment amount threshold under that option.

If we calculate Clinician B's payments individually as proposed, we would calculate the Threshold Score as follows:

$$\frac{\$150 + \$760}{\$800 + \$1200} = 46\%$$

Because Clinician B's Threshold Score is less than the 50 percent QP Payment Amount Threshold, Clinician B would not be a QP based on this result. However, if we apply the weighting methodology, we would calculate the Threshold Score as follows:

$$\frac{\left(\frac{\$300}{\$1000} \times \$800\right) + \$760}{\$800 + \$1{,}200} = 50\%$$

Based upon this Threshold Score, Clinician B would be a QP under the All-Payer Combination Option.

We would calculate the eligible clinician's Threshold Scores both individually and with this weighted methodology, and then use the most advantageous score when making a QP determination. We believe that this approach promotes consistency between the Medicare Option and the All-Payer Combination Option to the extent possible. We seek comment on this approach.

(c) Title XIX Excluded Payments and Patients

Sections 1833(z)(2)(B)(ii)(I)(bb) and 1833(z)(2)(C)(ii)(I)(bb) of the Act direct us to exclude payments made under Title XIX in a state where no Medicaid Medical Home Model or

Medicaid APM is available under that state program. To carry out this exclusion, in the CY 2017 Quality Payment Final Rule, we finalized that for both the payment amount and patient count methods, Title XIX payments or patients will be excluded from the numerator and denominator for the QP determination unless:

(1) A state has in operation at least one Medicaid APM or Medicaid Medical Home Model that is determined to be an Other Payer Advanced APM; and

(2) The relevant 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 APM Entity actually participates in such Other Payer Advanced APMs (81 FR 77475).

For purposes of the discussion below on the exclusion of Title XIX payments and patients in QP determinations, when we refer to Medicaid APMs or Medicaid Medical Home Models, we mean to refer to those that are Other Payer Advanced APMs. We also discussed that if a state operates such an Other Payer Advanced APM at a sub-state level such that eligible clinicians who do not practice in the area are not eligible to participate, Medicaid payments or patients should not be included in those eligible clinicians' QP calculations because no Medicaid Medical Home Model or Medicaid APM was available for their participation (81 FR 77475).

We propose that we will use the county level to determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model at a sub-state level. We believe that the county level is appropriate as in our experience, the county level is the most common geographic unit used by states when creating payment arrangements under Title XIX at the sub-state level. We believe that applying this exclusion at the county level would allow us to carry out this exclusion in accordance with the statute in a way that would not penalize eligible clinicians who have no Medicaid APMs or Medicaid Medical Home Models available to them. We seek comment on this proposal.

We propose that, in states where a Medicaid APM or Medicaid Medical Home Model only exists in certain counties, we would exclude Title XIX data from an 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. We would require eligible clinicians to identify and certify the county where they saw the most patients during the relevant All-Payer QP Performance Period. If this county is not in a county where a Medicaid APM or Medicaid Medical Home Model was available during the All-Payer QP Performance Period, then Title XIX payments would be excluded from the eligible clinician's QP calculations. We are proposing this approach to ensure that, before including Title XIX payment or patient count information in calculating QP determinations, eligible clinicians have a meaningful opportunity to participate in a Medicaid APM or Medicaid Medical Home Model determined to be an Other Payer Advanced APM in a manner that would allow for both positive and negative contributions to their QP threshold score under the All-Payer Combination Option. We seek comments on this proposal.

As we discuss in section II.D.6.c.(3) of this proposed rule, we need to determine whether there are Medicaid APMs and Medicaid Medical Home Models available in each state prior to end of the All-Payer QP Performance Period in order to properly implement the statutory exclusion of Title XIX payments and patients, which is why we finalized in the CY 2017 Quality Payment Program final rule that we will identify Medicaid APMs and Medicaid Medical Home Models that are Other Payer Advanced APMs prior to the QP Performance Period (81 FR 77478).

In addition to excluding payments based on county-level geography, we propose to exclude Title XIX payments and patients from the QP determination calculation when the only Medicaid APMs and Medicaid Medical Home Models available in a given county are not

available to the eligible clinician in question based on their specialty. We believe that this proposal is consistent with the statutory requirement to exclude Title XIX data from the calculations when no Medicaid APM or Medicaid Medical Home Model is available. In cases where participation in such a model is limited to eligible clinicians in certain specialties, we do not believe the Medicaid APM or Medicaid Medical Home Model would effectively be available to eligible clinicians who are not in those specialties. We therefore believe it would be inappropriate and inequitable to include Title XIX payments and patients in such eligible clinicians' QP determination calculations. We propose to identify Medicaid APM or Medicaid Medical Home Models that are only open to certain specialties through questions asked of states in the Payer Initiated Process and of APM Entities and eligible clinicians in the Eligible Clinician Initiated Process. We would exclude Title XIX data from an eligible clinician's QP calculations unless the eligible clinician practiced under one of the specialty codes eligible to participate in a Medicaid APM or Medicaid Medical Home Model that was available in the county where the eligible clinician saw the most patients. We would use the method generally used in the Quality Payment Program to identify an eligible clinician's specialty or specialties. We seek comment on this proposal.

We also wish to clarify that payment arrangements offered by Medicare-Medicaid Plans, operating under the Financial Alignment Initiative for Medicare-Medicaid Enrollees, will not be considered to be either Medicaid APMs or Medicaid Medical Home Models, and that the presence of such payment arrangements in a state will not preclude the exclusion of Title XIX payment and patients in the All-Payer Combination Option calculations for eligible clinicians in that state if no Medicaid APM or Medicaid Medical Home Model is otherwise in operation in the state. Medicare-Medicaid Plans are limited to certain Medicare-Medicaid enrollees, and enter into payment arrangements that do not uniformly segregate Title XVIII and Title XIX funds. As such, payments to eligible clinicians in Medicare-Medicaid plans cannot consistently be

attributed to funding under either Title XVIII or XIX. Additionally, given that Medicare is generally the primary payer for services furnished by eligible clinicians to dual Medicare-Medicaid enrollees, any possible segregable Title XIX funding for professional services through these payment arrangements would be de minimus. We do not believe it would be appropriate to consider these payment arrangements exclusively focused on this population as Medicaid APMs or Medicaid Medical Home Models.

(d) Payment Amount Method

In the CY 2017 Quality Payment Program final rule, we finalized that we will calculate an All-Payer Combination Option Threshold Score for eligible clinicians in an APM Entity using the payment amount method (81 FR 77476 through 77477). We finalized that the numerator will be the aggregate of all payments from all 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. We finalized that the denominator will be the aggregate of all payments from all payers, except excluded payments, 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.

We finalized that we will calculate the Threshold Score by dividing the numerator value by the denominator value, which will result in a percent value Threshold Score. We 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 (81 FR 77475).

We propose to maintain the policies we finalized for the payment amount method as finalized, with some proposed modifications. We propose these changes to facilitate the implementation of the payment amount method while providing eligible clinicians with some flexibility in choosing the timeframe for making QP determinations. To carry out our proposal

to make QP determinations at the eligible clinician level only, we propose that the numerator would be the aggregate of all payments from all payers, except those excluded, attributable to the eligible clinician only, under the terms of all Advanced APMs and Other Payer Advanced APMs from either January 1 through March 31 or January 1 through June 30 of the All-Payer QP Performance Period. We also propose 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. We seek comment on this approach.

(e) Patient Count Method

We finalized that the Threshold Score calculation for the patient count method would include patients for whom the eligible clinicians in an APM Entity furnish services and receive payment under the terms of an Other Payer Advanced APM, except for those that are excluded (81 FR 77477 through 77478). We finalized that the numerator would be the number of unique patients to whom eligible clinicians in the APM Entity furnish services that are included in the aggregate expenditures used under the terms of all their Other Payer Advanced APMs during the QP Performance Period plus the patient count numerator for Advanced APMs (81 FR 77477 through 77478). We finalized that the denominator would be the number of unique patients to whom eligible clinicians in the APM Entity furnish services under all payers, except those excluded (81 FR 77477 through 77478). We finalized that we will calculate the Threshold Score by dividing the numerator value by the denominator value, which will result in a percent value Threshold Score (81 FR 77477 through 77478). We will compare that Threshold Score to the finalized QP Patient Count Threshold and the Partial QP Patient Count Threshold and determine the QP status of the eligible clinicians for the payment year (81 FR 77477 through 77478). We finalized that we would count each unique patient one time in the numerator and one time in the denominator (81 FR 77477 through 77478).

We intend to carry out QP determinations using the patient count method as finalized with some proposed modifications. We propose these changes to facilitate the implementation of the patient count method while providing eligible clinicians with some flexibility in choosing the timeframe for making QP determinations. To carry out our proposal to make QP determinations at the eligible clinician level only, we propose to count each unique patient one time in the numerator and one time in the denominator across all payers to align with our finalized policy for patient counts at the eligible clinician level. We propose that the numerator would be the number of unique patients the eligible clinician furnishes services to under the terms of all of 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 QP Performance Period. We propose 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 QP Performance Period. We seek comment on this approach.

(4) Submission of Information for QP Determinations under the All-Payer Combination Option

In the CY 2017 Quality Payment Program final rule, we finalized that either APM Entities or individual eligible clinicians must submit by a date and in a manner determined by us: (1) payment arrangement information necessary to assess whether each other payer arrangement is an Other Payer Advanced APM, including information on financial risk arrangements, use of CEHRT, and payment tied to quality measures; (2) for each payment arrangement, the amounts of payments for services furnished through the arrangement, the total payments 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 expected expenditures), and (3) the total number of patients furnished any service through the arrangement (81 FR 77480). We also finalized that if we do not receive sufficient information to complete our evaluation of

an other payer arrangement and to make QP determinations, we would not assess the eligible clinicians under the All-Payer Combination Option (81 FR 77480).

(a) Required Information

In order for us to make QP determinations for an eligible clinician under the All-Payer Combination Option, we need information for all of the Other Payer Advanced APMs in which an eligible clinician participated during the All-Payer QP Performance Period. Eligible clinicians can participate in other payer arrangements that we determine are Other Payer Advanced APMs through the Payer Initiated Process, through the Eligible Clinician Initiated Process, or both. We discuss the submission of information that pertains to Other Payer Advanced APM determinations in section II.D.6.c.(7)(a) of this proposed rule.

In order for us to make QP determinations under the All-Payer Combination Option using either the payment amount or patient count method, we would need to receive all of the payment amount and patient count information: (1) attributable to the eligible clinician through every Other Payer Advanced APM; and (2) for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician during the All-Payer QP Performance Period. We clarify that eligible clinicians will not need to submit Medicare payment or patient information for QP determinations under the All-Payer Combination Option.

To make calculations for the snapshot dates as proposed in section II.D.6.d.(4)(b) of this proposed rule, we will need this payment amount and patient count information from January 1 through June 30 of the calendar year 2 years prior to the payment year. We will need this payment amount and patient count information submitted in a way that allows us to distinguish information from January 1 through March 31 and from January 1 through June 30 so that we can make QP determinations based on the two snapshot dates as discussed above.

To meet the need for information in a way that we believe minimizes reporting burden, we propose to collect this payment amount and patient count information aggregated for the two

proposed snapshot time frames: from January 1 through March 31 and from January 1 through June 30. We seek comment on this approach, particularly as to the feasibility of submitting information in this way and suggestions on how to further minimize reporting burden. Alternatively, if we finalize an All-Payer QP Performance Period of January 1 through March 31, we would need payment amount and patient count information only from January 1 through March 31. If we retain the current finalized QP Performance Period, we would need information aggregated for three snapshot timeframes: from January 1 through March 31, January 1 through June 30, and January 1 through August 31.

As we discuss in section II.D.6.d.(3)(a) of this proposed rule, we are proposing to make QP determinations under the All-Payer Combination Option only at the eligible clinician level. As a result, we propose that all of this payment and patient information must be submitted at the eligible clinician level, and not at the APM Entity group level as we finalized in rulemaking last year.

To minimize reporting burden on individual eligible clinicians and to allow eligible clinicians to submit information to us as efficiently as possible, we propose to allow eligible clinicians to have APM Entities submit this information on behalf of any of the eligible clinicians in the APM Entity group at the individual eligible clinician level. We seek comments on these proposals, particularly regarding the feasibility of APM Entities reporting this information for some or all of the eligible clinicians in the APM Entity group.

Additionally, we propose that if an APM Entity or eligible clinician submits sufficient information only for the payment amount or patient count method, but not for both, we will make a QP determination based on the one method for which we receive sufficient information. We believe that this proposal is consistent with our overall approach, particularly because we have finalized that we will use the more advantageous of the Threshold Scores to make QP

determinations (81 FR 77475). We clarify that APM Entities or eligible clinicians can submit information to allow us to use both the payment amount and patient count methods.

To facilitate and ease burden for information submissions, we also propose to create a form that APM Entities or eligible clinicians would be able to use to submit this payment amount and patient count information. APM Entities and eligible clinicians would be required to use this form for submitting the payment and patient information.

We seek comment on these proposals.

(b) QP Determination Submission Deadline

We propose that APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination, as well as the payment amount and patient count information sufficient for us to make QP determinations by December 1 of the calendar year that is 2 years to prior to the payment year, which we refer to as the QP Determination Submission Deadline.

We believe that December 1 is the latest date in the year that we could receive information, and be able to complete QP determinations and notify eligible clinicians of their QP status in time for them to report to MIPS as needed. We also proposed this date for the QP Determination Submission Deadline to provide eligible clinicians requesting QP determinations under the All-Payer Combination Option as much time as possible to gather and submit information.

In the CY 2017 Quality Payment Program final rule, we finalized that without sufficient information we will not make QP determinations under the All-Payer Combination Option (81 FR 77480). As such, we will not make QP determinations for an eligible clinician under the All-Payer Combination Option if we do not receive information sufficient to make a QP

determination under either the payment amount or patient count method by the QP Determination Submission Deadline.

We seek comment on these proposals.

(c) Certification and Program Integrity

We propose that a new requirement be added at §414.1440(f)(2) stating 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 that they submitted to us is true, accurate, and complete. In the case of information submitted by the APM Entity, we propose that the certification must be made by an individual with the authority to legally bind the APM Entity. This certification would accompany the Eligible Clinician Initiated Submission Form, which both eligible clinicians and APM Entities use for the Eligible Clinician Initiated Process. We seek comment on these proposals.

We propose to revise the monitoring and program integrity provisions at §414.1460 to further promote the integrity of the All-Payer Combination Option. In the CY 2017 Quality Payment Program final rule, we finalized at §414.1460(e) that an APM Entity or eligible clinician that submits information to us under §414.1445 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 (81 FR 77555). We also finalized at §414.1460(c) 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 (81 FR 77555). We propose to revise §414.1460(e) to apply to information submitted to us under §414.1440 for QP determinations. We also propose to add paragraph (3) to §414.1460(e) stating that an APM Entity or eligible clinician who submits information to us under §414.1445 or

§414.1440 must provide such information and supporting documentation to us upon request. We seek comments on these proposals.

(d) Use of Information

In the CY 2017 Quality Payment Program final rule, we finalized that, to the extent permitted by federal law, we 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 (81 FR 77479 through 77480).

We believe that it is similarly appropriate for us to maintain the confidentiality of information submitted to us for the purposes of QP determinations to the extent permitted by federal law. Therefore, we propose that, to the extent permitted by federal law, we will maintain confidentiality of the information that APM Entities or eligible clinicians submit to us for purposes of QP determinations under the All-Payer Combination Option, in order to avoid dissemination of potentially sensitive contractual information or trade secrets.

(5) Example

In Tables 56 and 57, we provide examples where an eligible clinician is in a Medicare ACO Model that we have determined to be an Advanced APM, a commercial ACO arrangement, and a Medicaid APM from January 1 through June 30, 2019. We would use the information below to determine that eligible clinician's QP status for payment year 2021.

We would calculate the Threshold Scores for the APM Entity group in the Advanced APM under the Medicare Option. For the payment amount method, as shown in Table 56, the APM Entity group would not attain QP status under the Medicare Option, which for payment year 2021 requires a QP payment amount Threshold Score of 50 percent. The APM Entity group would also fail to attain Partial QP status under the Medicare Option, which for payment year 2021 requires a Partial QP payment amount Threshold Score of 40 percent. For the patient count

method, as shown in Table 57, the APM Entity group would not attain QP status under the Medicare Option, which for payment year 2021 requires a QP patient count Threshold Score of 35 percent. The APM Entity group would not attain Partial QP status under the Medicare Option, which for payment year 2021 requires a Partial QP patient count Threshold Score of 25 percent.

TABLE 56: All-Payer Combination Option Example – Payment Amount Method

Payer	Level	Payments to group/eligible clinician by payer (in dollars)	Total payments to group/eligible clinician by payer (in dollars)	Threshold Score (percentage)
Medicare Option				
Advanced APM (Medicare)	APM Entity Group	300,000	1,000,000	30%
All-Payer Combination Option				
Advanced APM (Medicare)	Eligible Clinician	20,000	50,000	
Other Payer Advanced APM (Commercial)	Eligible Clinician	20,000	50,000	
Medicaid APM	Eligible Clinician	80,000	100,000	
Totals for All-Payer Combination Option	Eligible Clinician	120,000	200,000	60%

TABLE 57: All-Payer Combination Option Example – Patient Count Method

Payer	Level	Patients of group/eligible clinician by payer	Total patients of group/eligible clinician by payer	Threshold Score (percentage)
Medicare Option				
Advanced APM (Medicare)	APM Entity Group	2,200	10,000	22%
All-Payer Combination Option				
Advanced APM (Medicare)	Eligible Clinician	200	1,000	
Other Payer Advanced APM (Commercial)	Eligible Clinician	100	500	
Medicaid APM	Eligible Clinician	500	1,000	
Totals for All-Payer Combination Option	Eligible Clinician	800	2,500	32%

The APM Entity group did not attain QP or Partial QP status under either the payment amount or patient count method under the Medicare Option. However, because under both methods of calculation, the APM Entity group meets or exceeds the required Medicare threshold for the year under the All-Payer Combination Option of 25 percent and 20 percent, respectively, eligible clinicians within the APM Entity group would be eligible to obtain QP status through the All-Payer Combination Option. The eligible clinicians in the APM Entity group would have been notified of this as we share information on a regular basis on their QP status under each snapshot. For payment year 2021, the eligible clinicians in this APM Entity group would submit their payment amount or patient count data from all payers to calculate their Threshold Score under the All-Payer Combination Option.

In this example, the eligible clinician score exceeds the QP payment amount Threshold under the All-Payer Combination Option, which for payment year 2021 is 50 percent, but the eligible clinician only exceeds the Partial QP patient count Threshold under the All-Payer

Combination Option, which for payment year 2021 is 40 percent. We would use the more advantageous score, so the eligible clinician would be a QP for payment year 2021.

Alternatively, if we were to use the APM Entity weighted methodology for calculation of a Threshold Score using the payment amount method as described in section II.D.6.d.(3)(d) of this proposed rule, we would apply the weighting methodology as follows:

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

$$\frac{\left(\frac{\$300,000}{\$1,000,000} \times \$50,000\right) + \$100,000}{\$50,000 + \$150,000} = 58\%$$

The eligible clinician would obtain a Threshold Score of 58 percent. This would be slightly below the Threshold Score obtained from the individual eligible clinician payment count calculation, but it would still exceed the QP payment amount Threshold of 50 percent under the All-Payer Combination Option. Based upon this Threshold Score, the eligible clinician would be a QP under the All-Payer Combination Option.

(6) Partial QP Election to Report to MIPS

In the 2017 Quality Payment Program final rule, we finalized under the Medicare Option that, in the 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 then be subject to MIPS reporting requirements and payment adjustments (81 FR 77449). To promote alignment with the Medicare Option and to simplify requirements when possible, we propose that eligible clinicians who are Partial QPs for the year under the All-Payer Combination Option would make the election whether to report to MIPS and

then be subject to MIPS reporting requirements and payment adjustments. We seek comment on this approach.

(7) Summary Proposals

To summarize, we are proposing the following:

- We propose to establish the All-Payer QP Performance Period, which would begin on January 1 and end on June 30 of the calendar year that is 2 years prior to the payment year.

- We propose to make QP determinations based on eligible clinicians' participation in Advanced APMs and Other Payer Advanced APMs for two time periods: between January 1 through March 31 and between January 1 through June 30 of the All-Payer QP Performance Period under the All-Payer Combination Option. We propose to use data for the same time periods for Medicare payments or patients and that of other payers. We also propose the eligible clinicians must request QP determinations under the All-Payer Combination Option and must submit to CMS payment amount and patient count data from other payers to support the determination.

- We propose to notify eligible clinicians of their QP status under the All-Payer Combination Option as soon as practicable after the proposed QP Determination Submission Deadline.

- We propose to make QP determinations under the All-Payer Combination Option at the individual eligible clinician level only.

- We propose to use the individual eligible clinician payment amounts and patient counts for Medicare in the All-Payer Combination Option. We propose that when the eligible clinician's Medicare Threshold Score calculated at the individual level would be a lower percentage than the one that is calculated at the APM Entity group level, we would apply a weighted methodology.

- We propose that we will determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model that has been determined to be an Other Payer Advanced APM at a sub-state level. We propose that we will use the county level to determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model an Other Payer Advanced APM at a sub-state level.

- We propose that in a state where we determine there are one or more Medicaid APMs or Medicaid Medical Home Models that are Other Payer Advanced APMs in operation, but only in certain counties, or only for eligible clinicians in certain specialties, we would further evaluate whether those Medicaid APMs or Medicaid Medical Home Models were available to each eligible clinician for whom we make a QP determination under the All-Payer Combination Option. We would identify the county in which the eligible clinician practices by having the eligible clinician submit that information to identify the county where they saw the most patients during the relevant All-Payer QP Performance Period when they request a QP determination. We also propose that if the eligible clinician's practice is in a county, or in a specialty, in which there is no Medicaid APM or Medicaid Medical Home Model in operation, all of that eligible clinician's Medicaid payments and patients would be excluded from the numerator and denominator of the calculations under the payment amount or patient count method, respectively. We also propose to identify Medicaid APM or Medicaid Medical Home Models that are only open to certain specialties through questions asked of states in the Payer Initiated Process and of eligible clinicians in the Eligible Clinician Initiated Process. We would use the method generally used in the Quality Payment Program to identify an eligible clinician's specialty or specialties.

- For the payment amount method we would first make a calculation under the Medicare Option using all Medicare payments for the APM Entity. If the minimum threshold score for the Medicare Option were met, we would make calculations under the All-Payer Combination Option. We propose that under the All-Payer Combination Option the numerator would be the

aggregate of all payments from all payers, except those excluded, that are made or attributable to the eligible clinician, under the terms of all Advanced APMs and Other Payer Advanced APMs. We also propose that the denominator would be the aggregate of all payments from all payers, except those excluded, that are made or attributed to the eligible clinician.

- For the patient count method under the All-Payer Combination Option, we propose to count each unique patient one time in the numerator and one time in the denominator across all payers to align with our finalized policy for patient counts at the eligible clinician level. We propose that the numerator would be the number of unique patients the eligible clinician furnishes services to under the terms of all of their Advanced APMs or Other Payer Advanced APMs. We propose that the denominator would be the number of unique patients the eligible clinician furnishes services to under all payers, except those excluded.

- We propose to collect the necessary payment amount and patient count information for QP determinations under the All-Payer Combination Option aggregated for the two proposed snapshot timeframes: from January 1 through March 31 and from January 1 through June 30. We propose that APM Entities may submit this information on behalf of any of the eligible clinicians in the APM Entity group at the individual eligible clinician level.

- We propose that if an APM Entity or eligible clinician submits sufficient information for either the payment amount or patient count method, but not for both, we will make a QP determination based on the one method for which we receive sufficient information.

- We propose that APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination, as well as the payment amount and patient count information sufficient for us to make QP determinations by December 1 of the calendar year that is 2 years to prior to the payment year, which we refer to as the QP Determination Submission Deadline.

- We propose that an APM Entity or eligible clinician who 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. In the case of information submitted by the APM Entity, we propose that the certification be made by an executive of the APM Entity. We also propose that this certification must accompany the form that APM Entities or eligible clinicians submit to us when requesting that we make QP determinations under the All-Payer Combination Option.

- We propose that APM Entities and eligible clinicians that submit information to CMS under §414.1445 for assessment under the All-Payer Combination Option or §414.1440 for QP determinations must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination, QP determinations, and the accuracy of APM Incentive Payments for a period of 10 years from the end of the All-Payer QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later.

- We propose that APM Entities and eligible clinicians that submit information to us under §414.1445 or §414.1440 must provide such information and supporting documentation to us upon request.

- We propose that, to the extent permitted by federal law, we will maintain confidentiality of the information that an APM Entity or eligible clinician submits to us for purposes of QP determinations under the All-Payer Combination Option, to avoid dissemination of potentially sensitive contractual information or trade secrets.

- We propose that eligible clinicians who are Partial QPs for the year under the All-Payer Combination Option would make the election whether to report to MIPS and then be subject to MIPS reporting requirements and payment adjustments.

We seek comment on these proposals.

7. Physician-Focused Payment Models (PFPMs)

a. Overview

Section 1868(c) of the Act established an innovative process for individuals and stakeholder entities (stakeholders) to propose physician-focused payment models (PFPMs) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC, established under section 1868(c)(1)(A) of the Act, is a federal advisory committee comprised of 11 members that provides advice to the Secretary. A copy of the PTAC's charter, established on January 5, 2016, is available at https://aspe.hhs.gov/charter-physician-focused-payment-model-technical-advisory-committee.

Section 1868(c)(2)(C) of the Act requires the PTAC to review stakeholders' proposed PFPMs, prepare comments and recommendations regarding whether such proposed PFPMs meet the PFPM criteria established by the Secretary, and submit those comments and recommendations to the Secretary. Section 1868(c)(2)(D) of the Act requires the Secretary to review the PTAC's comments and recommendations on proposed PFPMs and to post "a detailed response" to those comments and recommendations on the CMS website.

b. Definition of PFPM

(1) Definition of PFPM

In the CY 2017 Quality Payment Program final rule (81 FR 77555), we defined PFPM at §414.1465 as an Alternative Payment Model in which: Medicare is a payer; 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 the APM targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provide, order, or can significantly influence.

In the CY 2017 Quality Payment Program final rule (81 FR 77496) we finalized the requirement that PFPMs be tested as APMs with Medicare as a payer. We stated that a PFPM

could include other payers in addition to Medicare, but that other payer arrangements and Other Payer Advanced APMs are not PFPMs. Therefore, PFPM proposals would need to include Medicare as a payer.

In this proposed rule, we seek comment on whether to 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. A PFPM would then include Medicaid, CHIP, or Medicare (or some combination of these) as a payer. A PFPM might still include other payers in addition to Medicaid, CHIP, or Medicare; however, an other payer arrangement or Other Payer Advanced APM that includes only private payers, including a Medicare Advantage plan, would not be a PFPM. Medicare Advantage and other private plans paid to act as insurers on the Medicare program's behalf are considered to be private payers. The inclusion of Medicaid or CHIP as a payer would not imply the waiver of any requirements under Title XIX or Title XXI; PFPMs with Medicaid or CHIP as a payer would be required to follow all applicable regulations and requirements relevant to the approach they propose except those for which waivers are expressly provided under the terms of the PFPM in the event, and at the time, that the PFPM is implemented.

We believe broadening the definition of PFPM to include payment arrangements with Medicaid and CHIP, even if Medicare is not included in the payment arrangement, may complement the policies we are proposing within this rule for the All-Payer Combination Option. Broadening the definition of PFPM could potentially provide an opportunity for stakeholders to propose PFPMs to the PTAC that could be Other Payer Advanced APMs, and participation in such Other Payer Advanced APMs would contribute to an eligible clinician's ability to become a QP through the All-Payer Combination Option.

The PTAC's charge is to review submitted proposals and provide comments and recommendations to the Secretary regarding whether the proposals meet the PFPM criteria

established by the Secretary. The Secretary is then charged with reviewing and posting on the CMS website a detailed response to the PTAC's comments and recommendations.

Because the Secretary does not have authority to direct the design or development of payment arrangements that might be tested with private payers, we seek comment on, if we were to broaden the definition of PFPM, including in the scope of PFPMs only payment arrangements or models for which the Secretary and CMS could take subsequent action following the statutory PTAC review process.

We seek comment on whether broadening the definition of PFPMs would be inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population, such as pediatric issues or maternal health and whether changing the definition of PFPM may engage more stakeholders in designing PFPMs that include more populations beyond Medicare FFS beneficiaries. We seek comment on how the PFPM criteria could be applied to these payment arrangements. We seek comment on whether including more issues and populations fits within the PTAC's charge and whether stakeholders are interested in the opportunity to allow the PTAC to apply its expertise to a broader range of proposals for PFPMs.

The current definition of PFPM specifies that a PFPM is an APM. In the CY 2017 Quality Payment Program final rule (81 FR 77406), we noted that APM is defined under section 1833(z)(3)(C) of the Act as any of the following: (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. If a payment arrangement is a PFPM it must also be an APM. Under our current regulation, a model that does not meet the definition of APM is not a PFPM. However, a payment arrangement with Medicaid or CHIP as the payer, but not Medicare, would not necessarily meet the definition of APM. Therefore, we seek comment on whether we should, in tandem with potentially broadening the scope of PFPMs to include payment arrangements with

Medicaid and CHIP, require that a PFPM be an APM or a payment arrangement operated under legal authority for Medicaid or CHIP payment arrangements.

In the CY 2017 Quality Payment Program final rule (81 FR 77494), we stated that we anticipate PFPMs that are recommended by the PTAC and tested by CMS will be tested using section 1115A authority, although a model or payment arrangement does not need to be tested under section 1115A of the Act to be a PFPM. APMs tested under sections 1115A or 1866C of the Act, or demonstrations required by federal law, may include Medicaid or CHIP, but not necessarily Medicare, as a payer. We believe that because Medicaid and CHIP payment arrangements may be operated under other legal authorities than those included in the definition of APM, such as section 1115(a) waivers, section 1915(b) and (c) waivers, and state plan amendments, we may need to consider broadening the PFPM definition beyond APMs to correspond with potentially including Medicaid or CHIP as the only payer. We note that were our policy to change, PFPMs that are Medicaid or CHIP payment arrangements that fall outside the definition of APM would need to follow the processes and meet the requirements associated with the legal authorities on which they are based.

We believe it is important for PFPMs to include innovative payment methodologies. For that reason, we continue to believe that the definition of PFPM, as well as the PFPM criteria we established through rulemaking should apply exclusively to payment arrangements, and not to arrangements focused on care delivery reform without a payment reform component. We believe there are various statutory authorities outside of those specified in the definition of APM that might allow Medicaid and CHIP payment arrangements to be structured to address payment reform. We seek comment on whether states and stakeholders see value in having the definition of PFPM broadened to include payment arrangements with Medicaid or CHIP but not Medicare as a payer, and whether they see value in having proposals for PFPMs with Medicaid or CHIP but not Medicare as a payer go through the PTAC's review process.

(2) Relationship between PFPMs and Advanced APMs

Section 1868(c) of the Act does not require PFPMs to meet the criteria to be an Advanced APM for purposes of the incentives for participation in Advanced APMs under section 1833(z) of the Act, and we did not define PFPMs solely as Advanced APMs. Stakeholders may therefore propose as PFPMs either Advanced APMs or Medical Home Models, or other APMs. If we were to broaden the definition to include payment arrangements with Medicaid or CHIP but not Medicare as a payer, stakeholders could propose as PFPMs Medicaid APMs, Medicaid Medical Home Models, or other payer arrangements involving Medicaid or CHIP as a payer. We recognize that both stakeholders and the PTAC may want to discuss whether a proposed PFPM would be an Advanced APM in their proposals, comments, and recommendations.

c. PTAC Review Process of PFPM Proposals with Medicaid or CHIP as a Payer

In the CY 2017 Quality Payment Program final rule (81 FR 77491 through 77492), we described the roles of the Secretary, the PTAC, and CMS as they relate to PFPMs and the PTAC's review process. We believe that expanding the definition of PFPM to include Medicaid or CHIP as a payer, even when Medicare is not involved, might encourage innovation in additional areas and that stakeholders and states may benefit from the PTAC's review process.

We intend to continue to give serious consideration to proposed PFPMs recommended by the PTAC. Section 1868(c) of the Act does not require us to test proposals that are recommended by the PTAC. In the CY 2017 Quality Payment Program final rule (81 FR 77491), we explained that without being able to predict the volume, quality, or appropriateness of the proposed PFPMs on which the PTAC will make comments and recommendations, we are not in a position to commit to test all such models. We continue to believe this is the case. In addition, we acknowledge that any PFPMs with Medicaid or CHIP as a payer, as we are seeking comment on, could not be tested without significant coordination and cooperation with the state(s) involved. We could not ensure the agreement of the state(s) for which a PFPM is proposed with Medicaid

or CHIP as a payer, and therefore, similar to models with Medicare as the payer, we could not commit to testing these proposed payment arrangements. The Secretary and CMS must retain the ability to make final decisions on which PFPMs, whether they include Medicare as a payer or only include Medicaid or CHIP, are tested using section 1115A or section 1866C authority, and if so, when they are tested. Proposed PFPMs that the PTAC recommends to the Secretary but that are not immediately tested by us may be considered for testing at a later time.

We also could not speak to the length of time it would take a state to implement a PFPM with Medicaid or CHIP as a payer, or whether it would be shorter than the normal process for implementing a payment arrangement using Title XIX, Title XXI, or any other relevant legal authority.

The decision to test a model recommended by the PTAC that includes Medicare, Medicaid, or CHIP as a payer and is tested under section 1115A authority would not require submission of a second proposal to us; we would review the proposal submitted to the PTAC along with comments from the PTAC and the Secretary, and any other resources we believe would be useful. In order to further evaluate or proceed to test a proposed PFPM based on a recommendation from the PTAC under section 1115A authority, we may seek to obtain additional information based on the contents of the proposal. After a PFPM proposal has been recommended by the PTAC, if it is selected for further evaluation or testing under section 1115A authority, we may work with the individual stakeholders who submitted their proposals to consider design elements for testing the PFPM and make changes as necessary, to the extent that we are involved in the design and testing or operation of the PFPM. We note that if a PFPM we select for testing under section 1115A authority requires those interested to apply in order to participate, the stakeholder who submitted the proposal for a model to be established would still have to apply in order to participate in that model. PFPMs with Medicaid or CHIP as a payer

operated under legal authority other than 1115A would need to meet the requirements for that legal authority.

We believe that proposed PFPMs that include Medicare as a payer and that meet all of the PFPM criteria and are recommended by the PTAC may need less time to go through the development process; however, we cannot guarantee that the development process would be shortened, or estimate by how much it would be shortened. These processes depend on the nature of the PFPM's design, and any attempt to impose a deadline on them would not benefit stakeholders because it would not allow us to tailor the review and development process to the needs of the proposed PFPM. We could not speak to the length of time it would take a state to implement a PFPM with Medicaid or CHIP as a payer, or whether it would be shorter than the normal process. This would be true for Medicaid or CHIP payment arrangements tested using any legal authorities.

d. PFPM Criteria

In the CY 2017 Quality Payment Program final rule (81 FR 77496), we finalized the Secretary's criteria for PFPMs as required by section 1868(c)(2)(A) of the Act. The PFPM criteria are for the PTAC's use in discharging its duties under section 1868(c)(2)(C) of the Act to make comments and recommendations to the Secretary on proposed PFPMs.

We seek comment on the Secretary's criteria, including, but not limited to, whether the criteria are appropriate for evaluating PFPM proposals and are clearly articulated. In addition, we seek comment on stakeholders' needs in developing PFPM proposals that meet the Secretary's criteria. In particular, we want to know 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 how to gather supporting evidence for a PFPM proposal.

e. Summary

In summary, we seek comment on changing the definition of PFPM to include payment arrangements with Medicare, Medicaid or CHIP, or any combination of these, as a payer; and we seek comment on revising the definition to require that a PFPM be an APM or a payment arrangement operated under legal authority for Medicaid or CHIP payment arrangements. We also seek comments on the Secretary's criteria more broadly and stakeholders' needs in developing PFPM proposals that meet the Secretary's criteria.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to publish a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the required issues under section 3506(c)(2)(A) of the PRA for the following information collection requirements (ICRs).

Summary and Overview

The Quality Payment Program aims to do the following: (1) support care improvement by focusing on better outcomes for patients, decreased clinician burden, and preservation of independent clinical practice; (2) promote adoption of alternative payment models that align incentives across healthcare stakeholders; and (3) advance existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

The CY 2017 Quality Payment Program final rule established policies to implement MIPS, a program for certain eligible clinicians that makes Medicare payment adjustments based on performance on quality, cost and other measures and activities, and that consolidates

components of three precursor programs—the PQRS, the VM, and the Medicare EHR Incentive Program for eligible professionals. As prescribed by MACRA, MIPS focuses on the following: quality – including a set of evidence-based, specialty-specific standards; cost; practice-based improvement activities; and use of CEHRT to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.

In the CY 2017 Quality Payment Program final rule, we 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 CY 2017 Quality Payment Program final rule was approximately 11 million hours and a total labor cost of reporting of $1.311 million. The streamlining and simplification of data submission structures in the transition year resulted in a reduction in burden relative to the approved information collections for the legacy programs (PQRS and EHR Incentive Program for Eligible Professionals), which represented approximately 12 million hours for a total labor cost of reporting of $1.318 million. We estimate 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 CY 2017 Quality Payment Program final rule. The Quality Payment Program Year 2 reduction in burden based on this rule reflects several proposed policies, including our proposal for significant hardship or other type of exception, including a new significant hardship exception for small practices for the advancing care information performance category; our proposal to use a shorter version of the CAHPS for MIPS survey; our proposal to allow election of facility-based measurement for applicable MIPS eligible clinicians, thereby eliminating the need for additional quality data submission processes; and our proposal to allow MIPS eligible clinicians to form virtual groups which would create efficiencies in data submission.

In addition to the decline in burden due to the policies proposed in this rule, we anticipate further reduction in burden as a result of policies set forth in the CY 2017 Quality Payment Program final rule, including 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. We estimate 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. This expected growth is due in part to reopening of CPC+ and Next Generation ACO for 2018, and the ACO Track 1+ in response to public comments. These models are projected to have a large number of participants, the majority of whom are expected to reach QP status. Additional enrollees in currently active and new Advanced APMs are both considered in the growth estimate.

Our estimates assume clinicians who participated in the 2015 PQRS and who are not QPs in Advanced APMs in the 2017 Quality Payment Program performance period will continue to submit quality data as either MIPS eligible clinicians or voluntary reporters in the 2018 Quality Payment Program performance period. Our participation estimates are reflected in Table 65 for the quality performance category, Table 76 for the advancing information performance category, and Table 78 for the improvement activities performance category. We estimate that 36 percent of the 975,723 ineligible or excluded clinicians are expected to report voluntarily because they reported under PQRS. We expect them to continue to submit because (a) the collection and submission of quality data has been integrated into their clinician practice; and (b) the clinician types that were ineligible from MIPS in years 1 and 2 may

potentially become eligible in the future.

We also assume that previous PQRS participants who are not QPs will also submit under the improvement activities performance category, and will submit under the advancing care information performance category unless they receive a significant hardship or other type of exception, including a new significant hardship exception for small practices or are automatically assigned a weighting of zero percent for the advancing care information performance category. We are excluding the 110,159 QPs identified using a preliminary version of the file used for predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. Because we do not have an estimated participation status by TIN/NPI for clinicians who join Advanced APMs in 2017 and 2018, we cannot model the exclusion of the additional estimated 69,841 to 134,841 QPs clinicians that will become QPs for the 2018 performance period. Hence, these burden estimates may overstate the total burden for data submission under the quality, advancing care information, and improvement activities performance categories.

Our burden estimates assume that 36 percent of clinicians who do not exceed the low-volume threshold or are not eligible clinician types will voluntarily submit quality data under MIPS because they submitted quality data under the PQRS. Hence, the proposed changes in low-volume threshold will increase our estimate of the proportion of clinicians who will submit data voluntarily, but will not affect the estimated number of respondents. Section II.C.2.c. of this rule proposes a low-volume threshold of less than or equal to $90,000 in allowed Medicare Part B charges or less than or equal to 200 Medicare patients. The CY 2017 Quality Payment Program final rule established a low-volume threshold of less than or equal to $30,000 in allowed Medicare Part B charges or less than or equal to 100 Medicare patients.

The revised MIPS requirements and burden estimates for all ICRs listed below (except

for CAHPS for MIPS and virtual groups election) were submitted as a request for revision of OMB control number 0938-1314. The CAHPS for MIPS ICR was submitted as a request for revision of OMB control number 0938-1222. The virtual groups ICR has a 60 data day federal register notice (82 FR 27257) published on June 14, 2017. ICR-comments related to virtual group election are due on or before August 14, 2017.

A. Wage Estimates

To derive wage estimates, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). Table 58 in this proposed rule presents the mean hourly wage (calculated at 100 percent of salary), the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method. We have selected the occupations in Table 58 based on a study (Casalino et al., 2016) that collected data on the staff in physician's offices involved in the quality data submission process.[27]

In addition, to calculate time costs for beneficiaries who elect to complete the CAHPS for MIPS survey, we have used wage estimates for Civilian, All Occupations, using the same BLS data discussed in this section of the proposed rule. We have not adjusted these costs for fringe benefits and overhead because direct wage costs represent the "opportunity cost" to

[27]Lawrence P. Casalino et al., "US Physician Practices Spend More than $15.4 Billion Annually to Report Quality Measures," Health Affairs, 35, no. 3 (2016): 401-406.

beneficiaries themselves for time spent completing the survey. To calculate time costs for virtual groups to prepare their written formal agreements, we have used wage estimates for Legal Support Workers, All Others.

TABLE 58: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Billing and Posting Clerks	43-3021	$18.06	$18.06	$36.12
Computer Systems Analysts	15-1121	$44.05	$44.05	$88.10
Physicians	29-1060	$101.04	$101.04	$202.08
Practice Administrator (Medical and Health Services Managers)	11-9111	$52.58	$52.58	$105.16
Licensed Practical Nurse (LPN)	29-2061	$21.56	$21.56	$43.12
Legal Support Workers, All Other	23-2099	31.81	31.81	63.62
Civilian, All Occupations	Not applicable	$23.86	N/A	$23.86

Source: Occupational Employment and Wage Estimates May 2016, U.S. Department of Labor, Bureau of Labor Statistics. https://www.bls.gov/oes/current/oes_nat.htm

B. Framework for Understanding the Burden of MIPS Data Submission

Because of the wide range of information collection requirements under MIPS, 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. As shown in the first row of Table 59, MIPS eligible clinicians that are not in MIPS APMs and other clinicians voluntarily submitting data will submit data either as individuals, groups, or virtual groups to the quality, advancing care information, and improvement activities performance categories. For MIPS APMs, the organizations submitting data on behalf of participating MIPS eligible clinicians will vary across categories of data, and in some instances across APMs. For the 2018 MIPS performance period, the quality data submitted by Shared Savings Program ACOs, Next Generation ACOs, and Other MIPS APMs on behalf of their participant eligible clinicians will fulfill any MIPS submission requirements for the quality performance category.

For the advancing care information performance category, billing TINs will submit data

on behalf of participants who are MIPS eligible clinicians. For the improvement activities performance category, we will assume no reporting burden for MIPS APM participants because we will assign the improvement activities performance category score at the MIPS APM level and all APM Entity groups in the same MIPS APM will receive the same score. Advanced APM participants who are determined to be Partial QPs may incur additional burden if they elect to participate in MIPS, which is discussed in more detail in section II.D.5. of this proposed rule.

TABLE 59: Clinicians or Organizations Submitting MIPS Data on Behalf of Clinicians, by Type of Data and Category of Clinician

	Type of Data Submitted			
Category of Clinician	**Quality Performance Category**	**Advancing Care Information Performance Category**	**Improvement Activities Performance Category**	**Other Data submitted on behalf of MIPS eligible clinician**
MIPS Eligible Clinicians (not in MIPS APMs) and other clinicians voluntarily submitting data	As group, virtual groups, or individual clinicians	As group, virtual groups, or individuals. Clinicians who practice primarily in a hospital, ambulatory surgical center based clinicians, non-patient facing clinicians, PAs, NPs, CNSs and CRNAs are automatically eligible for a zero percent weighting for the advancing care information performance category. Clinicians approved for significant hardship exceptions are also eligible for a zero percent weighting.	As group, virtual groups, or individual clinicians	Groups electing to use a CMS-approved survey vendor to administer CAHPS must register. Groups electing to submit via CMS Web Interface for the first time must register. Virtual groups must register via email.
Facility-based clinicians and groups that elect facility-based measurement	Clinicians and groups electing facility-based measurement will receive a quality score based on their facility's Hospital VBP	Facility-based clinicians may be eligible for a zero percent weighting for the advancing care information category.	As groups, virtual groups, or individual clinicians.	Facility-based clinicians that elect facility-based measurement make the election online.

Category of Clinician	Type of Data Submitted			
	Quality Performance Category	**Advancing Care Information Performance Category**	**Improvement Activities Performance Category**	**Other Data submitted on behalf of MIPS eligible clinician**
	data submission. The burden has been previously counted under the Hospital VBP rule, and is not included in burden estimates here.			
Eligible Clinicians participating in the Shared Savings Program or Next Generation ACO Model (both MIPS APMs)	ACOs submit to the CMS Web Interface on behalf of their participating MIPS eligible clinicians. [Not included in burden estimate because quality data submission to fulfill requirements of the Shared Savings Program and Next Generation ACO models are not subject to the Paperwork Reduction Act].[28]	Each group TIN in the APM Entity reports advancing care information to MIPS.[29]	CMS will assign the same improvement activities performance category score to each APM Entity group based on the activities involved in participation in the Shared Savings Program.[30] [The burden estimates assume no improvement activity reporting burden for APM participants.]	Advanced APM Entities will make election for participating MIPS eligible clinicians.
Eligible Clinicians participating in Other MIPS APMs	MIPS APM Entities submit to MIPS on behalf of their participating MIPS eligible clinicians [Not included in burden estimate because quality data submission	Each MIPS eligible clinician in the APM Entity reports advancing care information to MIPS through either group TIN or individual reporting. [The burden estimates assume group TIN-level	CMS will assign the same improvement activities performance category score to each APM Entity based on the activities involved in participation in the MIPS APM.	Advanced APM Entities will make election for participating eligible clinicians.

[28]Sections and 3021 and 3022 of the Affordable Care Act state the Shared Savings Program and testing, evaluation, and expansion of Innovation Center models are not subject to the Paperwork Reduction Act (42 U.S.C. 1395jjj and 42 U.S.C. 1315a(d)(3), respectively)

[29]For MIPS APMs other than the Shared Savings Program, both group TIN and individual clinician advancing care information data will be accepted. If both group TIN and individual scores are submitted for the same MIPS APM Entity, CMS would take the higher score for each TIN/NPI. The TIN/NPI scores are then aggregated for the APM Entity score.

[30] APM Entities participating in MIPS APMs do not need to submit improvement activities data unless the CMS-assigned improvement activities scores is below the maximum improvement activities score

	Type of Data Submitted			
Category of Clinician	**Quality Performance Category**	**Advancing Care Information Performance Category**	**Improvement Activities Performance Category**	**Other Data submitted on behalf of MIPS eligible clinician**
	to fulfill requirements of Innovation Center models are not subject to the Paperwork Reduction Act.]	reporting].	[The burden estimates assume no improvement activities performance category reporting burden for APM participants].	

The policies finalized in the CY 2017 Quality Payment Program final rule and proposed in this rule create some additional data collection requirements not listed in Table 59. These additional data collections, some of which were previously approved by OMB under control numbers 0938-1314 and 0938-1222 are as follows:

- Self-nomination of new and returning QCDRs and registries (0938-1314).
- CAHPS for MIPS survey completion by beneficiaries (0938-1222).
- Approval process for new and returning CAHPS for MIPS survey vendors.
- Call for new improvement activities.
- Other Payer Advanced APM identification: other payer initiated process.
- Opt out of performance data display on Physician Compare for voluntary reporters under MIPS.

C. ICR Regarding Burden for Virtual Group Election (§414.1315)

As described in section II.C.4.b. of this proposed rule, virtual groups are defined by a combination of two or more TINs and must report as a virtual group on measures in all quality, improvement activities, and advancing care information performance categories as virtual groups. Virtual groups may submit data through any of the mechanisms available to groups. We refer to section II.C.4. on additional requirements for virtual groups.

We propose an optional 2-stage process for enrollment. In stage 1, MIPS eligible clinicians have the option to request a determination of their eligibility to form a virtual group before they form a group and begin the stage 2 submission of an election to participate in a virtual group. For clinicians or groups that do not choose to participate in stage 1 of the election process, we will make an eligibility determination during stage 2 of the election process. We refer readers to section II.C.4.e. of this proposed rule for a discussion of the proposed virtual group election process.

As proposed in II.C.4.e. of this proposed rule, the submission of a virtual group election must include, at a minimum, detailed information pertaining to each TIN and NPI associated with the virtual group and detailed information for the virtual group representative, as well as confirmation of a written formal agreement between members of the virtual group.

We assume that virtual group participation will be relatively low in the first year because we have heard from stakeholders that they need at least 3-6 months to form groups and establish agreements before signing up. We are not able to give them that much time in the first year, rather closer to 60 days. Because of this we expect the number of virtual groups will be very small in the first year of virtual group implementation. Our assumptions for participation in a virtual group are shown in Table 60. We assume that only those eligible clinicians that reported historically will participate in virtual groups in the first year because of the limited lead time to create processes. Also, while virtual groups may use the same submission mechanisms as groups, we are estimating based on stakeholder feedback that the 16 virtual groups reflected in Table 60 will report by registry. Table 60 also shows that we estimate that approximately 765 MIPS eligible clinicians will decide to join 16 virtual groups for the 2018 MIPS performance period. The virtual groups could range in size from a few clinicians to hundreds of clinicians, as long as each participant is a solo practice or TIN with 10 or fewer eligible clinicians. In order to estimate the number of clinicians available to participate in virtual groups, we used the data

prepared to support the 2017 performance period initial determination of clinician eligibility (available via the NPI lookup on qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016. We also used the initial small practice determinations made on the same date range. We estimated the number of clinicians who would not participate due to being a QP using a version of the file used for the predictive qualifying Alternative Payment Model participants (QP) analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. We assume an average of 5 TINs per virtual group with an average of 9.5 clinicians in each TINs across each virtual group or approximately 48 eligible clinicians per virtual group (5 TINs x 9.5 clinicians per TIN). For purposes of this burden estimate for the 2018 MIPS performance period, we assumed that approximately one percent of eligible clinicians will participate in approximately 16 virtual groups consisting of approximately 5 TINs per virtual group will be formed (765 MIPS eligible clinicians ÷ 48 eligible clinicians per virtual group) or 80 TINs total that will participate in virtual groups (16 virtual groups X 5 MIPS eligible clinicians per TIN).

We assume that the virtual election process will require 10 hours per virtual group, similar to the burden of the QCDR or registry self-nomination process finalized in §414.1400. We assume that 8 hours of the 10 burden hours per virtual group will be computer systems analyst's time or the equivalent with an average labor cost of $88.10/hour, and an estimated cost of $704.80 per virtual group ($88.10/hour X 8 hours). We also assume that 2 hours of the 10 burden hours per virtual group will be legal support services professionals assisting in formulating the written virtual agreement with an average labor cost of $63.62/hour, with a cost of $127.24 per virtual group ($63.62/hour X 2 hours). Therefore, the total burden cost per virtual group associated with the election process is $832.04 ($704.80 + $127.24). We also assume that 16 new virtual groups will go through the election process leading to a total burden of $13,313

($832.04 X 16 virtual groups). We estimate that the total annual burden hours will be 160 (16 virtual groups X 10 hours).

TABLE 60: Estimated Burden for Virtual Group Election Process

	Burden Estimate
Total Estimated Number of MIPS eligible clinicians in TINs of 10 eligible clinicians or fewer submitting data in MIPS (a)	765
Total Estimated Number of eligible TINs (10 eligible clinicians or fewer) (b)	80
Estimated # of Virtual Groups (c)	16
Estimated Total Annual Burden Hours for Virtual Group to prepare written formal agreement (d)	2
Estimated Total Annual Burden Hours for Virtual Group Representative to Submit Application to Form Virtual Group (e)	8
Estimated Total Annual Burden Hours per Virtual Group (f)	10
Estimated Total Annual Burden Hours for Virtual Groups (g) = (c)*(f)	**160**
Estimate Cost to Prepare Formal Written Agreement (@ legal support services professional's labor rate of $63.62) (h)	$127.24
Estimated Cost to Elect Per Virtual Group (@ computer systems analyst's labor rate of $88.10/hr.) (i)	$704.80
Estimated Total Annual Burden Cost Per Virtual Group (j)	$832.04
Estimated Total Annual Burden Cost (k) = (c)*(j)	**$13,313**

While the formation of virtual groups will result in a burden for virtual group registration, we also estimate that the formation of virtual groups will result in a decline in burden from other forms of data submission. Because we assume burden is the same for each organization (group, virtual group, or eligible clinician) submitting quality, improvement activities or advancing care information performance category data, virtual groups will reduce burden by reducing the time needed to prepare data for submission, review measure specifications, register or elect to submit data via a mechanism such as QCDR, registry, CMS Web Interface, or EHR. This reduction in burden is described in each of the quality, improvement activities, and advancing care information performance category sections below.

As stated earlier, the information collection request for the virtual group election process will be submitted for OMB review and approval separately from this rulemaking process. Please note that the 60-day Federal Register notice already published on June 14, 2017 (82 FR 27257) and the related comment period ends August 14, 2017. When the 30-day Federal Register notice publishes, it will not only announce that we are formally submitting the

information collection request to OMB but it will also inform the public on its additional opportunity to review the information collection request and submit comments.

D. ICR Regarding Burden for Election of Facility-Based Measurement (§414.1345)

In section II.C.7.a.(4) of this proposed rule, we propose that for the 2020 MIPS payment year (2018 MIPS performance period), we would allow facility-based MIPS eligible clinicians to be given a MIPS score in the quality and cost performance categories that is based on the performance of the facility in which they provide services. We propose at §414.1380(e)(2)(i) that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they furnish 75 percent or more of their covered professional services (as defined in section 1848(k)(3)(A) of the Act) in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, as identified by place of service code 21, and the emergency room, as identified by place of service code 23, based on claims for a period prior to the performance period as specified by CMS.

These MIPS eligible clinicians may elect to participate in facility-based measurement during the performance period. For the 2020 MIPS payment year (2018 MIPS performance period), we will base our assumptions for these eligible clinicians on the Hospital VBP Program.

In Table 61, we estimate participation in facility-based measurement, based on 2015 data from the PQRS and the first 2019 payment year MIPS eligibility and special status file as described in 81 FR 77069 and 77070.[31] We estimate 18,207 respondents (17,943 MIPS eligible clinicians who practice primarily in the hospital electing as individuals and 264 groups with 75 percent or more of their clinicians qualifying as clinicians who practice primarily in the

[31] The data used for our estimates defined hospital-based clinicians as those who furnish 75 percent or more of their covered professional service in sites of service identified by place service codes 21, 22, or 23. The proposal defines facility-based clinicians as those who furnish 75 percent or more of their covered professional service in sites of service identified by place service codes 21 and 23.

hospital) will elect facility-based measurement in the 2018 MIPS performance period. We estimate that the 17,943 individual clinicians electing facility-based scoring are comprised of 20 percent (10,353) of a total of the approximately 51,767 of clinicians who practice primarily in the hospital that previously submitted as individuals in the 2017 MIPS performance period; 80 percent (7,590) of a total of 9,488 clinicians who practice primarily in the hospital that we estimate will not have submitted in the 2017 MIPS performance period. We believe that the 80 percent (7,590) of the total 9,488 would not have submitted in the 2017 MIPS performance period because of the additional effort required to report MIPS measures in addition to measures required for the Hospital Value-Based Purchasing program. We have heard this from hospitalists and other clinicians and we believe that the inclusion of this opportunity within MACRA was in response to this concern. We estimate that 20 percent (or 264) of groups that would have previously submitted on behalf of clinicians in the 2017 MIPS performance period will elect facility-based measurement on behalf of their 12,125 clinicians.

TABLE 61: Estimated Number of Individual Clinicians and Groups Who Practice Primarily in the Hospital to Elect Facility-Based Measurement

	Counts
Estimated # of clinicians who practice primarily in the hospital that previously submitted as individuals under the 2017 MIPS performance period to elect facility-based measurement in the 2018 MIPS performance period (a)	10,353
Estimated # of clinicians who practice primarily in the hospital that did not submit under the 2017 MIPS performance period to elect facility-based measurement as individuals in the 2018 MIPS performance period (b)	7,590
Estimated # of clinicians who practice primarily in the hospital to elect facility-based measurement as individuals in the 2017 MIPS performance period (c)= (a)+ (b)	17,943
Estimated # of clinicians who practice primarily in the hospital that previously submitted as groups under the 2017 MIPS performance period to elect facility-based measurement in the 2018 MIPS performance period (d)	12,125
Estimated # of groups who practice primarily in the hospital that previously submitted on behalf of clinicians as groups under the 2017 MIPS performance period to elect facility-based measurement in the 2018 MIPS performance period (e)	264
Estimated # of respondents that elect facility-based measurements (including individual clinicians who practice primarily in the hospital electing facility-based measurement and groups electing facility-based measurement) (f)=(c)+(e)	**18,207**

Although the election of facility-based measurement generates burden, it will also result in the reduction of burden in the quality performance category because certain clinicians and

groups will no longer be required to submit data for this category. Hence, our burden estimates for the quality performance category consider the reduction in burden for clinicians who practice primarily in the hospital that previously submitted data for this performance category and elected to use facility-based measurement. The reduction in burden is described in the quality performance category section below. We assume that there will be no reduction in burden related to the advancing care information performance category because MIPS eligible clinicians who practice primarily in the hospital are not required to submit data for this performance category.

As shown in Table 62, we estimate that the election to participate via facility-based measurement will take 1 hour of staff time, comparable to the CMS Web Interface registration process. We assume that the staff involved in the election process to participate via facility-based measurement will mainly be billing clerks or their equivalent, who have an average labor cost of $36.12/hour. Therefore, assuming the total burden hours per group or individual clinician associated with the election process is 1 hour, the total annual burden hours are 18,207 (18,207 groups or individual clinicians X 1 hour). We estimate that the total cost to groups and individual clinicians associated with the election process will be approximately $36.12 ($36.12 per hour X 1 hour per group or eligible clinician). We also assume that 18,207 individual clinicians or groups will go through the election process leading to a total burden of $657,637 ($36.12 X 18,207 clinicians).

TABLE 62: Estimated Burden for Election to Participate in Facility-Based Measurement

	Burden Estimate
Estimated # of respondents to elect facility-based measurements (including individual clinicians who practice primarily in the hospital electing facility-based measurement and groups electing facility-based measurement) (a)	18,207
Estimated # of Burden Hours Per Group or Eligible Clinician to Elect Facility-based Measurement (b)	1
Estimated Total Annual Burden Hours (c) = (a)*(b)	18,207

Estimated Cost Per Clinician or Group Practice to Elect Facility-Based Measurement (@ billing clerk's labor rate of $36.12/hr.) (d)	$36.12
Estimated Total Annual Burden Cost (e) = (c)*(d)	$657,637

E. ICRs Regarding Burden for Third Party Reporting (§414.1400)

Under MIPS, quality, advancing care information, and improvement activities performance category data may be submitted via relevant third party intermediaries, such as qualified registries, QCDRs and health IT vendors. The CAHPS for MIPS survey data, which counts as one quality performance category measure, can be submitted via CMS-approved survey vendors. The burdens associated with qualified registry and QCDR self-nomination and the CAHPS for MIPS survey vendor applications are discussed below.

1. Burden for Qualified Registry and QCDR Self-Nomination[32]

For the 2017 MIPS performance period, 120 qualified registries and 113 QCDRs were qualified to report quality measures data for purposes of the PQRS, an increase from 114 qualified registries and 69 QCDRs in CY 2016.[33] Under MIPS, we believe that the number of QCDRs and qualified registries will continue to increase because: (1) many MIPS eligible clinicians will be able to use the qualified registry and QCDR for all MIPS submission (not just for quality submission) and (2) QCDRs will be able to provide innovative measures that address practice needs. Qualified registries or QCDRs interested in submitting quality measures results and numerator and denominator data on quality measures to us on their participants' behalf will need to complete a self-nomination process to be considered qualified to submit on behalf of MIPS eligible clinicians or groups, unless the qualified registry or QCDR was qualified to submit on behalf of MIPS eligible clinicians or groups for prior program years and did so

[32]We do not anticipate any changes in the CEHRT process for health IT vendors as we transition to MIPS. Hence, health IT vendors are not included in the burden estimates for MIPS.

[33]The full list of qualified registries for 2017 is available at https://qpp.cms.gov/docs/QPP_MIPS_2017_Qualified_Registries.pdf and the full list of QCDRs is available at https://qpp.cms.gov/docs/QPP_2017_CMS_Approved_QCDRs.pdf.

successfully.

We estimate that the self-nomination process for qualifying additional qualified registries or QCDRs to submit on behalf of MIPS eligible clinicians or groups for MIPS will involve approximately 1 hour per qualified registry or QCDR to complete the online self-nomination process. The self-nomination form is submitted electronically using a web-based tool. We are proposing to eliminate the option of submitting the self-nomination form via email that was available in the transition year.

In addition to completing a self-nomination statement, qualified registries and QCDRs will need to perform various other functions, such as meeting with CMS officials when additional information is needed. In addition, QCDRs calculate their measure results. QCDRs must possess benchmarking capability (for non-MIPS quality measures) that compares the quality of care a MIPS eligible clinician provides with other MIPS eligible clinicians performing the same quality measures. For non-MIPS measures the QCDR must provide to us, if available, data from years prior (for example, 2016 data for the 2018 MIPS performance period) before the start of the performance period. In addition, the QCDR must provide to us, if available, the entire distribution of the measure's performance broken down by deciles. As an alternative to supplying this information to us, the QCDR may post this information on their website prior to the start of the performance period, to the extent permitted by applicable privacy laws. The time it takes to perform these functions may vary depending on the sophistication of the entity, but we estimate that a qualified registry or QCDR will spend an additional 9 hours performing various other functions related to being a MIPS qualified registry or QCDR.

As shown in Table 63, we estimate that the staff involved in the qualified registry or QCDR self-nomination process will mainly be computer systems analysts or their equivalent, who have an average labor cost of $88.10/hour. Therefore, assuming the total burden hours per

qualified registry or QCDR associated with the self-nomination process is 10 hours, the annual burden hours is 2,330 (233 (113 + 120) QCDRs or qualified registries X 10 hours). We estimate that the total cost to a qualified registry or QCDR associated with the self-nomination process will be approximately $881.00 ($88.10 per hour X 10 hours per qualified registry). We also estimate that 233 qualified registries or QCDRs will go through the self-nomination process leading to a total burden of $205,273 ($881.00 X 233).

The burden associated with the qualified registry and QCDR submission requirements in MIPS will be the time and effort associated with calculating quality measure results from the data submitted to the qualified registry or QCDR by its participants and submitting these results, the numerator and denominator data on quality measures, the advancing care information performance category, and improvement activities data to us on behalf of their participants. We expect that the time needed for a qualified registry to accomplish these tasks will vary along with the number of MIPS eligible clinicians submitting data to the qualified registry or QCDR and the number of applicable measures. However, we believe that qualified registries and QCDRs already perform many of these activities for their participants. We believe the estimate noted in this section represents the upper bound of QCDR burden, with the potential for less additional MIPS burden if the QCDR already provides similar data submission services.

Based on the assumptions previously discussed, we provide an estimate of total annual burden hours and total annual cost burden associated with a qualified registry or QCDR self-nominating to be considered "qualified" to submit quality measures results and numerator and denominator data on MIPS eligible clinicians.

TABLE **63: Estimated Burden for QCDR and Registry Self-Nomination**

	Burden Estimate
Estimated # of Qualified registries or QCDRs Self-Nominating (a)	233
Estimated Total Annual Burden Hours Per Qualified Registry or QCDR (b)	10

	Burden Estimate
Estimated Total Annual Burden Hours for Qualified Registries or QCDRs (c) = (a)*(b)	**2,330**
Estimated Cost Per Qualified Registry or QCDR (@ computer systems analyst's labor rate of $88.10/hr.) (d)	$881.00
Estimated Total Annual Burden Cost for Qualified registries or QCDRs (e) = (a)*(d)	**$205,273**

2. Burden for CAHPS for MIPS Survey Vendors

In the CY 2017 Quality Payment Program final rule (81 FR 77386), we finalized the definition, criteria, required forms, and vendor business requirements needed to participate in MIPS as a survey vendor. For purposes of MIPS, we defined a CMS-approved survey vendor at §414.1305 as a survey vendor that is approved by us for a particular performance period to administer the CAHPS for MIPS survey and transmit survey measures data to us. At §414.1400(i), we require that vendors undergo the CMS-approval process each year in which the survey vendor seeks to transmit survey measures data to us. We finalized the criteria for a CMS-approved survey vendor for the CAHPS for MIPS survey.

We estimate that it will take a survey vendor 10 hours to submit the information required for the CMS-approval process, including the completion of the Vendor Participation Form and compiling documentation, including the quality assurance plan,that demonstrates that they comply with Minimum Survey Vendor Business Requirements. This is comparable to the burden of the QCDR and qualified registry self-nomination process. As shown in Table 64, we assume that the survey vendor staff involved in collecting and submitting the information required for the CAHPS for MIPS certification will be computer systems analysts, who have an average labor cost of $88.10/hour. Therefore, assuming the total burden hours per CAHPS associated with the application process is 10 hours, the annual burden hours is 150 (15 CAHPS vendors X 10 hours). We estimate that the total cost to each CAHPS vendor associated with the application process will be approximately $881.00 ($88.10 per hour X 10 hours per CAHPS vendor). We estimate that 15 CAHPS vendors will go through the process leading to a

total burden of $13,215 ($881.00 X 15 CAHPS vendors).

Based on the assumptions previously discussed, we provide an estimated number of total annual burden hours and total annual cost burden associated with the survey vendor approval process in Table 64.

TABLE 64: Estimated Burden for CAHPS Survey Vendor Application

	Burden Estimate
Estimated # of New CAHPS Vendors Applying (a)	15
Estimated # of Burden Hours Per Vendor to Apply (b)	10
Estimated Cost Per Vendor Reporting (@ computer systems analyst's labor rate of $88.10/hr.) (c)	$881.00
Estimated Total Annual Burden Hours (d) = (a)*(b)	**150**
Estimated Total Annual Burden Cost for CAHPS Vendor Application Process (e) = (a)*(c)	**$13,215**

F. ICRs Regarding the Quality Performance Category (§414.1330 and §414.1335)

Two groups of clinicians will submit quality data under MIPS: those who submit as MIPS eligible clinicians, and other clinicians who opt to submit data voluntarily but will not be subject to MIPS payment adjustments.

Historically, the PQRS has never experienced 100 percent participation; the participation rate for 2015 was 69 percent. For purposes of these analyses, we assume that clinicians who participated in the 2015 PQRS and who are not QPs in Advanced APMs in the 2017 Quality Payment Program performance period will continue to submit quality data as either MIPS eligible clinicians or voluntary reporters in the 2018 MIPS performance period. In addition, as shown in Table 62, regarding our burden estimates for election of facility-based measurement, we assume that approximately 18,207 individual clinicians or groups will elect to participate in facility-based measurement for the 2018 MIPS performance period and will not be required to submit any additional quality performance category data under MIPS. Based on 2015 data from the PQRS, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on

qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016, and a version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. We estimate that at least 92 percent of MIPS eligible clinicians not participating in MIPS APMs will submit quality performance category data including those participating as individual clinicians, groups, or virtual groups. We assume that 100 percent of MIPS APM Entities will submit quality data to CMS as required under their models.[34] We anticipate that the professionals submitting data voluntarily will include clinicians that are ineligible for the Quality Payment Program, clinicians that do not exceed the low-volume threshold, and newly enrolled Medicare clinicians. Based on those assumptions, using data from the 2015 PQRS, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov), and a preliminary version of the file used for the predictive QP analysis made available on qpp.cms.gov on June 2, 2017, we estimate that an additional 292,351 clinicians, or 36 percent of clinicians excluded from or ineligible from MIPS, will submit MIPS quality data voluntarily. Because in the projected growth in the number of QPs over time, we are predicting a decline in the rate of voluntary quality data submission among clinicians excluded from or ineligible for MIPS relative to our estimated voluntary reporting rate of 45 percent in the CY 2017 Quality Payment Program final rule. Historically, clinicians who are expected to be QPs in 2018 MIPS performance period were much more likely to have submitted quality data under the 2015 PQRS than other clinicians excluded from or ineligible from MIPS. Due to data limitations, our assumptions about quality performance category participation for the purposes of our burden estimates differs from our assumptions about

[34]We estimate that 110,159 clinicians that participated in the 2015 PQRS will be QPs who will not be not required to submit MIPS quality performance category data under MIPS, and are not included in the numerator or denominator of our participation rate.

quality performance category participation in the impact analysis.[35]

Our burden estimates for data submission combine the burden for MIPS eligible clinicians and other clinicians submitting data voluntarily. Apart from clinicians who practice primarily in the hospital electing facility-based measurement and clinicians that became QPs in the first QP performance period, we assume that clinicians will continue to submit quality data under the same submission mechanisms that they used under the 2015 PQRS. As discussed in more detail in the section of this proposed rule describing the burden for facility-based measurement (III.D.), we assume that some eligible clinicians who practice primarily in the hospital will elect facility-based measurement, rather than submit quality data via other mechanisms. Further, as discussed in more detail in the section of this proposed rule describing the burden for the virtual group application process (III.C.), we assume that the approximately 80 TINs that elect to form the approximately 16 virtual groups will continue to use the same submission mechanism as under the 2015 PQRS, but the submission will be at the virtual group, rather than group level. Our burden estimates for the quality performance category do not include the burden for the quality data that MIPS APM Entities submit to fulfill the requirements of their models. Sections 3021 and 3022 of the Affordable Care Act state the Shared Savings Program and the testing, evaluation, and expansion of Innovation Center models are not subject to the Paperwork Reduction Act (42 U.S.C. §1395jjj and 42 U.S.C. §1315a(d)(3), respectively).[36] Tables 65, 66, and 67 explain our revised estimates of the number of organizations (including groups, virtual groups, and individual MIPS eligible clinicians) submitting data on behalf of clinicians via each of the quality submission

[35]As noted, the COI section of this rule uses the actual overall average participation rate of 92 percent in quality data submission based on 2015 PQRS data. The RIA section of this rule uses the actual participation rate for practices with more than 15 clinicians and assumes a minimum 90 percent participation (standard assumption or 80 percent participation (alternative assumption) for practices with 1-15 clinicians.

[36]Our estimates do reflect the burden that MIPS APM participants of submitting advancing care information data, which is outside the requirements of their models.

mechanisms. The proposed policies related to both virtual groups and facility-based measurement are reflected, as is the proposed policy to score quality measures submitted via multiple submission mechanisms.

Table 65 provides our estimated counts of clinicians that will submit quality performance category data as MIPS individual clinicians, groups, or virtual groups in the 2018 MIPS performance period. The first step was to estimate the number of clinicians to submit as an individual clinician or group via each mechanism during the 2017 MIPS performance period using 2015 PQRS data on individuals and groups submitting through various mechanisms and excluding clinicians identified as QPs in a preliminary version of the file used for the predictive qualifying APM participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. The second step was to subtract out the estimated number of clinicians who practice primarily in the hospital to elect facility-based scoring as groups or individuals in the 2018 MIPS performance period. Further detail on our methods to estimate the number of clinicians who practice primarily in the hospital to elect facility-based scoring as individual clinicians or groups is provided on the burden for the election of facility-based measurement (section III.D. of this proposed rule).

Based on these methods, Table 65 shows that in the 2018 MIPS performance period, an estimated 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.

Our estimated numbers of clinicians to submit as individual clinicians, groups, or virtual groups via each submission mechanism account for the policy proposed under section

II.C.6.a.(1) of this rule 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 65: Estimated Number of Clinicians Submitting Quality Performance Category Data by Mechanism

	Claims	QCDR/ registry	EHR	CMS Web Interface
Estimated number of clinicians to submit via mechanism (as individual clinicians, groups, or virtual groups) in Quality Payment Program Year 1 (excludes QPs) (a)	371,987	236,908	118,395	101,939
Subtract out: Estimated number of clinicians to submit via mechanism (as individual clinicians, groups or virtual groups) in Quality Payment Program Year 1 that will opt for facility-based scoring in Quality Payment Program Year 2 (b)	7,985	11,339	3,154	0
Estimated number of clinicians to submit via mechanism (as individual clinicians or groups) in Quality Payment Program Year 2 (excludes QPs and facility-based measurement) (c) = (a)-(b)	364,002	225,569	115,241	101,939

Table 65 provides estimates of the number of clinicians to submit quality measures via each mechanism, regardless of whether they decide to submit as individual clinicians or as part of groups or virtual groups. Because our burden estimates for quality data submission assume that burden is reduced when clinicians elect to submit as part of a group or virtual group, we also separately estimate the expected number of clinicians to submit as individuals or part of groups or virtual groups.

Table 66 uses methods similar to those described for Table 65 to estimate the number of clinicians to submit as individual clinicians via each mechanism in Quality Payment Program Year 2. We estimate that approximately 364,002 clinicians will submit as individuals via claims submission mechanisms; approximately 86,046 clinicians will submit as individuals via qualified registry or QCDR submission mechanisms; and approximately 60,253 clinicians will

submit as individuals via EHR submission mechanisms. Individual clinicians cannot elect to submit via CMS Web Interface. Consistent with the proposed policy to allow individual clinicians to be scored on quality measures submitted via multiple mechanisms, our columns in Table 66 are not mutually exclusive.

TABLE 66: Estimated Number of Clinicians Submitting Quality Performance Category Data as Individuals

	Claims	QCDR/ registry	EHR	CMS Web Interface
Estimated number of Clinicians to submit data as individuals in Quality Payment Program Year 1 (excludes QPs) (a)	371,987	88,078	60,589	0
Subtract out: Estimated number of clinicians to submit via mechanism as individuals in Quality Payment Program Year 1 that will opt for facility-based scoring in Quality Payment Program Year 2 (b)	7,985	2,032	336	0
Estimated number of clinicians to submit via mechanism as individuals in Quality Payment Program Year 2 (excludes QPs and facility-based measurement) (c)=(a)-(b)	364,002	86,046	60,253	0

Table 67 provides our estimated counts of groups or virtual groups to submit quality data on behalf of clinicians via each mechanism in the 2018 MIPS performance period and reflects our assumption that the formation of virtual groups will reduce burden. Except for groups who practice primarily in the hospital electing facility-based measurement and groups comprised entirely of QPs, we assume that groups that submitted quality data as groups under the 2015 PQRS will continue to submit quality data either as groups or virtual groups via the same submission mechanisms in the 2018 MIPS performance period. The first step in estimating the numbers of groups or virtual groups to submit via each mechanism in the 2018 MIPS performance period was to estimate the number of groups to submit on behalf of clinicians via each mechanism in the 2017 MIPS performance period. We used 2015 PQRS data on groups submitting on behalf of clinicians via various mechanisms and excluded groups comprised entirely of QPs in a preliminary version of the file used for the predictive qualifying

Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016. The second step was to subtract out the estimated number of groups who practice primarily in the hospital that will elect facility-based measurement. Further detail on our methods to estimate the number of groups who practice primarily in the hospital to elect facility-based scoring on behalf of clinicians is provided in section III.D. of this proposed rule, on the burden for the election of facility-based measurement. The third and fourth steps in Table 67 reflect our assumption that virtual groups will reduce the burden for quality data submission by reducing the number of organizations to submit quality data on behalf of clinicians. We assume that 40 groups that previously submitted on behalf of clinicians via QCDR or qualified registry submission mechanisms will elect to form 8 virtual groups that will submit via QCDR and qualified registry submission mechanisms. We assume that another 40 groups that previously submitted on behalf of clinicians via EHR submission mechanisms will elect to form another 8 virtual groups via EHR submission mechanisms. Hence, the third step in Table 67 is to subtract out the estimated number of groups under each submission mechanism that will elect to form virtual groups, and the fourth step in Table 67 is to add in the estimated number of virtual groups that will submit on behalf of clinicians via each submission mechanism.

Specifically, we assumed that 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. Groups cannot elect to submit via claims submission mechanism.

TABLE 67: Estimated Number of Groups and Virtual Groups Submitting Quality Performance Category Data by Mechanism **on Behalf of Clinicians**

	Claims	QCDR/ registry	EHR	CMS Web Interface
Estimated number of groups to submit via mechanism (on behalf of clinicians) in Quality Payment Program Year 1 (excludes QPs) (a)	0	2,672	928	298
Subtract out: Estimated number groups to submit via mechanism on behalf of clinicians in Quality Payment Program Year 1 that will opt for facility-based scoring in Quality Payment Program Year 2 (b)	0	185	79	0
Subtract out: Estimated number groups to submit via mechanism on behalf of clinicians in Quality Payment Program Year 1 that will submit as Virtual Groups in Quality Payment Program Year 2 (c)	0	40	40	0
Add in: Estimated number of virtual groups to submit via mechanism on behalf of clinicians in Quality Payment Program Year 2 (d)	0	8	8	0
Estimated number groups to submit via mechanism on behalf of clinicians in Quality Payment Program Year 2 (e)=(a)-(b)-(c)+(d)	0	2,455	817	298

These burden estimates have some limitations. We believe it is difficult to quantify the burden accurately because clinicians and groups may have different processes for integrating quality data submission into their practices' work flows. Moreover, the time needed for a clinician to review quality measures and other information, select measures applicable to their patients and the services they furnish, and incorporate the use of quality data codes into the office workflows is expected to vary along with the number of measures that are potentially applicable to a given clinician's practice. Further, these burden estimates are based on historical rates of participation in the PQRS program, and the rate of participation in MIPS are expected to differ.

We believe the burden associated with submitting the quality measures will vary depending on the submission method selected by the clinician, group, or virtual group. As such, we break down the burden estimates by clinicians, groups, and virtual groups by the submission method used.

We anticipate that clinicians and groups using QCDR, qualified registry, and EHR

submission mechanisms will have the same start-up costs related to reviewing measure specifications. As such, we estimate for clinicians, groups, and virtual groups using any of these three submission mechanisms a total of 7 staff hours needed to review the quality measures list, review the various submission options, select the most appropriate submission option, identify the applicable measures or specialty measure sets for which they can report the necessary information, review the measure specifications for the selected measures or measures group, and incorporate submission of the selected measures or specialty measure sets into the office work flows. Building on data in a recent article, Casalino et al. (2016), we assume that a range of expertise is needed to review quality measures: 2 hours of an office administrator's time, 1 hour of a clinician's time, 1 hour of an LPN/medical assistant's time, 1 hour of a computer systems analyst's time, and 1 hour of a billing clerk's time.[37] In the CY 2017 Quality Payment Program final rule we estimated 3 hours for an administrator's time for data submission. Because the new CMS Application Programming Interface (API) will be available for EHR, registry and QCDR, and CMS Web Interface submission mechanisms, we have reduced our estimate to 2 hours of an office administrator's time for data submission. This CMS API will streamline the process of reviewing measure specifications and submitting measures for third party submission mechanisms. (We have also reduced our burden estimate for CMS Web Interface to reflect the new CMS API in a separate section below.).[38]

For the claims submission mechanism, we estimate that the start-up cost for a MIPS eligible clinician's practice to review measure specifications is $596.80, including 3 hours of a practice administrator's time (3 hours X $105.16=$315.48), 1 hour of a clinician's time (1 hour

[37]Our burden estimates are based on prorated versions of the estimates for reviewing measure specifications in Lawrence P. Casalino et al., "US Physician Practices Spend More than $15.4 Billion Annually to Report Quality Measures," Health Affairs, 35, no. 3 (2016): 401-406. The estimates were annualized to 50 weeks per year, and then prorated to reflect that Medicare revenue is 30 percent of all revenue paid by insurers, and then adjusted to reflect that the decrease from 9 required quality measures under PQRS to 6 required measures under MIPS.
[38]CMS: New API Will Automate MACRA Quality Measure Data Sharing. http://healthitanalytics.com/news/cms-new-api-will-automate-macra-quality-measure-data-sharing.

X $202.08/hour=$202.08), 1 hour of an LPN/medical assistant's time (1 hour X $43.12), and 1 hour of a billing clerk's time (1 hour X $36.12/hour = $36.12). These start-up costs pertain to the specific quality submission methods below, and hence appear in the burden estimate tables.

For the purposes of our burden estimates for the claims, qualified registry and QCDR, and EHR submission mechanisms, we also assume that, on average, each clinician, group, or virtual group will submit 6 quality measures.

Our estimated number of respondents for the claims and EHR submission mechanisms increased relative to the estimates in the CY 2017 Quality Payment Program final rule because our estimates now reflect the proposed policy to allow individual clinicians and groups to be scored on quality measures submitted via multiple mechanisms. Our estimated number of respondents for the QCDRs and qualified registries submission mechanisms has declined relative to the CY 2017 Quality Payment final rule because our estimates now reflect the proposed policies allowing certain eligible clinicians who practice primarily in the hospital to elect facility-based measurement, as well as the proposed policy to allow practices of 10 or fewer eligible clinicians to participate as part of a virtual group. The number of respondents for CMS Web Interface has declined relative to the estimates in the CY 2017 Quality Payment Program final rule because our estimates now exclude the CMS Web Interface data submitted by Shared Savings Program and Pioneer ACOs to fulfill the requirement of their models. As noted in this section of the proposed rule, information collections associated with the Shared Savings Program and the testing, evaluation, and expansion of CMS Innovation Center models are not subject to the Paperwork Reduction Act.

1. Burden for Quality Data Submission by Clinicians: Claims-Based Submission

As noted in Table 65, based on 2015 PQRS data, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016,

and a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016, we assume that 364,002 individual clinicians will submit quality data via claims. We anticipate the claims submission process for MIPS will be operationally similar to the way the claims submission process functioned under the PQRS. Specifically, clinicians will need to gather the required information, select the appropriate quality data codes (QDCs), and include the appropriate QDCs on the claims they submit for payment. Clinicians will collect QDCs as additional (optional) line items on the CMS-1500 claim form or the electronic equivalent HIPAA transaction 837-P, approved by OMB under control number 0938-1197.

The total estimated burden of claims-based submission will vary along with the volume of claims on which the submission is based. Based on our experience with the PQRS, we estimate 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. As shown in Table 68, we also estimate that the cost of quality data submission using claims will range from $19.38 (0.22 hours X $88.10) to $951.48 (10.8 hours X $88.10). The total estimated annual cost per clinician ranges from the minimum burden estimate of $704.28 to a maximum burden estimate of $1,636.38. The burden will involve becoming familiar with MIPS data submission requirements. As noted in Table 68, we believe that the start-up cost for a clinician's practice to review measure specifications totals 7 hours, which includes 3 hours of a practice administrator's time (3 hours X $105.16 = $315.48), 1 hour of a clinician's time (1 hour X $202.08/hour = $202.08), 1 hour of an LPN/medical assistant's time (1 hour X $43.12 = $43.12), 1 hour of a computer systems analyst's time (1 hour X $88.10 = $88.10), and 1 hour of a billing clerk's time (1 hour X $36.12/hour = $36.12).

Considering both data submission and start-up costs, the total estimated burden hours per clinician ranges from a minimum of 7.22 hours (0.22 + 3 + 1 + 1 + 1 + 1) to a maximum of 17.8 hours (10.8 + 3 + 1 + 1 + 1 + 1). The total estimated annual cost per clinician ranges from the minimum estimate of $704.28 ($19.38 + $315.48 + $88.10 + $43.12 + $36.12 + $202.08) to a maximum estimate of $1,636.38 ($951.48 + $315.48 + $88.10 + $43.12 + $36.12 + $202.08). Therefore, total annual burden cost is estimated to range from a minimum burden estimate of $256,359,329 (364,002 X $704.28) to a maximum burden estimate of $595,645,593 (364,002 X $1,636.38).

Based on the assumptions discussed in this section of the proposed rule, Table 68 summarizes the range of total annual burden associated with clinicians using the claims submission mechanism.

TABLE 68: Burden Estimate for Quality Performance Category: Clinicians Using the Claims Submission Mechanism

	Minimum Burden	Median Burden	Maximum Burden Estimate
Estimated # of Clinicians (a)	364,002	364,002	364,002
Burden Hours Per Clinician to Submit Quality Data (b)	0.22	1.58	10.8
Estimated # of Hours Office Administrator Review Measure Specifications (c)	3	3	3
Estimated # of Hours Computer Systems Analyst Review Measure Specifications (d)	1	1	1
Estimated # of Hours LPN Review Measure Specifications (e)	1	1	1
Estimated # of Hours Billing Clerk Review Measure Specifications (f)	1	1	1
Estimated # of Hours Clinician Review Measure Specifications (g)	1	1	1
Estimated Annual Burden hours per Clinician (h) = (b)+(c)+(d)+(e)+(f)+(g)	7.22	8.58	17.8
Estimated Total Annual Burden Hours (i) = (a)*(h)	**2,628,094**	**3,123,137**	**6,479,236**
Estimated Cost to Submit Quality Data (@ computer systems analyst's labor rate of $88.10/hr.) (j)	$19.38	$139.20	$951.48
Estimated Cost to Review Measure Specifications (@ practice administrator's labor rate of $105.16/hr.) (k)	$315.48	$315.48	$315.48

	Minimum Burden	Median Burden	Maximum Burden Estimate
Estimated Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $88.10/hr.) (l)	$88.10	$88.10	88.10
Estimated Cost to Review Measure Specifications (@ LPN's labor rate of $43.12/hr.) (m)	$43.12	$43.12	$43.12
Estimated Cost to Review Measure Specifications (@ billing clerk's labor rate of $36.12/hr.) (n)	$36.12	$36.12	$36.12
Estimated Cost to Review Measure Specifications (@ physician's labor rate of $202.08/hr.) (o)	$202.08	$202.08	$202.08
Estimated Total Annual Cost Per Clinician (p) = (j)+(k)+(l)+(m)+(n)+(o)	$704.28	$824.10	$1,636.38
Estimated Total Annual Burden Cost (q) = (a)*(p)	**$256,359,329**	**$299,974,048**	**$595,645,593**

2. Burden for Quality Data Submission by Individuals, Groups, and Virtual Groups Using Qualified Registry and QCDR Submissions

As noted in Table 65 and based on 2015 PQRS data, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016, a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016, we assume that 225,569 clinicians will submit quality data as individuals, groups, or virtual groups via qualified registry or QCDR submissions. Of these, we expect 86,046 clinicians, as shown in Table 66, to submit as individuals and 2,455 groups, as shown in Table 67, are expected to submit on behalf of the remaining 139,523 clinicians. Given that the number of measures required is the same for clinicians, groups, and virtual groups, we expect the burden to be the same for each respondent submitting data via qualified registry or QCDR, whether the clinician is participating in MIPS as an individual, group or virtual group.

We estimate that burdens associated with QCDR submissions are similar to the burdens

associated with qualified registry submissions. Therefore, we discuss the burden for both data submissions together below. For qualified registry and QCDR submissions, we estimate an additional time burden for respondents (individual clinicians, groups, and virtual groups) to become familiar with MIPS submission requirements and, in some cases, specialty measure sets and QCDR measures. Therefore, we believe that the start-up cost for an individual clinician or group to review measure specifications and submit quality data to total $851.35. For review costs, this total includes 3 hours per respondent to submit quality data (3 hours X $88.10/hour = $264.00), 3 hours of a practice administrator's time (2 hours X $105.16/hour = $210.32), 1 hour of a clinician's time (1 hours X $202.08/hour =$202.08), 1 hour of a computer systems analyst's time (1 hour X $88.10/hour = $88.10), 1 hour of an LPN/medical assistant's time, (1 hour X $43.12/hour = $43.12), and 1 hour of a billing clerk's time (1 hour X $36.12/hour = $36.12). Clinicians, groups, and virtual groups will need to authorize or instruct the qualified registry or QCDR to submit quality measures' results and numerator and denominator data on quality measures to us on their behalf. We estimate that the time and effort associated with authorizing or instructing the quality registry or QCDR to submit this data will be approximately 5 minutes (0.083 hours) per clinician or group (respondent) for a total burden cost of $7.31, at a computer systems analyst's labor rate (.083 hours X $88.10/hour). Hence, we estimate 9.083 burden hours per respondent, with annual total burden hours of 803,855 (9.083 burden hours X 88,501 respondents). The total estimated annual cost per respondent is estimated to be approximately $851.05. Therefore, total annual burden cost is estimated to be $75,318,776 (88,501 X $851.05). Based on these assumptions, we have estimated the burden for these submissions.

TABLE 69: Burden Estimate for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group or Virtual Group) Using the Qualified Registry/QCDR Submission

	Burden Estimate
# of clinicians submitting as individuals (a)	86,046
# of groups or virtual groups submitting via QCDR or registry on behalf of individual clinicians (b)	2,455
# of Respondents (groups and virtual groups plus clinicians submitting as individuals) (c)=(a)+(b)	88,501
Estimated Burden Hours Per Respondent to Report Quality Data (d)	3
Estimated # of Hours Office Administrator Review Measure Specifications (e)	2
Estimated # of Hours Computer Systems Analyst Review Measure Specifications (f)	1
Estimated # of Hours LPN Review Measure Specifications (g)	1
Estimated # of Hours Billing Clerk Review Measure Specifications (h)	1
Estimated # of Hours Clinician Review Measure Specifications (i)	1
Estimated # of Hours Per Respondent to Authorize Qualified Registry to Report on Respondent's Behalf) (j)	0.083
Estimated Annual Burden Hours Per Respondent (k)= (d)+(e)+(f)+(g)+(h)+(i)+(j)	9.083
Estimated Total Annual Burden Hours (l) = (c)*(k)	803,855
Estimated Cost Per Respondent to Submit Quality Data (@ computer systems analyst's labor rate of $88.10/hr.) (m)	$264.00
Estimated Cost to Review Measure Specifications (@ practice administrator's labor rate of $105.16/hr.) (n)	$210.32
Estimated Cost Computer System's Analyst Review Measure Specifications (@ computer systems analyst's labor rate of $88.10/hr.) (o)	$88.10
Estimated Cost LPN Review Measure Specifications (@ LPN's labor rate of $43.12/hr.) (p)	$43.12
Estimated Cost Billing Clerk Review Measure Specifications (@ clerk's labor rate of $36.12/hr.) (q)	$36.12
Estimated Cost Clinician Review Measure Specifications (@ physician's labor rate of $202.08/hr.) (r)	$202.08
Estimated Burden for Submission Tool Registration etc. (@ computer systems analyst's labor rate of $88.1/hr.) (s)	$7.31
Estimated Total Annual Cost Per Respondent (t) = (m)+(n)+(o)+(p)+(q)+(r)+(s)	$851.05
Estimated Total Annual Burden Cost (u) = (c)*(t)	$75,318,776

3. Burden for Quality Data Submission by Clinicians, Groups, and Virtual Groups: EHR Submission

As noted in Tables 65, 66 and 67, based on our analysis of 2015 PQRS data, data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016, and a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants QP analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between the date range January 1, 2016 through August 31, 2016, we assume that 115,241 clinicians will submit quality data as individuals or groups via EHR submissions; 60,253 clinicians are expected to submit as individuals; and 817 groups are expected to submit on behalf of 56,772 clinicians. We expect the burden to be the same for each respondent submitting data via qualified registry or QCDR, whether the clinician is participating in MIPS as an individual or group.

Under the EHR submission mechanism, the individual clinician or group may either submit the quality measures data directly to us from their EHR or utilize an EHR data submission vendor to submit the data to us on the clinician's or group's behalf.

To prepare for the EHR submission mechanism, the clinician or group must review the quality measures on which we will be accepting MIPS data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from their EHR, and submit the necessary data to the CMS-designated clinical data warehouse or use a health IT vendor to submit the data on behalf of the clinician or group. We assume the burden for submission of quality measures data via EHR is similar for clinicians, groups, and virtual groups who submit their data directly to us from their CEHRT and clinicians, groups, and virtual groups who use an EHR data submission vendor to submit the data on their behalf. To submit data to us directly from their CEHRT, clinicians, groups, and virtual groups must have access to a CMS-specified identity management system which we believe takes less than 1 hour to obtain. Once a clinician or group has an account for this CMS-specified

identity management system, they will need to extract the necessary clinical data from their EHR, and submit the necessary data to the CMS-designated clinical data warehouse.

We estimate that obtaining an account on a CMS-specified identity management system will require 1 hour per respondent for a cost of $88.10 (1 hour X $88.10/hour), and that submitting a test data file to us will also require 1 hour per respondent for a cost of $88.10 (1 hour X $88.10/hour). For submitting the actual data file, we believe that this will take clinicians or groups no more than 2 hours per respondent for a cost of submission of $176.20 (2 hours X $88.10/hour). The burden will involve becoming familiar with MIPS submission. We believe that the start-up cost for a clinician or group to submit the test data file and review measure specifications is a total 7 hours, 1 hour for the test data submission and 6 hours for reviewing measuring which includes 2 hours of a practice administrator's time (2 hours X $105.16/hour = $210.32), 1 hour of a clinician's time (1 hour X $202.08/hour = $202.08), 1 hour of a computer systems analyst's time (1 hour X $88.10/hour = $88.10), 1 hour of an LPN/medical assistant's time (1 hour X $43.12/hour = $43.12), and 1 hour of a billing clerk's time (1 hour X $36.12/hour = $36.12). Hence, we estimated 10 total burden hours per respondent with annual total burden hours of 610,700 (10 burden hours X 61,070 respondents). The total estimated annual cost per respondent is estimated to be $932.14. Therefore, total annual burden cost is estimated to be $56,925,790 = (61,070 respondents X $932.14).

Based on the assumptions discussed in this section of the proposed rule, we have estimated the burden for the quality data submission using EHR submission mechanism below.

TABLE **70: Burden Estimate for Quality Performance Category: Clinicians (Submitting Individually or as Part of a Group or Virtual Group) Using the EHR Submission Mechanism**

	Burden estimate
# of clinicians submitting as individuals (a)	60,253
# of Groups and Virtual Groups submitting via EHR on behalf of individual clinicians (b)	817
# of Respondents (Groups and Virtual Groups plus clinicians submitting as individuals) (c)=(a)+(b)	61,070
Estimated Burden Hours Per Respondent to Obtain Account in CMS-Specified Identity Management System (d)	1
Estimated Burden Hours Per Respondents to Submit Test Data File to CMS (e)	1
Estimated Burden Hours Per Respondent to Submit MIPS Quality Data File to CMS (f)	2
Estimated # of Hours Office Administrator Review Measure Specifications (g)	2
Estimated # of Hours Computer Systems Analyst Review Measure Specifications (h)	1
Estimated # of Hours LPN Review Measure Specifications (i)	1
Estimated # of Hours Billing Clerk Review Measure Specifications (j)	1
Estimated # of Hours Clinicians Review Measure Specifications (k)	1
Estimated Annual Burden Hours Per Respondent (l)=(d)+(e)+(f)+(g)+(h)+(i)+(j)+(k)	10
Estimated Total Annual Burden Hours (m)=(c)*(l)	610,700
Estimated Cost Per Respondent to Obtain Account in CMS-specified identity management system (@ computer systems analyst's labor rate of $88.10/hr.) (n)	$88.10
Estimated Cost Per Respondent to Submit Test Data File to CMS (@ computer systems analyst's labor rate of $88.10/hr.) (o)	$88.10
Estimated Cost Per Respondent to Submit Quality Data (@ computer systems analyst's labor rate of $88.10/hr.) (p)	$176.20
Estimated Cost to Review Measure Specifications (@ practice administrator's labor rate of $105.16/hr.) (q)	$210.32
Estimated Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $88.10/hr.) (r)	$88.10
Estimated Cost to Review Measure Specifications (@ LPN's labor rate of $43.12/hr.) (s)	$43.12
Estimated Cost to Review Measure Specifications (@ clerk's labor rate of $36.12/hr.) (t)	$36.12
Estimated Cost to D21Review Measure Specifications (@ physician's labor rate of $202.08/hr.) (u)	$202.08
Estimated Total Annual Cost Per Respondent (v)=(n)+(o)+(p)+(q)+(r)+(s)+(t)+(u)	$932.14
Estimated Total Annual Burden Cost (w)=(c)*(v)	$56,925,790

4. Burden for Quality Data Submission via CMS Web Interface

Based on 2015 PQRS data and as shown in Table 67, we assume that 298 groups will submit quality data via the CMS Web Interface in the 2018 MIPS performance period. We anticipate that approximately 252,808 clinicians will be represented.

The burden associated with the group submission requirements under the CMS Web Interface is the time and effort associated with submitting data on a sample of the organization's beneficiaries that is prepopulated in the CMS Web Interface. Based on experience with PQRS GPRO Web Interface submission mechanism, we estimate that, on average, it will take each group 74 hours of a computer systems analyst's time to submit quality measures data via the CMS Web Interface at a cost of $88.10 per hour, for a total cost of $6,519 (74 hours X $88.10/hour). Our estimate of 74 hours for submission includes the time needed for each group to populate data fields in the web interface with information on approximately 248 eligible assigned Medicare beneficiaries and then submit the data (we will partially pre-populate the CMS Web Interface with claims data from their Medicare Part A and B beneficiaries). The patient data either can be manually entered or uploaded into the CMS Web Interface via a standard file format, which can be populated by CEHRT. Because the CMS API will streamline the measure submission process for many groups, we have reduced our estimate of the computer system's analyst time needed for submission from 79 hours in the CY 2017 Quality Payment Program final rule to 74 hours. Because each group must provide data on 248 eligible assigned Medicare beneficiaries (or all eligible assigned Medicare beneficiaries if the pool of eligible assigned beneficiaries is less than 248), we assume that entering or uploading data for one Medicare beneficiary requires approximately 18 minutes of a computer systems analyst's time (74 hours ÷ 248 patients).

The total annual burden hours are estimated to be 22,052 (298 groups X 74 annual

hours), and the total annual burden cost is estimated to be $1,942,662 (298 groups X $6,519).

Based on the assumptions discussed in this section of the proposed rule, we have calculated the following burden estimate for groups submitting to MIPS with the CMS Web Interface.

TABLE 71: Burden Estimate for Quality Data Submission via the CMS Web Interface

	Burden Estimate
Estimated # of Eligible Group Practices (a)	298
Estimated Total Annual Burden Hours Per Group to Submit (b)	74
Estimated Total Annual Burden Hours (c) = (a)*(b)	22,052
Estimated Cost Per Group to Report (@ computer systems analyst's labor rate of $88.10/hr.) (d)	$88.10
Estimated Total Annual Cost Per Group (e) = (b)*(d)	$6,519
Estimated Total Annual Burden Cost (f) = (a)*(e)	$1,942,662
	By Eligible Clinician or Group
Estimated # of Participating Eligible Professionals (g)	252,808
Average Burden Hours Per Eligible Professional (h) = (c) ÷ (g)	0.09
Estimated Cost Per Eligible Professional to Report Quality Data (i) = (f) ÷ (g)	$7.68

5. Burden for Beneficiary Responses to CAHPS for MIPS Survey

Under MIPS, groups of two or more clinicians can elect to contract with a CMS-approved survey vendor and use the CAHPS for MIPS survey as one of their six required quality measures. Beneficiaries that choose to respond to the CAHPS for MIPS survey will experience burden.

The usual practice in estimating the burden on public respondents to surveys such as CAHPS is to assume that respondent time is valued, on average, at civilian wage rates. As previously explained, the BLS data show the average hourly wage for civilians in all occupations to be $23.86. Although most Medicare beneficiaries are retired, we believe that their time value is unlikely to depart significantly from prior earnings expense, and we have used the average hourly wage to compute the dollar cost estimate for these burden hours.

Under the 2018 MIPS performance period, we assume that 461 groups will elect to

report on the CAHPS for MIPS survey, which is equal to the number of groups reporting via CAHPS for the PQRS for reporting period 2015.[39] Table 72 shows the estimated annualized burden for beneficiaries to participate in the CAHPS for MIPS Survey. Based on historical information on the numbers of CAHPS for PQRS survey respondents, we assume that an average of 287 beneficiaries will respond per group. Therefore, the CAHPS for MIPS survey will be administered to approximately 132,307 beneficiaries per year (461 groups X an average of 287 beneficiaries per group responding).

We are proposing to use a shorter version of the CAHPS for MIPS survey with 58 items, as compared to 81 items for the version that will be used in the transition year. The proposed shorter survey is estimated to require an average administration time of 12.9 minutes (or 0.22 hours) in English (at a pace of 4.5 items per minute). We assume the Spanish survey would require 15.5 minutes (assuming 20 percent more words in the Spanish translation). Because less than 1 percent of surveys were administered in Spanish for reporting year 2016, our burden estimate reflects the length of the English survey. Our proposal would reduce beneficiary burden compared to the transition year; we estimate that the 81-item survey requires an average administration time of 18 minutes in English and 21.6 minutes in Spanish. Compared to the survey for reporting year 2016, this is a reduction of 5.1 minutes (18 minutes – 12.9 minutes) in administration time for the English version and a reduction of 6.1 (21.6 minutes - 15.5 minutes) minutes in administration time for the Spanish version.

Given that we expect approximately 132,307 respondents per year, the annual total burden hours are estimated to be 29,108 hours (132,307 respondents X 0.22 burden hours per

[39]Because the CAHPS for PQRS survey was required for groups of 100 or more clinicians under the PQRS, we expect that group participation in CAHPS for MIPS survey, which is optional under MIPS, may be somewhat lower. Hence, we assume that the number of groups electing to use the CAHPS for MIPS survey will be equivalent to the second highest participation rate for CAHPS for PQRS survey, which occurred in year 2015 when 461 groups used the survey. The most popular year of the CAHPS for PQRS survey was reporting year 2016, when 514 groups used the survey.

respondent). The estimated total burden annual burden cost is $694,612 (132,307 X $5,25).

TABLE 72: Burden Estimate for Beneficiary Participation in CAHPS for MIPS Survey

	Burden Estimate
Estimated # of Eligible Group Practices Administering CAHPS for Physician Quality Reporting Survey (a)	461
Estimated # of Beneficiaries Per Group Responding to Survey (b)	287
Estimated # of Total Beneficiary Respondents (c)=(a)*(b)	132,307
Estimated # of Burden Hours Per Beneficiary Respondent (d)	0.22
Estimated Cost Per Beneficiary (@ labor rate of $23.86/hr.) (e)	$5.25
Estimated Total Annual Burden Hours (f) = (c)*(d)	**29,108**
Estimated Total Annual Burden Cost for Beneficiaries Responding to CAHPS MIPS (g) = (c)*(e)	**$694,612**

6. Burden for Group Registration for CMS Web Interface

Groups interested in participating in MIPS using the CMS Web Interface for the first time must complete an on-line registration process. After first time registration, groups will only need to opt out if they are not going to continue to submit via the CMS Web Interface. In Table 73 we estimate that the registration process for groups under MIPS involves approximately 1 hour of administrative staff time per group. We assume that a billing clerk will be responsible for registering the group and that, therefore, this process has an average computer systems analyst labor cost of $88.10 per hour. Therefore, assuming the total burden hours per group associated with the group registration process is 1 hour, we estimate the total cost to a group associated with the group registration process to be approximately $88.10 ($88.10 per hour X 1 hour per group). We assume that approximately 10 groups will elect to use the CMS Web Interface submission mechanism in the 2018 MIPS performance period. The total annual burden hours are estimated to be 10 (10 groups X 1 annual hour), and the total annual burden cost is estimated to be $881.00 (10 groups X $88.10).

TABLE **73: Total Estimated Burden for Group Registration for CMS Web Interface**

	Burden Estimate
Estimated Number of New Groups Registering for CMS Web Interface (a)	10
Estimated Annual Burden Hours Per Group (b)	1
Estimated Total Annual Burden Hours (c) = (a)*(b)	**10**
Estimated Cost per Group to Register for CMS Web Interface @ computer systems analyst's labor rate of $88.10/hr.) (d)	$88.10
Estimated Total Annual Burden Cost for CMS Web Interface Group Registration (e) = (a)*(d)	**$881**

7. Burden for Group Registration for CAHPS for MIPS Survey

Under MIPS, the CAHPS for MIPS survey counts for one measure towards the MIPS quality performance category and, as a patient experience measure, also fulfills the requirement to submit at least one high priority measure in the absence of an applicable outcome measure. Groups that wish to administer the CAHPS for MIPS survey must register by June of the applicable 12-month performance period, and electronically notify CMS of which vendor they have selected to administer the survey on their behalf. In the 2018 MIPS performance period, we assume that 461 groups will enroll in the MIPS for CAHPS survey.

As shown in Table 74, we assume that the staff involved in the group registration for CAHPS for MIPS Survey will mainly be computer systems analysts or their equivalent, who have an average labor cost of $88.10/hour. We assume the CAHPS for MIPS Survey registration burden estimate includes the time to register for the survey as well as select the CAHPS for MIPS Survey vendor. Therefore, assuming the total burden hours per registration is 1 hour and 0.5 hours to select the CAHPS for MIPS Survey vendor that will be used and electronically notify CMS of their selection, the total burden hours for CAHPS for MIPS registration is 1.5. We estimate the total annual burden hours as 692 (461 groups X 1.5 hours). We estimate the cost per group for CAHPS for MIPS Survey registration is $132.15 ($88.10 X 1.5 hours). We estimate that the total cost associated with the registration process is $60,921 ($132.15 per hour X 461 hours per group).

TABLE 74: Burden Estimate for Group Registration for CAHPS for MIPS Survey

	Burden Estimate
Estimated # of Groups Registering for CAHPS (a)	461
Estimated Total Annual Burden Hours for CAHPS Registration (b)	1.5
Estimated Total Annual Burden Hours for CAHPS Registration (c) = (a)*(b)	**692**
Estimated Cost to Register for CAHPS@ computer systems analyst's labor rate of $88.10/hr.) (d)	$132.15
Estimated Total Annual Burden Cost for CAHPS Registration (e) = (a)*(d)	**$60,921**

G. ICRs Regarding Burden Estimate for Advancing Care Information Data (§414.1375)

During the 2018 MIPS performance period, clinicians, groups, and virtual groups can submit advancing care information data through qualified registry, QCDR, EHR, CMS Web Interface, and attestation data submission methods. We have worked to further align the advancing care information performance category with other MIPS performance categories. We anticipate that most organizations will use the same data submission mechanism for the advancing care information and quality performance categories, and that the clinicians, practice managers, and computer systems analysts involved in supporting the quality data submission will also support the advancing care information data submission process. Hence, the burden estimate for the submission of advancing care information data below shows only incremental hours required above and beyond the time already accounted for in the quality data submission process. While this analysis assesses burden by performance category and submission mechanism, we emphasize that MIPS is a consolidated program and submission analysis and decisions are expected to be made for the program as a whole.

1. Burden for Advancing Care Information Application

As stated in the CY 2017 Quality Payment Program final rule, some MIPS eligible clinicians may not have sufficient measures applicable and available to them for the advancing care information performance category, and as such, they may apply to have the advancing care information category re-weighted to zero in the following circumstances: insufficient internet

connectivity, extreme and uncontrollable circumstances, lack of control over the availability of CEHRT (81 FR 77240 through 77243). As described in section II.C.6.f.(7)(a) of this proposed rule, we are proposing to allow MIPS eligible clinicians to apply to have their advancing care information performance category re-weighted to zero through the Quality Payment Program due to a significant hardship exception or exception for decertified EHR technology. We are also proposing that MIPS eligible clinicians who are in small practices (15 or fewer clinicians) may, beginning with the 2018 performance period and 2020 MIPS payment year, request a reweighting to zero for the advancing care information category due to a significant hardship. We are proposing to rely on section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, as our authority for the significant hardship exceptions.

Table 75 shows the estimated annualized burden for clinicians to apply for a reweighting to zero of their advancing care information performance category due to a significant hardship exception or as a result of a decertification of an EHR, as well as an application for significant hardship by small practices. Based on 2016 data from the Medicare EHR Incentive Program and the first 2019 payment year MIPS eligibility and special status file, we assume 50,689 respondents (eligible clinicians, groups, or virtual groups) will submit a request for reweighting to zero of their advancing care information category due to a significant hardship exception, decertification of an EHR or significant hardship for small practices through the Quality Payment Program. We estimate that 6,699 respondents (eligible clinicians, groups, or virtual groups) will submit a request for a reweighting to zero for the advancing care information performance category due to extreme and uncontrollable circumstances or as a result of a decertification of an EHR, and 43,990 respondents will submit a request for a reweighting to zero for the advancing care information performance category as a small practice. The application to request a reweighting to zero for the advancing care information performance

category due to significant hardship is a short online form that requires identifying which type of hardship or if decertification of an EHR applies and a description of how the circumstances impair the ability to submit the advancing care information data, as well as some proof of circumstances beyond the submitter's control. The estimate to submit this application is 0.5 hours of a computer system analyst's time. Given that we expect 50,689 applications per year, the annual total burden hours are estimated to be 25,345 hours (50,689 respondents X 0.5 burden hours per respondent). The estimated total annual burden is $2,232,850 (50,689 X $44.05).

TABLE 75: Burden Estimate for Application for Advancing Care Information Reweighting

	Burden estimate
# of Eligible Clinicians, Groups, or Virtual Groups Applying Due to Significant Hardship and Other Exceptions (a)	6,699
# of Eligible Clinicians, Groups, or Virtual Groups Applying Due to Significant Hardship as Small Practice (b)	43,990
Total respondents Due to Hardships, Other Exceptions and Hardships for Small Practices (c)	50,689
Estimated Burden Hours Per Applicant for Advancing Care Information (d)	0.5
Estimated Total Annual Burden Hours (e)=(a)*(c)	25,345
Estimated Cost Per Applicant for Advancing Care Information (@ computer systems analyst's labor rate of $88.10/hr.) (f)	$44.05
Estimated Total Annual Burden Cost (g)=(a)*(f)	$2,232,850

2. Number of Organizations Submitting Advancing Care Information Data on Behalf of Eligible Clinicians

A variety of organizations will submit advancing care information data on behalf of clinicians. Clinicians not participating in a MIPS APM can submit as individuals or as part of a group or virtual group. Group TINs may submit advancing care information data on behalf of clinicians in MIPS APMs, or, except for participants in the Shared Savings Program, clinicians in MIPS APMs may submit advancing care information performance category data individually. Because group TINs in APM Entities will be submitting advancing care information data to fulfill the requirements of submitting to MIPS, we have included MIPS APMs in our burden estimate for the advancing care information performance category. Consistent with the list of

APMs that are MIPS APMs on the QPP website,[40] we assume that 5 MIPS APMs that do not also qualify as Advanced APMs will operate in the 2018 MIPS performance period: Track 1 of the Shared Savings Program, CEC (one-sided risk arrangement), OCM (one-sided risk arrangement), and the Comprehensive Primary Care Plus Model (CPC+). Further, we assume that group TINs will submit advancing care information data on behalf of partial QPs that elect to participate in MIPS.

As shown in Table 76, based on 2015 data from the Medicare EHR Incentive Program and the data prepared to support the 2017 performance period initial determination of clinician eligibility and special status determination (available via the NPI lookup on qpp.cms.gov) using a date range of September 1, 2015 – August 31, 2016, we estimate that 265,895 individual MIPS eligible clinicians and 301 groups or virtual groups, representing 106,406 MIPS eligible clinicians, will submit advancing care information data. These estimates reflect that under the policies finalized in CY 2017 Quality Payment Program final rule, certain MIPS eligible clinicians will be eligible for automatic reweighting of their advancing care information performance category score to zero, including MIPS eligible clinicians that practice primarily in the hospital, physician assistants, nurse practitioners, clinician nurse specialists, certified registered nurse anesthetists, and non-patient facing clinicians. These estimates also account for the significant hardships finalized in the CY 2017 Quality Payment Program final rule and our proposed policies for significant hardship exceptions, including for MIPS eligible clinicians in small practices, as well as exceptions due to decertification of an EHR. Due to data limitations, our estimate of the number of clinicians to submit advancing care information data does not account for our proposal to rely on section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, to assign a scoring weight of zero percent for the

[40] https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.

advancing care information performance category for MIPS eligible clinicians who are determined to be based in ambulatory surgical centers (ASCs).

Further, we anticipate that the 480 Shared Savings Program ACOs will submit data at the ACO participant group TIN-level, for a total of 15,945 group TINs. We anticipate that the three APM Entities electing the one-sided track in the CEC model will submit data at the group TIN-level, for an estimated total of 100 group TINs submitting data. We anticipate that the 195 APM Entities in the OCM (one-sided risk arrangement) will submit data at APM Entity level, for an estimated total of 6,478 group TINs. Based on a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016, we estimate 2 APM Entities in the CPC+ model will submit at the group TIN-level, for an estimated total of 2 group TINs submitting data. Based on preliminary data, we assume that 1 CPC+ APM entity will submit data because one or more of its participants is a partial QP, and that 1 CPC+ APM Entity will submit data because some of its participants qualify as either as QPs or partial QPs. The total estimated number of respondents is estimated at 288,721.

TABLE 76: Estimated Number of Respondents to Submit Advancing Care Information Performance Data on Behalf of Clinicians

	Estimated # of Respondents	Estimated # of APM Entities
Number of Individual clinicians to submit advancing care information (a)	265,895	
Number of groups or virtual groups to submit advancing care information (b)	301	
Shared Savings Program ACO Group TINs (c)	15,945	480
CEC one-sided risk track participants[41] (d)	100	3
OCM one-sided risk arrangement Group TINs (e)	6,478	195
CPC+ TINs (f)	2	2
Total (g) = (a) + (b) + (c) + (d) + (e) + (f)	288,721	680

3. Burden for Submission of Advancing Care Information Data

[41] The 3 CEC APM Entities reflected in the burden estimate are the non-large dialysis organizations participating in the one-sided risk track.

In Table 76, we estimate that up to approximately 288,721 respondents will be submitting data under the advancing care information performance category, 265,895 clinicians, 301 groups or virtual groups, 15,945 group TINs within the Shared Savings Program ACOs, 100 group TINs within the APM Entity participating in CECs in the one-sided risk track, and 6,478 group TINs within the OCM (one-sided risk arrangement), and 2 CPC+ group TINs. We estimate this is a significant reduction in respondents from the 2017 MIPS performance period as a result of our proposed policy to provide significant hardship exceptions, including for MIPS eligible clinicians in small practices, as well as for situations due to decertification of an EHR, and our proposed policy to allow eligible clinicians to participate as part of a virtual group.

In the CY 2017 Quality Payment Program final rule, our burden estimates assumed all clinicians who submitted quality data would also submit under advancing care information. For this proposed rule, MIPS special status eligibility data were available to model exceptions. The majority (214,302) of the difference in our estimated number of respondents is due to the availability of MIPS special status data to identify clinicians and groups that would also not need to report advancing care information data under transition year policies, including hospital-based eligible clinicians, clinician types eligible for automatic reweighting of their advancing care information performance category score, non-patient facing clinicians, and clinicians facing a significant hardship. The remaining decline in respondents is due to policies proposed in this rule, including 25,881 respondents who would be excluded under the new proposed significant hardship exception for small practices.

Our burden estimates in the CY 2017 Quality Payment Program final rule assumed that during the transition year, 3 hours of clinician time would be required to collect and submit advancing care information performance category data. We anticipate that the year-over-year consistency of data submission processes, measures, and activities and the further alignment of the advancing care information performance category with other performance categories will

reduce the clinician time needed under this performance category in the 2018 MIPS performance period. Further, for some practices the staff mix requirements in the 2018 MIPS performance period may be driven more by transition to 2015 CEHRT. Therefore, as shown in Table 77, the total burden hours for an organization to submit data on the specified Advancing Care Information Objectives and Measures is estimated to be 3 incremental hours of a computer analyst's time above and beyond the clinician, practice manager, and computer system's analyst time required to submit quality data. The total estimated burden hours are 866,163 (288,721 respondents X 3 hours). At a computer systems analyst's hourly rate, the total burden cost is $76,308,960 (288,721 X $264.30/hour).

TABLE 77: Estimated Burden for Advancing Care Information Performance Category Data Submission

	Burden Estimate
# of respondents submitting advancing care information data on behalf of clinicians (a)	288,721
Estimated Total Annual Burden Hours Per Respondent (b)	3
Estimated Total Annual Burden Hours (c) = (a)*(b)	866,163
Estimated Cost Per Respondent to Submit Advancing Care Information data (@ computer systems analyst's labor rate of $88.10/hr.) (d)	$264.30
Estimated Total Annual Burden Cost (e) = (a)*(d)	$76,308,960

H. ICR Regarding Burden for Improvement Activities Submission (§414.1355)

Requirements for submitting improvement activities did not exist in the legacy programs replaced by MIPS, and we do not have historical data which is directly relevant. A variety of organizations and in some cases, individual clinicians, will submit improvement activity performance category data. For clinicians who are not part of APMs, we assume that clinicians submitting quality data as part of a group or virtual group through the QCDR and registry, EHR, and CMS Web Interface submission mechanisms will also submit improvement activities data. Further, we assume that clinicians and groups that practice primarily in the hospital that elect facility-based measurement for the quality performance category will also submit improvement activities data. As noted in section II.C.6.g.(3)(c) of the proposed rule, MIPS eligible clinicians

participating in MIPS APMs do not need to submit improvement activities data unless the CMS-assigned improvement activities score is below the maximum improvement activities score. As represented in Table 78, we estimate 520,654 clinicians will submit improvement activities as individuals during the 2018 MIPS performance period, an estimated 3,818 groups to submit improvement activities on behalf of clinicians during the 2018 MIPS performance period, and an additional 16 virtual groups to submit improvement activities, resulting in 524,488 total respondents. The burden estimates assume there will be no improvement activities burden for MIPS APM participants. We will assign the improvement activities performance category score at the APM level; each APM Entity within the same MIPS APM will be assigned the same score.

TABLE 78: Estimated Numbers of Organizations Submitting Improvement Activities Performance Category Data on Behalf of Clinicians

	Count
Estimated # of clinicians to participate in Improvement Activities data submission as individuals during the 2018 MIPS performance period (a)	520,654
Estimated # of Groups to submit improvement activities on behalf of clinicians during the 2018 MIPS performance period (b)	3,818
Estimated # of Virtual Groups to submit improvement activities on behalf of clinicians during the 2018 MIPS performance period (c)	16
Total # of Respondents (Groups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the 2018 MIPS performance period (d) = (a) + (b) + (c)	524,488

In Table 79, we estimate that approximately 524,488 respondents will be submitting data under the improvement activities performance category. Our burden estimates in the CY 2017 Quality Payment Program final rule assumed that during the transition year, 2 hours of clinician time would be required to submit data on the specified improvement activities. For this proposed rule, our burden estimate has been revised to assume that the total burden hours to submit data on the specified improvement activities will be 1 hour of computer system analyst time in addition to time spent on other performance categories. Our revised estimate is based on feedback from stakeholders that these are activities they have already been doing and tracking so there is no additional development of material needed. Additionally, the same improvement activity may be

reported across multiple performance periods so many MIPS eligible clinicians will not have any additional information to develop for the 2018 MIPS performance period. The total estimated burden hours are 524,488 (524,488 responses X 1 hour). At a computer systems analyst's hourly rate, the total burden cost is $46,207,393 (524,488 X $88.10/hour).

TABLE 79: Estimated Burden for Improvement Activities Submission

	Burden Estimate
Total # of Respondents (Groups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the 2018 MIPS performance period (a)	524,488
Estimated Total Annual Burden Hours Per Respondent (b)	1
Estimated Total Annual Burden Hours (c)	524,488
Estimated Cost Per Respondent to Submit Improvement Activities (@ computer systems analyst's labor rate of $88.10/hr.) (d)	$88.10
Estimated Total Annual Burden Cost (e) = (a)*(d)	$46,207,393

I. ICR Regarding Burden for Nomination of Improvement Activities §414.1360)

For the 2018 MIPS performance period, we are also proposing to allow clinicians, groups, and other relevant stakeholders to nominate new improvement activities using a nomination form provided on the Quality Payment Program website at qpp.cms.gov, and to send their proposed new improvement activities to us via email. As shown in Table 80, based on response to an informal call for new proposed improvement activities during the transition year, we estimate that approximately 150 organizations (clinicians, groups or other relevant stakeholders) will nominate new improvement activities. We estimate it will take an estimated 0.5 hours per organization to submit an activity to us, including an estimated 0.3 hours per practice for a practice administrator to identify and submit an activity to us via email at a rate of $105.16/hour for a total of $31.55 per activity and clinician review time of 0.2 hours at a rate of $202.08/hour for a total of $40.42 per activity. We estimate that the total annual burden cost is $10,796 (150 x $71.96).

TABLE 80: Estimated Burden for Nomination of Improvement Activities

	Burden estimate
# of Organizations Nominating New Improvement Activities (a)	150
Estimated # of Hours Per Practice Administrator to Identify and Propose Activity (b)	0.30
Estimated # of Hours Per Clinician to Identify Activity (c)	0.20
Estimated Annual Burden Hours Per Respondent (d)= (b) + (c)	0.50
Estimated Total Annual Burden Hours (e) = (a)*(d)	75.00
Estimated Cost to Identify and Submit Activity (@ practice administrator's labor rate of $105.16/hr.) (f)	$31.55
Estimated Cost to Identify Improvement Activity (@ physician's labor rate of $202.08/hr.) (g)	$40.42
Estimated Total Annual Cost Per Respondent (h)=(f)+(g)	$71.97
Estimated Total Annual Burden Cost (i)=(a)*(h)	$10,796

J. ICRs Regarding Burden for Cost (§414.1350)

The cost performance category relies on administrative claims data. The Medicare Parts A and B claims submission process is used to collect data on cost measures from MIPS eligible clinicians. MIPS eligible clinicians are not asked to provide any documentation by CD or hardcopy. Therefore, under the cost performance category, we do not anticipate any new or additional submission requirements for MIPS eligible clinicians.

K. ICR Regarding Partial QP Elections (§414.1430)

APM Entities may face a data submission burden under MIPS related to Partial QP elections. Advanced APM participants will be notified about their QP or Partial QP status before the end of the performance period. For Advanced APMs the burden of partial QP election would be incurred by a representative of the participating APM Entity. For the purposes of this burden estimate, we assume that all MIPS eligible clinicians determined to be Partial QPs will participate in MIPS.

Based on our analyses of a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016, we assume that approximately 17 APM Entities will face the data submission requirement in the 2018 performance period.

As shown in Table 81, we assume that 17 APM Entities will make the election to participate as a partial QP in MIPS. We estimate it will take the APM Entity representative 15 minutes to make this election. Using a computer systems analyst's hourly labor cost, we estimate a total burden cost of just $375 (17 participant X $22.03).

TABLE 81: Estimated Burden for Partial QP Election

	Burden Estimate
# of APM Entities Electing Partial QP Status on behalf of their Participants (a)	17
Estimated Burden Hours Per Respondent to Elect to Participate as Partial QP (d)	0.25
Estimated Total Annual Burden Hours (e)= (c)*(d)	4.25
Estimated Cost Per Respondent to Elect to Participate as Partial QP (@ computer systems analyst's labor rate of $88.10/hr.) (f)	$22.03
Estimated Total Annual Burden Cost (g) = (c)*(f)	$375

L. ICRs Regarding Other Payer Advanced APM Identification: Payer-Initiated Process (§414.1440)

Beginning in Quality Payment Program Year 3, the All-Payer Combination Option will be an available pathway to QP status for eligible clinicians participating sufficiently in Advanced APMs and Other Payer Advanced APMs. The All-Payer Combination Option allows for eligible clinicians to achieve QP status through their participation in both Advanced APMs and Other Payer Advanced APMs. In order to include an eligible clinician's participation in Other Payer Advanced APMs in their QP threshold score, we will need to determine if certain payment arrangements with other payers meet the criteria to be Other Payer Advanced APMs. To provide eligible clinicians with advanced notice prior to the start of the 2019 QP performance period, and to allow other payers to be involved prospectively in the process, we have outlined in section II.D.6.a. of this proposed rule a payer-initiated identification process for identifying payment arrangements that qualify as Other Payer Advanced APMs. This payer-initiated identification process of Other Payer Advanced APMs will begin in CY 2018, and determinations would be applicable for the Quality Payment Program Year 3.

As shown in Table 82, we estimate 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. The estimated burden to apply is 10 hours per payment arrangement, for a total annual burden hours of 3,000 (300 X 100). We estimate a total cost per payer of $881.00 using a computer system analyst's rate of $88.10/hour (10 X 81.10). The total annual burden cost for all other payers is $264,300 (300 X $881.00).

TABLE 82: Burden for Prospective Identification of Other Payer Advanced APMs

	Burden Estimate
Estimated # of other payer payment arrangements (50 Medicaid, 150 MA Organizations, 100 Multi-payers) (a)	300
Estimated Total Annual Burden Hours Per other payer payment arrangement (b)	10
Estimated Total Annual Burden Hours (c) = (a)*(b)	3,000
Estimated Cost Per Other Payer (@ computer systems analyst's labor rate of $88.10/hr.) (d)	$881.00
Estimated Total Annual Burden Cost for Identifying Other Payer Advanced APMs (e) = (a)*(d)	$264,300

M. ICRs Regarding Burden for Voluntary Participants to Elect Opt Out of Performance Data Display on Physician Compare (§414.1395)

We estimate 22,400 clinicians and groups who will voluntarily participate in MIPS but will also elect not to participate in public reporting. Table 83 shows that for these voluntary participants, they may submit a request to opt out which is estimated at 0.25 hours of a computer system analyst's labor rate of $88.10. The total annual burden hours for opting out is estimated at 5,600 hours (22,400 X 0.25). The total annual burden cost for opting out for all requesters is estimated at $493,472 (22,400 X $22.03).

TABLE 83: Burden for Voluntary Participants to Elect Opt Out of Performance Data Display on Physician Compare

	Burden Estimate
Estimated # of Voluntary Participants Opting Out of Physician Compare (a)	22,400
Estimated Total Annual Burden Hours Per Opt-out Requester (b)	0.25
Estimated Total Annual Burden Hours for Opt-out Requester (c) = (a)*(b)	5,600
Estimated Cost Per Physician Compare Opt-out Request@ computer systems analyst's labor rate of $88.10/hr.) (d)	$22.03
Estimated Total Annual Burden Cost for Opt-out Requester (e) = (a)*(d)	$493,472

N. Summary of Annual Burden Estimates

Table 84 includes the total estimated burden of recordkeeping and data submission of the proposed rule 9,391,175 hours with total labor cost of $856,996,819. In order to understand the burden implications of the proposals in this rule, we have also estimated a baseline burden of continuing the policies and information collections set forth in the CY 2017 Quality Payment Program final rule into the 2018 performance period. This estimated baseline burden of 9,523,975 hours and a total labor cost of $869,369,094 is lower than the burden approved for information collection related to the CY 2017 Quality Payment Program final rule[42] because we anticipate greater respondent familiarity with the measures and data submission methods in their second year of participation and because the number of QPs that are excluded from MIPS is expected to continue to grow. Further, our estimated baseline burden estimates reflect the recent availability of data sources to more accurately reflect the number of the organizations exempt from the advancing care information performance category.

We estimate 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. The Quality Payment Program Year 2 reduction in burden based on proposals in this rule reflects several

[42] The burden estimate for the CY 2017 Quality Payment Program final rule was 10,940,417 hours for a total labor cost of $1,349,763,999. For comparability for the burden estimate in this proposed rule, the burden estimate for the CY 2017 Quality Payment Program final rule has been updated using 2016 wages.

proposed policies, including our proposal for significant hardship or other type of exception, including a new significant hardship exception for small practices for the advancing care information performance category. Our burden estimates also reflect the proposed reduction in the length of the CAHPS survey; our proposal to allow clinicians that practice primarily in the hospital to elect to use facility-based measurements, thereby eliminating the need for additional quality data submission processes; and our proposal to allow MIPS eligible clinicians to form virtual groups, which would create efficiencies in data submission.

TABLE 84: Proposed Annual Recordkeeping and Submission Requirements

	Respondents/ responses	Hours per response	Total annual burden hours	Labor cost of submission	Total annual burden cost
Registration for Virtual Groups	16	10.0	160	Varies (See Table 60)	$13,313
Election of Facility-Based Measurement	18,207	1.0	18,207	$36.12	$657,637
QCDR and Registries self- nomination	233	10.0	2,330	$88.10	205,273
CAHPS Survey Vendor Application	15	10.0	150	$88.10	$13,215
(Quality Performance Category) Claims Submission Mechanism	364,002	17.8	6,479,236	Varies (See Table 68)	$595,645,593
(Quality Performance Category) Qualified Registry or QCDR Submission Mechanisms	88,501	9.1	803,855	Varies (See Table 69)	$75,318,776
(Quality Performance Category) EHR-Submission Mechanism	61,070	10.0	610,700	Varies (See Table 70)	$56,925,790
(Quality Performance Category) CMS Web Interface Submission Mechanism	298	74.0	22,052	$88.10	$1,942,662
(Quality Performance Category) Registration and Enrollment for CMS Web Interface	10	1.0	10	$88.10	$881
(CAHPS for MIPS Survey) Beneficiary Participation	132,307	0.22	29,108	$23.86	$694,612
(CAHPS for MIPS Survey) Group Registration	461	1.5	692	$88.10	$60,921
§414.1375 (Advancing Care Information) Performance Category Significant Hardships, including for small practices and decertification of EHRs	50,689	0.5	25,345	$88.10	$2,232,850
(Advancing Care Information Performance Category) Data Submission	288,721	3.0	866,163	$88.10	$76,308,960
(Improvement Activities Performance Category) Data Submission	524,488	1.00	524,488	$88.10	$46,207,393
(Improvement Activities Performance Category) Call for Activities	150	0.5	75	Varies (See Table 80)	$10,796
(Partial Qualifying APM Participant (QP) Election)	17	0.3	4	$88.10	$375

	Respondents/ responses	Hours per response	Total annual burden hours	Labor cost of submission	Total annual burden cost
Other Payer Advanced APM Identification: Other Payer Initiated Process	300	10.0	3,000	$88.10	$264,300
(Physician Compare) Opt Out for Voluntary Participants	22,400	0.3	5,600	$88.10	$493,472
TOTAL	1,551,885		9,391,175		$856,996,819

O. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed in this section of the proposed rule, please visit our website at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410-786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule and identify the rule (CMS–5522–P), the ICR's CFR citation, CMS ID number, and OMB control number (0938-1222 for CAHPS for MIPS and 0938-1314 for all other ICRs). ICR-related comments are due August 21, 2017.

We have invited public comments on the virtual group election process under a separate **Federal Register** Notice (82 FR 27257) published on June 14, 2017. ICR-comments related to virtual group election are due on or before August 14, 2017. Because of the statutory requirement for the virtual group election process to take place prior to the start of the 2018 MIPS performance period, we have an earlier deadline for public comments on the virtual group election process to allow for earlier approval date for that information collection.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule is necessary to make statutorily required policy changes and other policy updates to the Merit-based Incentive Payment System (MIPS) established under MACRA as well as the policies related to the Advanced APM provisions of MACRA, which together are referred to as the Quality Payment Program. As required by MACRA, MIPS consolidates several quality programs, including components of the Medicare Electronic Health Record Incentive Program, the Physician Quality Reporting System (PQRS), and the Physician Value-Based Payment Modifier (VM) and Physician Feedback Program. The MACRA effectively ends these programs after CY 2018 and authorizes MIPS' operation beginning in CY 2019.

The Quality Payment Program is structured to improve care quality over time with input from clinicians, patients, and other stakeholders. We have sought and continue to seek feedback from the health care community through various public avenues such as listening sessions, request for information and rulemaking where we have received feedback that many clinical practices are still working towards implementing the Quality Payment Program. This proposed rule for Quality Payment Program Year 2 reflects this feedback and includes several proposals that extend transition year policies finalized in the CY 2017 Quality Payment Program final rule with comment period; however, we also include 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 (MIPS payment year 2021). Additionally, we address elements of MACRA that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring. We also include proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the Quality Payment Program, including policies related to the All-Payer Combination Option for the APM incentive.

B. Overall Impact

We have examined the impact of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2013), the Regulatory Flexibility Act (Pub. L. 96-354 enacted September 19, 1980) (RFA), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 14-04 enacted March 22, 1995), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 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). We estimate, as discussed below in this section, 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, we estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs,

was issued on January 30, 2017. As shown in the discussion of Table 84 in the Collection of Information section of this proposed rule, we estimate that this proposed rule would reduce the ICR burden by 132,620 hours and would result in a further reduction in burden costs of $12.4 million in the Quality Payment Program Year 2 relative to Quality Payment Program Year 1. As shown in the discussion of Regulatory Review Costs in section V.E. of this proposed rule, we estimate that total regulatory review costs associated with the Quality Payment Program would be approximately $4.8 million.

The Regulatory Flexibility Act (RFA) 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. Note that Small Business Administration (SBA) standards for small entities differ than the definition of a small practice under MIPS finalized in the CY 2017 Quality Payment Program final rule 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 annual receipts for an office of other health practitioners. (For details, see the SBA's Web site at http://www.sba.gov/content/table-smallbusiness-size-standards (refer to the 620000 series)).

Approximately 95 percent 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

(IRFA).

As discussed below, approximately 572,000 MIPS eligible clinicians will be required to submit data under MIPS. As shown later in this analysis, however, potential reductions in Medicare Part B payment for MIPS eligible clinicians under the MIPS are a small percentage of their total Medicare Part B paid charges—5 percent in the 2020 payment year—though rising to as high as 9 percent in subsequent years. On average, clinicians' Medicare billings are only approximately 23 percent of their total revenue,[43] so even those MIPS eligible clinicians that receive a negative MIPS payment adjustment under MIPS would rarely face losses in excess of 3 percent of their total revenues, the HHS standard for determining whether an economic effect is "significant." (In order to determine whether a rule meets the RFA threshold of "significant" impact, HHS has, for many years, used as a standard adverse effects that exceed 3 percent of either revenues or costs.) However, because there are so many affected MIPS eligible clinicians, even if only a small proportion is significantly adversely affected, the number could be "substantial." Therefore, we are unable to conclude that an Initial Regulatory Flexibility Analysis (IRFA) is not required. Accordingly, the analysis and discussion provided in this section, as well as elsewhere in this final rule with comment period, together meet the requirements for an IRFA. We note that whether or not a particular MIPS eligible clinician or other eligible clinician is adversely affected would depend in large part on the performance of that MIPS eligible clinician or other eligible clinician, and that CMS will offer significant technical assistance to MIPS eligible clinicians and other eligible clinicians in meeting the new standards.

[43] Based on National Health Expenditure Data, Physicians and Clinical Services Expenditures, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

For the 2018 MIPS performance period, this proposed rule has several key proposals that will provide regulatory relief for clinicians and practices and help increase ways for successful participation. These include implementing virtual groups, raising the low volume threshold, continuing to allow the use of 2014 Edition CEHRT (Certified Electronic Health Record Technology), and adding a new significant hardship exception for the advancing care information performance category for MIPS eligible clinicians who are in small practices, as summarized in section I.D.4.c. of this proposed rule.

In addition, section 1102(b) of the Act requires us 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, we define 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. We are not preparing an analysis for section 1102(b) of the Act because we have 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 (UMRA) also 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. We do 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 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. We have outlined in section II.D.6.(a) of 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. We do 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.

We have prepared the following analysis, which together with the information provided in the rest of this proposed rule, meets all assessment requirements. The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we would use to minimize the burden on small entities. As indicated elsewhere in this proposed rule, we are implementing a variety of changes to our regulations, payments, or payment policies to implement statutory provisions. We provide information for each of the policy changes in the relevant sections of this proposed rule. We note that many of the MIPS policies from the CY 2017 Quality Payment Program final rule were only defined for the 2017 MIPS performance period and 2019 MIPS payment year (including the performance threshold, the performance category reweighting policies, and many scoring policies for the quality performance category) which precludes us from developing a baseline for the 2018 MIPS performance period and 2020 MIPS payment year if there were no new regulatory action. We are unaware of any relevant federal rules that duplicate, overlap, or conflict with this proposed rule. The relevant sections of this proposed rule contain a description

of significant alternatives if applicable.

C. Changes in Medicare Payments

Section 101 of the MACRA, (1) repeals the Sustainable Growth Rate (SGR) formula for physician payment updates in Medicare, and (2) requires that we establish MIPS for eligible clinicians under which the Secretary must use a MIPS eligible clinician's final score to determine and apply a MIPS payment adjustment factor to the clinician's Medicare Part B payments for a year.

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 percent a year during CYs 2016 through 2019. The estimates in this RIA take those legislated rates as the baseline for the estimates we make 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.

As required by the MACRA, overall payment rates for services for which payment is made under the PFS would remain at the 2019 level through 2025, but starting in 2019, the amounts paid to individual MIPS eligible clinicians and other eligible clinicians would be subject to adjustment through one of two mechanisms, depending on whether the clinician achieves the threshold for participation in Advanced APMs to be considered a Qualifying APM Participant (QP) or Partial QP, or is instead evaluated under the MIPS.

1. Estimated Incentive Payments to QPs in Advanced APMs

From 2019 through 2024, eligible clinicians receiving a sufficient portion of Medicare Part B payments for covered professional services or seeing a sufficient number of Medicare patients through Advanced APMs as required to become QPs would receive a lump-sum APM Incentive Payment equal to 5 percent of their estimated aggregate payment amounts for

Medicare covered professional services in the preceding year, as discussed in section II.D. of this proposed rule.

The APM Incentive Payment is separate from, and in addition to, the payment for covered professional services furnished by an eligible clinician during that year. Eligible clinicians who become QPs for a year would not need to report to MIPS and would not receive a MIPS payment adjustment to their Part B payments. Eligible clinicians who do not become QPs, but meet a slightly lower threshold to become Partial QPs for the year, may elect to report to MIPS and would then be scored under MIPS and receive a MIPS payment adjustment, but do not receive the APM Incentive Payment. For the 2018 Medicare QP Performance Period, we define Partial QPs to be eligible clinicians in Advanced APMs who have at least 20 percent, but less than 25 percent, of their payments for Part B covered professional services through an Advanced APM Entity, or furnish Part B covered professional services to at least 10 percent, but less than 20 percent, of their Medicare beneficiaries through an Advanced APM Entity. If the Partial QP elects to be scored under MIPS, they would be subject to all MIPS requirements and would receive a MIPS payment adjustment. This adjustment may be positive or negative. If an eligible clinician does not meet either the QP or Partial QP standards, the eligible clinician would be subject to MIPS, would report to MIPS, and would receive the corresponding MIPS payment adjustment.

Beginning in 2026, payment rates for services furnished by clinicians who achieve QP status for a year would be increased each year by 0.75 percent for the year, while payment rates for services furnished by clinicians who do not achieve QP status for the year would be increased by 0.25 percent. In addition, MIPS eligible clinicians would receive positive, neutral, or negative MIPS payment adjustments to their Part B payments in a payment year based on performance during a prior performance period. Although the MACRA amendments established overall payment rate and procedure parameters until 2026 and beyond, this impact analysis

covers only the second payment year (2020) of the Quality Payment Program in detail. After 2020, while overall payment levels will be partially bounded, we have also acknowledged in the preamble that the Department will likely revise its quality and other payment measures and overall payment thresholds and other parameters as clinicians' behavior changes.

We estimate 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 percent 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. We estimate that the aggregate total of the APM incentive payment of 5 percent of Part B allowed charges for QPs would be between approximately $590 and $800 million for the 2020 Quality Payment Program payment year. These estimates reflect longstanding HHS policy not to attempt to predict the effects of future rulemaking in order to maximize future Secretarial discretion over whether, and if so how, payment or other rules would be changed.

We project the number of eligible clinicians that will be excluded from MIPS as QPs using several sources of information. First, the projections are anchored in the most recently available public information on Advanced APMs. The projections reflect APMs that will be operating in 2018. This proposed rule indicates which APMs would be Advanced APMs under proposed policies, including the Next Generation ACO Model, Comprehensive Primary Care Plus (CPC+) Model, Comprehensive ESRD Care (CEC) Model, Episode Payment Models (EPM), Vermont All-Payer ACO Model[44], Comprehensive Care for Joint Replacement Payment Model (CEHRT Track), Oncology Care Model (Two-Sided Risk Arrangement), ACO Track 1+ Model, the Shared Savings Program Tracks 2 and 3. We also project Advanced APM

[44] Vermont ACOs will be participating in an Advanced APM during 2018 through a modified version of the Next Generation ACO Model. The Vermont Medicare ACO Initiative will be an Advanced APM beginningin 2019.

participation based on applicant counts and estimated acceptance rates to Advanced APMs that had open application periods as of early 2017. We use a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016, for the first Medicare QP Performance Period for 2017. We examine the extent to which Advanced APM participants would meet the QP thresholds of having at least 25 percent of their Part B covered professional services or at least 20 percent of their Medicare beneficiaries furnished Part B covered professional services through the Advanced APM Entity. The preliminary version of this file followed the methodologies for group (APM Entity level) determination of QP status outlined in the CY 2017 Quality Payment Program final rule with comment period. We also assumed that during the first Medicare QP Performance Period, the majority of eligible clinicians participating in Advanced APMs would be QPs based on the preliminary version of this file.

2. Estimated Numbers of Clinicians Eligible for MIPS

Certain clinicians may not be eligible to participate or may be excluded from participation in MIPS for various reasons. For example, the MACRA requires us to limit eligibility for the 2019 and 2020 MIPS payment years to specified clinician types. Additionally, we exclude eligible clinicians with billings that do not exceed the low volume threshold as proposed in section II.C.2.c. of this proposed rule: those with $90,000 or less in Part B allowed charges or 200 or fewer Medicare Part B patients as measured at the TIN/NPI level for individual reporting, the TIN level for group reporting, the APM Entity level for reporting under the APM scoring standard. We also exclude those who are newly enrolled to Medicare and those eligible clinicians who are QPs.

To estimate the number of clinicians that are not in MIPS due to an ineligible clinician type for CY 2018, our scoring model used the first 2019 Payment Year MIPS eligibility file as

described in 81 FR 77069 and 77070. The data file included 1.5 million clinicians who had Medicare Part B claims from September 1, 2015 to August 31, 2016 and included a 60-day claim run-out. We limited our analysis to those clinicians identified as MIPS eligible clinician types for the 2020 MIPS payment year: doctors of medicine, doctors of osteopathy, chiropractors, dentists, optometrists, podiatrists, nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists.

We estimated the number of clinicians excluded for low volume by comparing the allowed Medicare Part B charges in the first 2019 MIPS payment year eligibility file to the proposed low volume threshold. We used 2015 PQRS reporting data to determine whether clinicians have historically reported as a group and whether to make the low-volume determination at the individual (TIN/NPI) or group (TIN) level. We assumed all Shared Savings Program or Pioneer ACO participants would exceed the low volume threshold because the ACOs have a requirement for a minimum number of assigned beneficiaries.

Because of the lack of available data on which eligible clinicians would elect to participate as part of a virtual group under the policies proposed in section II.C.4 of this proposed rule, the scoring model does not reflect the proposed policies for scoring virtual groups.

We estimated the number of newly enrolled Medicare clinicians to be excluded from MIPS by assuming clinicians (NPIs) are newly enrolled if they have Part B charges in the eligibility file, but no Part B charges in 2015. Because of data limitations, this newly enrolled modeling methodology is different than the one that will be used under the policies finalized under §§414.1310 and 414.1315.

To exclude QPs from our scoring model, we used a preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016 for the first Medicare QP Performance Period for 2017 that included

clinicians participating in Advanced APMs active as of mid-March 2017. We assumed that all partial QPs would participate in MIPS and included them in our scoring model. Because of the expected growth in Advanced APM participation, the estimated number of QPs excluded from our model based on data from the 2017 Quality Payment Program performance period (74,920) is lower than the summary level projection for the 2018 Quality Payment Program performance period based on the expected growth in APM participation (180,000-245,000). 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. Hence, our model may overestimate the fraction of clinicians and allowed Medicare Part B charges that will remain subject to MIPS after the exclusions.

We have estimated the cumulative effects of these exclusions in Table 85. We estimate that 65 percent of clinicians' $124,029 million in allowed Medicare Part B charges will be included in MIPS. Further, we estimate that approximately 37 percent 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 our scoring model excluding clinicians that submitted via measures groups under the 2015 PQRS, since that data submission mechanism was eliminated under MIPS.

TABLE 85: Projected Number of Clinicians Ineligible for or Excluded from MIPS in CY 2018, by Reason*

Reason for Exclusion	Count of Medicare clinicians (TIN/NPIs) remaining after exclusion	Part B allowed charges remaining after exclusion ($ in millions)	Count of Medicare clinicians (TIN/NPIs) excluded	Part B allowed charges excluded ($ in millions
ALL MEDICARE CLINICIANS BILLING PART B	1,548,022	$124,029		
Subset to clinician types that are eligible for 2020 MIPS payment year**	1,314,733	$101,733	233,289	$22,296
Exclude Newly Enrolled Clinicians***	1,232,779	$101,243	81,954	$490
Additionally, Exclude Low Volume Clinicians****	647,219	$87,147	585,560	$14,096
Additionally, Exclude Qualifying APM Participants (QPs)*****	572,299	$80,658	74,920	$6,489
TOTAL REMAINING IN MIPS AFTER EXCLUSON	**572,299**	**$80,658**		
PERCENT ELIGIBLE CLINICIANS REMAINING IN MIPS AFTER EXCLUSIONS	**37%**	**65%**		
ADDITIONAL EXCLUSIONS FOR SCORING MODEL				
Exclude clinicians who previously submitted measures groups under 2015 PQRS	554,846	$71,930	17,453	$8,728
PERCENT ELIGIBLE CLINICANS REMAINING IN SCORING MODEL AFTER EXCLUSIONS	36%	58%		

* Allowed Medicare Part B charges for covered services of the clinician under Part B from September 1, 2015 to August 31, 2016 data. Payments estimated using 2015 or 2016 dollars.
** Section 1848(q)(1)(C) of the Act defines a MIPS eligible clinician for payment years 1 and 2 as a physician, physician's assistant, nurse practitioner, or clinical nurse anesthetist, or a group that includes such clinicians.
*** Newly enrolled Medicare clinicians in our scoring model had positive Part B charges between September 1, 2015 and August 31, 2016 but had no Part B charges for CY2015.
**** Low-volume clinicians have less than or equal to $90,000 in allowed Medicare Part B charges or less than or equal to 200 Medicare patients.
**** QPs have at least 25 percent of their Medicare Part B covered professional services or least 20 percent of their Medicare beneficiaries furnished part B covered professional services through an Advanced APM.

3. Estimated Impacts on Payments to MIPS Eligible Clinicians

Our scoring model includes eligible clinicians who will be required to submit MIPS data to us in year 1.[45] They are eligible clinicians who (a) are not QPs participating in Advanced APMs, (b) exceeded the low volume threshold, and (c) enrolled as Medicare clinicians prior to the current performance year.

Payment impacts in this proposed rule reflect averages by specialty and practice size

[45]Due to data limitations, our scoring model excluded the 17.453 MIPS eligible clinicians who submitted quality via the measures groups mechanism under the 2015 PQRS. The measures group submission mechanism is not available in MIPS.

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 here 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.

To estimate the impact of MIPS on clinicians required to report, we used the most recently available data, including 2014 and 2015 PQRS data, 2014 and 2015 CAHPS for PQRS data, 2014 and 2015 VM data, 2015 and 2016 Medicare and Medicaid EHR Incentive Program data, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov), preliminary version of the file used for the predictive qualifying Alternative Payment Model participants analysis made available on qpp.cms.gov on June 2, 2017, and prepared using claims for services between January 1, 2016 through August 31, 2016 for the first Medicare QP Performance Period for 2017, the 2017 MIPS published measure benchmarks, and other available data to model the scoring provisions described in this regulation. First, we arithmetically calculated a hypothetical final score for each MIPS eligible clinician based on quality, advancing care information, and improvement activities performance categories.

We estimated the quality performance category score using measures submitted to PQRS for the 2015 performance period. For quality measures submitted via the claims, EHR, qualified registry, QCDR, and CMS-approved survey vendor submission mechanisms, we applied the published benchmarks developed for the 2017 MIPS performance period. For quality measures submitted via Web Interface, we applied the published benchmarks developed for the 2017 Shared Savings Program where available, and did not calculate scores for measures for which

Shared Savings Program benchmarks did not exist. For the all-cause hospital readmission measure we used the 2015 VM analytic file, which was the most recent data available, and calculated our own benchmarks based on 2015 data since published benchmarks were not yet available. In order to estimate the impact of improvement for the quality performance category, we estimated a quality performance category percent score using 2014 PQRS data, 2014 CAHPS for PQRS data, and 2014 VM data. Because we lack detailed information on which MIPS eligible clinicians would elect to submit as part of a virtual group and which MIPS eligible clinicians based primarily in inpatient hospital settings or in emergency departments would elect facility-based measurement, the proposed policies regarding virtual groups and facility-based measurement are not reflected in our scoring model. Our model applied the MIPS APM scoring standards proposed in section II.C.6.g. of this proposed rule to quality data from MIPS eligible clinicians that participated in the Shared Savings Program model in 2015.

We propose in section II.C.6.d.(2) of this proposed rule, for the cost performance category to have a zero percent weight and to not contribute to the 2020 MIPS payment year final score. Therefore, we did not include cost measures in this scoring model.

For the advancing care information performance category score, we used data from the 2015 Medicare and Medicaid EHR Incentive Programs. Because the EHR Incentive Programs are based on attestation at the NPI level, the advancing care information performance category scores are assigned to clinicians by their individual national provider identifier (NPI), regardless of whether the clinician was part of a group submission for PQRS. We assigned a score of 100 percent to MIPS eligible clinicians who attested in the 2015 Medicare EHR Incentive Program or received a 2015 incentive payment from the Medicaid EHR Incentive Program (after excluding incentive payments to adopt, implement, and upgrade). While we had attestation information for the Medicare EHR Incentive Program, we did not have detailed attestation information for the Medicaid EHR Incentive Program. Therefore, we used incentive payments (excluding the adopt

implement and upgrade incentive payments) as a proxy for attestation in the Medicaid EHR Incentive Program. Our rationale for selecting a 100 percent performance score is that the requirements to achieve a base score of 50 percent in MIPS are lower than the EHR Incentive Program requirements to attest for meaningful use (which determined whether program requirements were met on an all or nothing basis). We anticipate clinicians who met EHR Incentive Program requirements for meaningful use will be able to achieve an advancing care information performance category score of 100 percent. Because the minimum requirements for meaningful use did not allow partial scoring, we believe the clinicians who met the minimum requirements would be able to achieve an advancing care information performance category score of 100 percent. For example, the minimum requirements to attest to Modified Stage 2 objectives and measures for the 2017 Medicare EHR Incentive Program (assuming no measure exceptions and an immunization registry is available) would translate into an advancing care information performance score of 85 percent. Generally, we see that clinicians have performance greater than the minimum requirements, which is the reason we estimated an advancing care information performance category score of 100 percent.

For those clinicians who did not attest in either the 2015 Medicare or Medicaid EHR Incentive Program, we evaluated whether the MIPS eligible clinician could have their advancing care information performance category score reweighted. The advancing care information performance category weight is set equal to zero percent, and the weight is redistributed to quality for non-patient facing clinicians, hospital-based clinicians, ASC-based clinicians, NPs, PAs, CRNAs, or CNSs, or those who request and are approved for a significant hardship or other type of exception, including a new significant hardship exception for small practices, or clinicians who are granted an exception based on decertified EHR technology. We used the non-patient facing and hospital-based indicators and specialty and small practice indicators as calculated in the initial MIPS eligibility run. Due to data limitations, we were not able to

reweight the advancing care information performance category scores of ASC-based clinicians in our scoring model. For significant hardship exceptions, we used the 2016 final approved significant hardship file. If a MIPS eligible clinician did not attest and did not qualify for a reweighting of their advancing care information performance category, the advancing care information performance category score was set equal to zero percent.

We modeled the improvement activities performance category score based on 2015 APM participation and historic participation in 2015 PQRS and 2015 Medicare and Medicaid EHR Incentive Programs. Our model identified the 2015 Shared Savings Program participants and assigned them an improvement activity score of 100 percent, consistent with our policy to assign a 100 percent improvement activities performance category score to Shared Savings Program participants in Quality Payment Program Payment Year 2019. Due to limitations in 2015 data, our model did not include 2015 participants in APMs other than the Shared Savings Program.

Clinicians and groups not participating in a MIPS APM were assigned an improvement activities score based on their performance in the quality and advancing care information performance categories. MIPS eligible clinicians whose 2015 PQRS data meets all the MIPS quality submission criteria (for example, submitting 6 measures with data completeness, including one outcome or high priority measures) and had an estimated advancing care information performance category score of 100 percent (if advancing care information is applicable to them) are assigned an improvement activities performance category score of 100 percent. MIPS eligible clinicians who did not participate in 2015 PQRS or the 2015 Medicare or Medicaid EHR Incentive Program (if it was applicable), earned an improvement activity performance category score of zero percent, with the rationale that these clinicians may be less likely to participate in MIPS if they have not previously participated in other programs.

For the remaining MIPS eligible clinicians not assigned an improvement activities performance category score of 0 or 100 percent in our model, we assigned a score that

corresponds to submitting one medium-weighted improvement activity. The MIPS eligible clinicians assigned an improvement activity performance category score corresponding to a medium-weighted activity include (a) those who submitted some quality measures under the 2015 PQRS but did not meet the MIPS quality submission criteria or (b) those who did not submit any quality data under the 2015 PQRS who attested under the Medicare EHR Incentive program or received an incentive payment (excluding adopt implement and upgrade payments) from the Medicaid EHR Incentive Program. We assumed that these clinicians may be likely to partially, but not fully participate, in the improvement activities category. For non-patient facing clinicians, clinicians in a small practice (consisting of 15 or fewer professionals), clinicians in practices located in a rural area, clinicians in a geographic healthcare professional shortage area (HPSA) practice or any combination thereof, the medium weighted improvement activity was assigned one-half of the total possible improvement activities performance category score (20 out of a 40 possible points or 50 percent) The remaining MIPS eligible clinicians not assigned an improvement activities performance category score of 0, 50, or 100 points were assigned a score corresponding to one medium-weighted activity (10 out of 40 possible points or 25 percent). Due to lack of available data, we were not able to identify MIPS eligible clinicians in patient-centered medical homes or comparable specialty societies in our scoring model. The policy finalized under §414.1380(b)(3) indicates that MIPS eligible clinicians in a patient centered medical home or a comparable specialty societies would qualify for improvement activities performance category score of 100 percent.

Our model assigns a final score for each TIN/NPI by multiplying each performance category score by the corresponding performance category weight, adding the products together, and multiplying the sum by 100 points. For MIPS eligible clinicians that had their advancing care information performance category score reweighted due to a significant hardship exception or automatic reweighting, the weight for the advancing care information performance category

was assigned to the quality performance category.

The scoring model reflects the proposed bonuses for complex patients and small practices in sections II.C.7.b.(1)(b) and II.C.7.b.(1)(c) of this proposed rule. Consistent with the proposal to define complex patients as those with high medical risk, our scoring model adds the average Hierarchical Condition Category (HCC) score across all the MIPS eligible clinician's patients (with a cap of three points) to the final score. We used the average HCC risk score calculated for each NPI in the 2015 Physician and Other Supplier Public Use File. We also generated a group average HCC risk score by weighing the scores for individual clinicians in each group by the number of beneficiaries they have seen. Our scoring model also adds 5 points to the final score for small practices that had a final score greater than 0 points. After adding any applicable bonus for complex patients and small practices, we set any final scores that exceeded 100 points to 100.

We then implemented an exchange function based on the provisions of this proposed rule to estimate the positive or negative MIPS payment adjustment based on the estimated final score and the estimated Medicare Part B paid charges. Due to data limitations, we assumed that the paid amount was 80 percent of Medicare Part B allowed charges. We iteratively modified the parameters of the exchange function distributions of MIPS payment adjustments that meet statutory requirements related to the linear sliding scale, budget neutrality and aggregate exceptional performance payment adjustment amounts (as finalized under §414.1405). Our model used a 15-point performance threshold and a 70-point additional performance threshold.

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, we have prepared two sets of analyses. The first analysis, which we label as standard participation assumptions, relies on the assumption

that a minimum 90 percent of MIPS eligible clinicians will participate in submitting quality performance category data to MIPS, regardless of practice size. Therefore, we assumed that, on average, the categories of practices with 1-15 clinicians would have 90 percent participation in the quality performance category. This assumption is an increase from existing historical data. 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.[46] 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, we assumed the average participation rates of those categories of clinicians would be the same as under the 2015 PQRS. Our assumption of 90 percent average participation for the categories of practices with 1-15 clinicians reflects our belief that small and solo practices will respond to the finalized policies and this proposed rule's flexibility, reduced data submission burden, financial incentives, and the support they will receive through technical assistance by participating at a rate close to that of other practice sizes, enhancing the existing upward trend in quality data submission rates. Therefore, we assume that the quality scores assigned to new participants reflect the distribution of MIPS quality scores. We also applied behavioral participation assumptions to the improvement activities performance category.

To simulate the impact of the standard model assumption, we randomly select a subset of non-participants and substitute the quality and improvement activity scores of randomly selected participants. For example, for a previously non-participating clinician, we substitute the scores

[46] 2015 PQRS Experience Report, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_Experience_Report.pdf.

of a randomly selected a MIPS eligible clinician with a quality score of 73 percent. The improvement activities performance category score is then computed using this alternative quality score. We did not apply the same participation assumptions to the advancing care information performance category because the category applies only to a subset of MIPS eligible clinicians, and, as noted above, would be weighted at zero percent for non-patient facing clinicians, hospital-based clinicians, ASC-based clinicians, NPs, PAs, CRNAs, or CNSs, and those who request and are approved for a significant hardship or other type of exception, including those in small practices. Further, we took into account that advancing care information performance category participation may be affected by the cost and time it may take to acquire and implement certified EHR technology needed to perform in that performance category.

The second analysis, which we label as "alternative participation assumptions," assumes a minimum participation rate in the quality and improvement activities performance categories of 80 percent. Because the 2015 PQRS participation rates for practices of more than 15 clinicians are greater than 80 percent, 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 86 summarizes the impact on Part B services of MIPS eligible clinicians by specialty for the standard participation assumptions.

Table 87 summarizes the impact on Part B services of MIPS eligible clinicians by specialty under the alternative participation assumptions.

Tables 89 and 90 summarize the impact on Part B services of MIPS eligible clinicians by practice size for the standard participation assumptions (Table 88) and the alternative participation assumptions (Table 89).

Tables 87 and 89 show that under our standard participation assumptions, the vast majority (96.1 percent) of MIPS eligible clinicians are anticipated to receive positive or neutral

payment adjustments for the 2020 MIPS payment year, with only 3.9 percent receiving negative MIPS payment adjustments. Using the alternative participation assumptions, Tables 88 and 90 shows that 94.3 percent of MIPS eligible clinicians are expected to receive positive or neutral payment adjustments.

The projected distribution of funds reflects this proposed rule's emphasis on increasing more complete reporting of MIPS eligible clinicians for the Quality Payment Program Performance Year 2, which continues the ramp to more robust participation in future MIPS performance years.

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

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Overall	**554,846**	**$57,544**	**96.6%**	**96.1%**	**76.8%**	**3.9%**	**673.3**	**-173.3**	**0.9%**
Addiction Medicine	71	$3	95.8%	95.8%	82.4%	4.2%	0.0	0.0	-0.2%
Allergy/ Immunology	1,692	$162	94.9%	94.9%	80.0%	5.1%	1.8	-0.8	0.6%
Anesthesiology	14,105	$789	97.8%	95.7%	74.5%	4.3%	7.8	-3.0	0.6%
Anesthesiology Assistant	588	$7	100.0%	99.8%	88.4%	0.2%	0.1	0.0	1.7%
Cardiac Electrophysiology	1,970	$341	97.5%	98.4%	81.5%	1.6%	4.7	-0.4	1.3%
Cardiac Surgery	1,181	$182	98.6%	98.3%	85.2%	1.7%	2.7	-0.2	1.4%
Cardiovascular Disease (Cardiology)	20,025	$3,600	96.5%	96.8%	80.9%	3.2%	47.2	-8.5	1.1%
Certified Clinical Nurse Specialist	896	$22	97.0%	96.4%	86.2%	3.6%	0.3	-0.2	0.4%
Certified Registered Nurse Anesthetist (CRNA)	16,600	$259	99.3%	98.0%	84.7%	2.0%	3.1	-0.7	0.9%
Chiropractic	581	$31	92.9%	92.6%	52.4%	7.4%	0.2	-0.2	-0.1%
Clinic or Group Practice	393	$51	97.7%	97.2%	96.9%	2.8%	0.9	-0.4	1.0%
Colorectal Surgery (Proctology)	1,046	$97	95.7%	96.2%	75.6%	3.8%	1.2	-0.3	0.9%
Critical Care (Intensivists)	2,730	$201	97.0%	96.6%	82.9%	3.4%	2.5	-0.7	0.9%
Dermatology	9,506	$2,510	91.8%	91.8%	69.6%	8.2%	27.2	-10.7	0.7%
Diagnostic Radiology	27,990	$3,317	97.0%	95.7%	58.8%	4.3%	26.3	-6.8	0.6%
Emergency Medicine	31,503	$1,728	99.1%	97.4%	56.2%	2.6%	12.8	-2.2	0.6%
Endocrinology	4,376	$336	97.3%	97.2%	80.1%	2.8%	4.3	-1.0	1.0%
Family Medicine***	54,171	$3,667	97.0%	96.9%	80.7%	3.1%	48.1	-11.1	1.0%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Gastroenterology	10,910	$1,204	96.0%	96.5%	79.2%	3.5%	15.6	-2.8	1.1%
General Practice	2,210	$214	91.3%	90.7%	74.7%	9.3%	1.9	-1.7	0.1%
General Surgery	14,135	$1,143	96.6%	96.6%	79.4%	3.4%	13.9	-3.5	0.9%
Geriatric Medicine	1,394	$121	96.4%	95.9%	77.0%	4.1%	1.4	-0.5	0.8%
Geriatric Psychiatry	119	$9	91.6%	89.9%	76.6%	10.1%	0.1	-0.1	-0.7%
Gynecological Oncology	807	$80	98.4%	98.3%	79.4%	1.7%	1.0	-0.1	1.0%
Hand Surgery	1,037	$131	92.8%	92.3%	67.8%	7.7%	1.3	-0.5	0.6%
Hematology	648	$109	98.6%	98.9%	83.5%	1.1%	1.5	0.0	1.4%
Hematology-Oncology	6,463	$2,929	97.5%	97.2%	77.3%	2.8%	32.4	-4.5	1.0%
Hospice and Palliative Care	645	$23	99.5%	99.1%	88.1%	0.9%	0.3	0.0	1.3%
Infectious Disease	4,571	$497	94.2%	94.1%	78.9%	5.9%	5.6	-2.7	0.6%
Internal Medicine	72,692	$6,917	95.9%	95.3%	80.0%	4.7%	86.1	-24.7	0.9%
Interventional Cardiology	2,716	$491	97.5%	98.5%	83.8%	1.5%	7.1	-0.4	1.3%
Interventional Pain Management	1,255	$333	90.0%	89.0%	62.8%	11.0%	3.2	-1.9	0.4%
Interventional Radiology	1,181	$232	97.0%	96.1%	67.9%	3.9%	1.8	-0.5	0.6%
Maxillofacial Surgery	194	$5	99.0%	99.0%	85.4%	1.0%	0.1	0.0	1.0%
Medical Oncology	2,530	$870	98.5%	98.4%	78.2%	1.6%	9.3	-0.8	1.0%
Nephrology	5,707	$1,073	95.1%	95.2%	78.2%	4.8%	12.9	-3.0	0.9%
Neurology	11,588	$1,141	95.3%	95.7%	77.8%	4.3%	12.9	-5.4	0.7%
Neuropsychiatry	67	$6	91.0%	91.0%	72.1%	9.0%	0.0	-0.1	-0.2%
Neurosurgery	3,850	$505	95.3%	95.2%	72.9%	4.8%	5.5	-1.8	0.7%
Nuclear Medicine	466	$66	97.0%	97.2%	81.2%	2.8%	0.7	-0.3	0.7%
Nurse Practitioner	50,649	$1,313	98.0%	97.8%	87.3%	2.2%	16.7	-7.0	0.7%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Obstetrics & Gynecology	15,587	$237	99.0%	99.1%	88.3%	0.9%	3.0	-0.6	1.0%
Ophthalmology	14,779	$6,451	96.8%	96.6%	73.6%	3.4%	99.0	-5.9	1.4%
Optometry	4,621	$439	94.5%	94.3%	69.2%	5.7%	5.0	-1.5	0.8%
Oral Surgery (Dentist only)	282	$7	97.5%	97.9%	89.1%	2.1%	0.1	-0.1	-0.4%
Orthopedic Surgery	17,504	$2,586	93.4%	93.3%	66.8%	6.7%	25.2	-9.9	0.6%
Osteopathic Manipulative Medicine	297	$22	96.0%	94.9%	79.1%	5.1%	0.2	-0.1	0.7%
Otolaryngology	6,854	$777	93.7%	92.5%	68.5%	7.5%	7.5	-3.6	0.5%
Pain Management	1,475	$291	88.1%	86.6%	63.4%	13.4%	2.6	-2.0	0.2%
Pathology	7,924	$770	96.6%	95.5%	65.0%	4.5%	6.1	-4.2	0.2%
Pediatric Medicine	4,007	$43	99.6%	99.6%	90.2%	0.4%	0.5	-0.1	1.1%
Peripheral Vascular Disease	57	$7	98.2%	96.5%	90.9%	3.5%	0.1	0.0	1.0%
Physical Medicine and Rehabilitation	5,237	$734	91.3%	90.5%	68.4%	9.5%	6.4	-5.0	0.2%
Physician Assistant	38,378	$875	98.7%	98.4%	84.1%	1.6%	11.2	-3.0	0.9%
Physician, Sleep Medicine	256	$18	96.5%	97.7%	80.8%	2.3%	0.2	0.0	0.9%
Plastic and Reconstructive Surgery	1,986	$170	94.7%	94.7%	77.5%	5.3%	1.8	-1.0	0.4%
Podiatry	9,558	$1,231	87.3%	87.0%	59.2%	13.0%	10.0	-9.1	0.1%
Preventive Medicine	221	$11	98.2%	97.7%	83.8%	2.3%	0.1	0.0	0.8%
Psychiatry	10,590	$487	93.9%	93.7%	75.2%	6.3%	4.2	-4.8	-0.1%
Pulmonary Disease	8,756	$1,111	96.2%	96.2%	80.0%	3.8%	13.8	-3.4	0.9%
Radiation Oncology	3,049	$810	97.9%	97.3%	80.8%	2.7%	9.0	-1.6	0.9%
Rheumatology	3,340	$1,126	97.2%	97.2%	80.5%	2.8%	15.0	-2.0	1.2%
Sports Medicine	792	$61	97.0%	96.8%	78.7%	3.2%	0.7	-0.1	0.9%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Surgical Oncology	713	$52	98.6%	98.9%	82.7%	1.1%	0.7	-0.1	1.2%
Thoracic Surgery	1,738	$203	97.8%	98.1%	82.9%	1.9%	2.8	-0.3	1.2%
Other	272	$34	94.9%	95.6%	84.6%	4.4%	0.4	-0.1	0.9%
Urology	8,590	$1,596	95.4%	96.1%	72.4%	3.9%	17.9	-3.4	0.9%
Vascular Surgery	2,725	$683	95.8%	96.0%	73.9%	4.0%	7.5	-2.1	0.8%

Notes:

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

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

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

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TABLE 87: MIPS Estimated Payment Year 2020 Impact on Estimated Paid Amount by Specialty, Alternative Participation Assumptions *

Clinician Specialty/Type	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Overall	**554,846**	**$57,544**	**94.5%**	**94.3%**	**77.1%**	**5.7%**	**782.9**	**-282.9**	**0.9%**
Addiction Medicine	71	$3	94.4%	94.4%	83.6%	5.6%	0.0	0.0	-0.2%
Allergy/ Immunology	1,692	$162	89.4%	90.0%	80.5%	10.0%	2.0	-1.5	0.3%
Anesthesiology	14,105	$789	96.8%	94.8%	74.5%	5.2%	9.0	-4.5	0.6%
Anesthesiology Assistant	588	$7	100.0%	99.8%	88.4%	0.2%	0.1	0.0	2.0%
Cardiac Electrophysiology	1,970	$341	96.9%	98.0%	81.6%	2.0%	5.6	-0.5	1.5%
Cardiac Surgery	1,181	$182	97.5%	97.3%	85.6%	2.7%	3.2	-0.4	1.6%
Cardiovascular Disease (Cardiology)	20,025	$3,600	94.1%	94.9%	81.2%	5.1%	54.8	-15.4	1.1%
Certified Clinical Nurse Specialist	896	$22	96.0%	95.4%	86.3%	4.6%	0.3	-0.2	0.3%
Certified Registered Nurse Anesthetist (CRNA)	16,600	$259	98.9%	97.6%	84.8%	2.4%	3.6	-1.1	1.0%
Chiropractic	581	$31	85.0%	86.1%	51.2%	13.9%	0.1	-0.4	-0.8%
Clinic or Group Practice	393	$51	97.2%	96.7%	96.8%	3.3%	1.0	-0.4	1.2%
Colorectal Surgery (Proctology)	1,046	$97	92.9%	94.3%	75.4%	5.7%	1.4	-0.4	0.9%
Critical Care (Intensivists)	2,730	$201	95.9%	95.7%	83.2%	4.3%	3.0	-0.9	1.0%
Dermatology	9,506	$2,510	85.3%	85.9%	69.9%	14.1%	31.0	-17.9	0.5%

Clinician Specialty/Type	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Diagnostic Radiology	27,990	$3,317	96.2%	94.9%	58.8%	5.1%	32.0	-9.3	0.7%
Emergency Medicine	31,503	$1,728	98.8%	97.2%	56.2%	2.8%	15.6	-2.9	0.7%
Endocrinology	4,376	$336	94.8%	95.1%	80.6%	4.9%	5.0	-1.9	0.9%
Family Medicine***	54,171	$3,667	95.2%	95.3%	80.9%	4.7%	55.7	-18.3	1.0%
Gastroenterology	10,910	$1,204	93.5%	94.4%	79.5%	5.6%	18.2	-4.8	1.1%
General Practice	2,210	$214	83.6%	83.9%	75.9%	16.1%	1.8	-3.4	-0.7%
General Surgery	14,135	$1,143	94.3%	94.4%	79.7%	5.6%	16.1	-5.9	0.9%
Geriatric Medicine	1,394	$121	94.3%	94.0%	77.3%	6.0%	1.6	-0.8	0.7%
Geriatric Psychiatry	119	$9	87.4%	86.6%	76.7%	13.4%	0.1	-0.1	-0.8%
Gynecological Oncology	807	$80	98.0%	97.9%	79.5%	2.1%	1.2	-0.2	1.3%
Hand Surgery	1,037	$131	89.9%	90.0%	67.7%	10.0%	1.5	-0.7	0.7%
Hematology	648	$109	98.0%	98.3%	83.7%	1.7%	1.8	-0.2	1.5%
Hematology-Oncology	6,463	$2,929	96.3%	96.3%	77.3%	3.7%	38.6	-6.0	1.1%
Hospice and Palliative Care	645	$23	99.4%	98.9%	88.1%	1.1%	0.4	0.0	1.6%
Infectious Disease	4,571	$497	89.8%	90.1%	79.3%	9.9%	6.2	-4.9	0.3%
Internal Medicine	72,692	$6,917	93.5%	93.1%	80.3%	6.9%	99.0	-40.6	0.8%
Interventional Cardiology	2,716	$491	97.0%	98.2%	83.8%	1.8%	8.4	-0.6	1.6%
Interventional Pain Management	1,255	$333	83.3%	83.2%	61.9%	16.8%	3.6	-3.1	0.1%
Interventional Radiology	1,181	$232	95.9%	94.9%	68.2%	5.1%	2.3	-0.8	0.6%

Clinician Specialty/Type	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Maxillofacial Surgery	194	$5	98.5%	98.5%	85.9%	1.5%	0.1	0.0	1.1%
Medical Oncology	2,530	$870	98.0%	97.8%	78.3%	2.2%	11.2	-1.1	1.2%
Nephrology	5,707	$1,073	91.7%	92.3%	78.5%	7.7%	14.9	-5.6	0.9%
Neurology	11,588	$1,141	92.1%	92.9%	78.0%	7.1%	14.5	-9.0	0.5%
Neuropsychiatry	67	$6	91.0%	91.0%	72.1%	9.0%	0.1	-0.1	0.0%
Neurosurgery	3,850	$505	92.7%	92.8%	73.2%	7.2%	6.4	-2.8	0.7%
Nuclear Medicine	466	$66	94.0%	94.4%	81.6%	5.6%	0.8	-0.5	0.5%
Nurse Practitioner	50,649	$1,313	97.2%	97.1%	87.5%	2.9%	19.3	-9.8	0.7%
Obstetrics & Gynecology	15,587	$237	98.6%	98.8%	88.4%	1.2%	3.6	-1.0	1.1%
Ophthalmology	14,779	$6,451	94.0%	94.0%	73.9%	6.0%	117.0	-11.1	1.6%
Optometry	4,621	$439	90.8%	91.0%	69.6%	9.0%	5.8	-2.6	0.7%
Oral Surgery (Dentist only)	282	$7	96.5%	96.8%	89.4%	3.2%	0.1	-0.1	-0.8%
Orthopedic Surgery	17,504	$2,586	90.1%	90.4%	66.7%	9.6%	29.3	-15.2	0.5%
Osteopathic Manipulative Medicine	297	$22	93.9%	93.6%	79.1%	6.4%	0.3	-0.1	0.7%
Otolaryngology	6,854	$777	88.8%	88.3%	68.5%	11.7%	8.4	-6.3	0.3%
Pain Management	1,475	$291	82.2%	81.6%	62.9%	18.4%	2.8	-3.2	-0.1%
Pathology	7,924	$770	95.1%	94.0%	65.2%	6.0%	7.1	-5.4	0.2%
Pediatric Medicine	4,007	$43	99.5%	99.5%	90.2%	0.5%	0.6	-0.1	1.2%
Peripheral Vascular Disease	57	$7	94.7%	94.7%	90.7%	5.3%	0.1	0.0	0.9%
Physical Medicine and Rehabilitation	5,237	$734	86.0%	85.7%	68.5%	14.3%	7.0	-8.0	-0.1%

Clinician Specialty/Type	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Estimated Paid Amount
Physician Assistant	38,378	$875	98.2%	97.9%	84.2%	2.1%	13.2	-4.3	1.0%
Physician, Sleep Medicine	256	$18	95.7%	96.9%	81.0%	3.1%	0.3	-0.1	1.1%
Plastic and Reconstructive Surgery	1,986	$170	90.9%	91.5%	77.6%	8.5%	1.9	-1.6	0.2%
Podiatry	9,558	$1,231	76.1%	77.0%	58.4%	23.0%	10.1	-16.9	-0.5%
Preventive Medicine	221	$11	95.9%	95.5%	84.8%	4.5%	0.1	-0.1	0.6%
Psychiatry	10,590	$487	90.1%	90.3%	75.8%	9.7%	4.3	-7.9	-0.7%
Pulmonary Disease	8,756	$1,111	93.4%	93.8%	80.3%	6.2%	15.9	-5.9	0.9%
Radiation Oncology	3,049	$810	96.9%	96.4%	80.9%	3.6%	10.8	-2.2	1.1%
Rheumatology	3,340	$1,126	95.0%	95.5%	80.5%	4.5%	17.6	-3.5	1.3%
Sports Medicine	792	$61	96.5%	96.3%	78.9%	3.7%	0.8	-0.2	1.1%
Surgical Oncology	713	$52	98.2%	98.5%	82.6%	1.5%	0.8	-0.1	1.4%
Thoracic Surgery	1,738	$203	96.4%	97.0%	83.0%	3.0%	3.3	-0.6	1.3%
Other	272	$34	93.8%	94.5%	84.4%	5.5%	0.5	-0.2	1.0%
Urology	8,590	$1,596	92.9%	93.9%	72.5%	6.1%	21.2	-5.7	1.0%
Vascular Surgery	2,725	$683	93.1%	93.8%	73.8%	6.2%	8.6	-3.6	0.7%

*Alternative scoring model assumes that a minimum of 80 percent of clinicians within each practice size category would participate in quality data submission.
**2014, 2015 and 2016 data used to estimate 2018 payment adjustments. Payments estimated using 2015 and 2016 dollars.
***Specialty descriptions as self-reported on Part B claims. Note that all categories are mutually exclusive, including General Practice and Family Practice. 'Family Medicine' is used here for physicians listed as 'Family Practice' in Part B claims.

TABLE 88: MIPS Estimated Payment Year 2020 Impact on Total Estimated Paid Amount by Practice Size, Standard Participation Assumptions *

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

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

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

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

TABLE 89: MIPS Estimated Payment Year 2020 Impact on Estimated Paid Amount by Practice Size, Alternate Participation Assumptions*

Practice Size	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges)	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of
ALL PRACTICE SIZES	**554,846**	**$57,544**	**94.5%**	**94.3%**	**77.1%**	**5.7%**	**782.9**	**-282.9**	**0.9%**
1-15 clinicians	114,424	$26,091	80.0%	81.2%	64.1%	18.8%	317.4	-224.7	0.4%
16-24 clinicians	22,296	$3,840	91.7%	89.1%	52.7%	10.9%	40.3	-17.9	0.6%
25-99 clinicians	99,285	$9,814	96.2%	94.9%	63.7%	5.1%	115.2	-29.9	0.9%
100 or more clinicians	318,841	$17,799	99.4%	99.2%	86.4%	0.8%	310.0	-10.4	1.7%

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

*Alternative scoring model assumes that a minimum of 80 percent of clinicians within each practice size category would participate in quality data submission.

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

4. Potential Costs of Advancing Care Information and Improvement Activities for Eligible Clinicians

We believe that most MIPS eligible clinicians who can report the advancing care information performance category of MIPS have already adopted an EHR during Stage 1 and 2 of the Medicare or Medicaid EHR Incentive Programs, and will have limited additional operational expenses related to compliance with the advancing care information performance category requirements.

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 advancing care information performance category requirements.

For some MIPS eligible clinicians, the advancing care information performance category will be weighted at zero percent of the final score. We will continue our policy that was finalized in §414.1375(a) to reweight the advancing care information performance category scores for certain MIPS eligible clinicians, including those who may have been exempt from the Medicare EHR Incentive Program such as hospital-based clinicians, non-patient facing clinicians, PAs, NPs, CNs and CRNAs. Further, as described in section II.6.f.(7)(a)(iv) of this proposed rule, we are proposing to rely on section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, to assign a scoring weight of zero percent for the advancing care information performance category for MIPS eligible clinicians who are determined to be based in ambulatory surgical centers (ASCs). As described in section II.6.f.(7)(a)(i) of this proposed rule, we are proposing to rely on section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act, to allow MIPS eligible clinicians to apply for a significant hardship exception and subsequently have their advancing care information performance category reweighted to zero when they are faced with a significant hardship. Relying on this same authority, we are also proposing a significant hardship exception

for the advancing care information performance category for MIPS eligible clinicians who are in small practices, as discussed in section II.6.f.7.(a)(ii) of this proposed rule, and are proposing an exception for MIPS eligible clinicians whose CEHRT has been decertified under ONC's Health IT Certification Program as discussed in section II.6.f.7.(a)(v) of this proposed rule. Additionally, we believe most MIPS eligible clinicians who can report the advancing care information performance category of MIPS have already adopted an EHR during Stage 1 and 2 of the Medicare EHR Incentive Program. As we have stated with respect to the Medicare EHR Incentive Program, we believe that 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 advancing care information performance category, but we are 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. This is not surprising since 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. Even physicians and hospitals that can meet Medicare EHR Incentive Program standards have not necessarily fully implemented all the functionality of their systems or fully exploited the diagnostic, prescribing, and coordination of care capabilities that these systems promise. Moreover, many of the most important benefits of EHR depend on interoperability among systems and this functionality is still lacking in many EHR systems.

A recent RAND report prepared for the ONC reviewed 236 recent studies that related the use of health IT to quality, safety, and efficacy in ambulatory and non-ambulatory care settings and found that—

"A majority of studies that evaluated the effects of health IT on healthcare quality, safety, and efficiency reported findings that were at least partially positive. These studies evaluated

several forms of health IT: metric of satisfaction, care process, and cost and health outcomes across many different care settings. Our findings agree with previous [research] suggesting that health IT, particularly those functionalities included in the Medicare EHR Incentive Program regulation, can improve healthcare quality and safety. The relationship between health IT and [health care] efficiency is complex and remains poorly documented or understood, particularly in terms of healthcare costs, which are highly dependent upon the care delivery and financial context in which the technology is implemented."47 Other recent studies have not found definitive quantitative evidence of benefits.48 Health IT vendors may face additional costs in Quality Payment Program Year 2 if they choose to develop additional capabilities in their systems to submit advancing care information and improvement activities performance category data on behalf of MIPS eligible clinicians. We request comments that provide information that would enable us to quantify the costs, costs savings, and benefits associated with implementation and compliance with the requirements of the advancing care information 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. Costs per full-time equivalent primary care clinician for improvement activities will vary across practices, including for some activities or certified patient-centered medical home practices, in incremental costs per encounter, and in estimated costs per member per month.

Costs may vary based on panel size and location of practice among other variables. For example, Magill (2015) conducted a study of certified patient-centered medical home practices

47 Paul G. Shekelle, et al. Health Information Technology: An Updated Systematic Review with a Focus on Meaningful Use Functionalities. RAND Corporation. 2014.

48 See, for example, Saurabh Rahurkar, et al, ''Despite the Spread of Health Information Exchange, There Is Little Information of Its Impact On Cost, Use, And Quality of Care,'' Health Affairs, March 2015; and Hemant K. Bharga and Abhay Nath Mishra, ''Electronic Medical Records and Physician Productivity: Evidence from Panel Data Analysis,'' Management Science, July 2014.

in two states.49 That study found that costs associated with a full-time equivalent primary care clinician, who were associated with certified patient-centered medical home practices, varied across practices. Specifically, the study found an average cost of $7,691 per month in Utah practices, and an average of $9,658 in Colorado practices. Consequently, certified patient-centered medical home practices incremental costs per encounter were $32.71 in Utah and $36.68 in Colorado (Magill, 2015). The study also found that the average estimated cost per member, per month, for an assumed panel of 2,000 patients was $3.85 in Utah and $4.83 in Colorado. However, given the lack of comprehensive historical data for improvement activities, we are unable to quantify those costs in detail at this time. We request comments that provide information that would enable us to quantify the costs, costs savings, and benefits associated implementation of improvement activities.

D. Impact on Beneficiaries

There are a number of changes in this proposed rule that would have an effect on beneficiaries. In general, we believe that the changes may have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. More broadly, we expect that over time clinician engagement in the Quality Payment Program may result in improved quality of patient care, resulting in lower morbidity and mortality. We believe the policies finalized in the CY 2017 Quality Payment Program final rule, as well as policies in this rule will lead to additional growth in the participation of both MIPS APMS and Advanced APMs. APMs promote seamless integration by way of their payment methodology and design that incentivize such care coordination. The policies that are being proposed regarding the All-Payer Combination Option and identification of Other Payer Advanced APMs will help facilitate both the development and participation in alternative payment arrangements in the private and public

49 Magill et al. ''The Cost of Sustaining a Patient-Centered Medical Home: Experience from 2 States.'' Annals of Family Medicine, 2015; 13:429–435.

sectors. Clinicians can focus their efforts around the care transformation in either Advanced APM or MIPS APM models and know that those efforts will be aligned with the Quality Payment Program, either through incentive payments for QPs or through MIPS scores calculated based on performance within the APM assessed at the APM Entity level.

Several Advanced APMs and MIPS APMS have shown evidence of improving the quality of care provided to beneficiaries and beneficiaries' experience of care. For example, the various shared savings initiatives already operating have demonstrated the potential for quality programs to delivers better quality healthcare, smarter spending, and to put beneficiary experience at the center. For example, in August of 2015, we issued 2014 quality and financial performance results showing that ACOs continue to improve the quality of care for Medicare beneficiaries while generating net savings to the Medicare trust fund, if shared savings paid out to these ACOs are not included.50 In 2014, the 20 ACOs in the Pioneer ACO Model and 333 Shared Shavings Program ACOs generated more than $411 million in total savings, which includes all ACOs' savings and losses but does not include shared savings payments to ACOs. Additionally, in their first years of implementation, both Pioneer and Shared Savings Program ACOs had higher quality care than Medicare FFS providers on measures for which comparable data were available. Shared Savings Program patients with multiple chronic conditions and with high predicted Medicare spending received better quality care than comparable FFS patients.51 Between the first and fourth performance periods, Pioneer ACOs improved their average quality score from 71 percent to 92 percent. The Shared Savings Program ACOs yielded $465 million in savings to the Medicare Trust Funds in 2014, not including shared savings payments paid out

50 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Factsheets-items/2015-08-25.html.

51 J.M. McWilliams et al., ''Changes in Patients' Experiences in Medicare Accountable Care Organizations.'' New England Journal of Medicine 2014; 371:1715–1724, DOI: 10.1056/NEJMsa1406552.

to ACOs.52 The Shared Savings Program ACOs generated total program savings (inclusive of all savings and losses relative to financial benchmarks, though not including shared savings payments) of $429 million for performance year 2015 (PY15).53 Of participating ACOs, 119 Shared Savings Program ACOs earned shared savings by holding spending far enough below their financial benchmarks and meeting quality standards. No Track 2 ACOs owed CMS losses. The financial results were that for (PY15), 83 ACOs had expenditures lower than their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings rate (MSR), and an increasing proportion of ACOs have generated savings above their MSR each year. For PY15, 31 percent of ACOs (120 of 392) generated savings above their MSR compared to 28 percent (92 of 333) in PY14 and 26 percent (58 of 220) in PY13. 54

For Pioneer ACOs, the financial and quality results continue to be positive, with several Pioneer ACOs generating greater savings in the model performance year 4 (PY4) (2015) and one ACO generating savings for the first time. While the cohort of Pioneer ACOs decreased between PY3 (2014) and PY4, they still generated total model savings of over $37 million. It is important to note that going into PY4, the benchmarks for the Pioneer ACOs were re-based, and the Model as a whole introduced new financial benchmarking methodologies. Re-basing refers to using a newer set of baseline years to compute financial benchmarks; the new benchmarks are therefore based on ACOs' spending during their initial years of participation in the Pioneer ACO Model. 55

Quality performance improved considerably from PY3 to PY4 and across all 4 years of

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53 CMS, "Medicare Accountable Care Organizations 2015 Performance Year Quality and Financial Results." Available at **https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html**.

54 CMS, Medicare Accountable Care Organizations 2015 Performance Year Quality and Financial Results, **https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html** (last accessed April 14, 2016).

55 *Id*.

the Pioneer ACO Model. Overall quality scores for nine of the 12 Pioneer ACOs were above 90 percent in PY4. All 12 Pioneers improved their quality scores from PY1 (2012) to PY4 by over 21 percentage points. The financial results were that the 12 Pioneer ACOs participating in PY4 were accountable for 461,442 beneficiaries, representing a nearly 24 percent increase in average aligned beneficiaries per ACO (up to 38,454) from PY3. PY4 was the first option year in the Pioneer ACO Model, where Pioneer ACOs were operating under a new financial benchmarking methodology. While the cohort of Pioneer ACOs decreased by nearly a third between PY3 and PY4 with several Pioneer ACOs transitioning to either the Shared Savings Program or the Next Generation ACO model Pioneer ACOs still generated total model savings (inclusive of all Pioneer ACO savings and losses relative to financial benchmarks) of over $37 million. Of the eight Pioneer ACOs that generated savings, six generated savings outside a minimum savings rate and earned shared savings, and of the four Pioneer ACOs that generated losses, one generated losses outside a minimum loss rate and owed shared losses.[56]

The results from the third program year (January through December 2015) of the original CPC Initiative indicate that the from 2013 to 2015 CPC practices transformed their care delivery —with the biggest improvements in risk-stratified care management, expanded access to care, and continuity of care. The CPC also improved patient experience slightly. Over the first 3 years, ED visits increased by 2 percent less for Medicare FFS beneficiaries in CPC practices relative to those in comparison practices.[57] [58]

As the early findings from the original CPC initiative and literature from other medical home models supported by payment suggest, we expect to see improvement in quality and

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[56] *Id*.

57 Peikes, D., Taylor, E., Dale, S., et al. "Evaluation of the Comprehensive Primary Care Initiative: Second Annual Report." Princeton, NJ: Mathematica Policy Research, April 13, 2016, available at **https://innovation.cms.gov/files/reports/cpci-evalrpt2.pdf**.

58 For more detail see Peikes, D., Anglin, G., Taylor, E., et al. "Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report." Princeton, NJ: Mathematica Policy Research, December 2016, available at **https://innovation.cms.gov/Files/reports/cpci-evalrpt3.pdf**.

patient experience of care.[59,60,61,62] Under CPC+, a higher proportion of the practice revenue is de-linked from FFS payment and there is thus more flexibility for practices to deliver care without a face-to-face encounter and instead in the modality that best meets patients' health care needs (that is, office visit, virtual visit, phone call, etc.).63 We anticipate that CPC+ will allow practices to get off the "FFS Treadmill"64 and achieve incentive neutrality (the incentive to bring a patient to the office is balanced with the incentive to provide the needed care outside of an office visit).[65,66]

While maintaining coverage of Original Medicare services and beneficiary freedom to choose providers, ACOs could potentially enhance care management of the chronically ill aligned population through the adoption of leading-edge technologies, care coordination techniques, and evidence-based benefit enhancements that motivate providers and beneficiaries to optimize care. The evidence discussed here focuses on the Next Generation Model elements of telehealth, home health care, and reduced cost sharing.

The transition from the inpatient setting to home is a critical period for patients, particularly elderly populations. Studies have examined a variety of interventions to help smooth care transitions. Interventions found in the literature include advance practice nurse-led

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59 Reid, R.J., Fishman, P.A., Yu, O., Ross, T.R., Tufano, J.T., Soman, M.P, & Larson, E.B. (2009). Patient-centered medical home demonstration: A prospective, quasi-experimental, before and after evaluation. *AJMC, 15*(9), e71-e87.

60 Maeng, D.D., Graham, J., Graf, T.R., Liberman, J.N., Dermes, N.B., Tomcavage, J., et al (2012). Reducing long-term cost by transforming primary care: Evidence from Geisinger's Medical Home Model. *AJMC, 18*(3), 149-155.

61 Nelson, K.M., Helfrich, C., Sun, H., Hebert, P.L., Liu, C.F., Dolan, E., et al. (2014). Implementation of the patient-centered medical home in the Veterans Health Administration: Associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. *JAMA Intern Med, 174*(8), 1350-1358.

62 DeVries, A., Li, C.H.W., Sridhar, G., Hummel, J.R., Breidbart, S., & Barron, J.J. (2012). Impact of medical homes on quality, Healthcare utilization, and costs. *AJMC, 18*(9), 534-544.

63 Mechanic, R.E., Santos, P., Landon, B.E., & Chernew, M.E. (2011). Medical group responses to global payment: early lessons from the 'Alternative Quality Contract' in Massachusetts. *Health Aff (Millwood), 30*(9), 1734-42.

64 Bitton, A., Schwartz, G.R., Stewart, E.E., Henderson, D.E., Keohane, C.A., Bates, D.W., & Schiff, G.D. (2012). Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *Milbank Q, 90*(3), 484-515.

65 Ash, A.S., & Ellis, R.P. (2012). Risk-adjusted payment and performance assessment for primary care. *Med Care, 50*(8), 643-53.

66 Vats, S., Ash, A.S., & Ellis, R.P. (2013). Bending the cost curve? Results from a comprehensive primary care payment pilot. *Med Care, 51*(11), 964-9.

comprehensive discharge planning and home visit follow-up protocols[67,68,69] and patient coaching accompanied by post-discharge home visits.70 While the intensity and content of these interventions vary, the use of a post-discharge home visit shortly after leaving the hospital appears to be effective in engaging and monitoring patients to decrease readmissions or emergency room visits. MedPAC has also noted that there may be a role for home health services in models that focus on chronic care needs and care coordination.71 The Next Generation ACO Model seeks to encourage ACOs to engage in post-discharge home visits to improve ACO patient outcomes by allowing ACOs to perform and bill for types of services not currently available under Original Medicare.

The study of the potential value and efficacy of telehealth and remote patient monitoring has become more prevalent in recent years as technology has enabled greater utilization of these services72. Studies and case studies from health systems have shown value in using telehealth platforms for activities such as e-visits73,74 and remote patient monitoring75, as well as for higher intensity care through real-time videoconferencing76, particularly to enable older adults to receive care more rapidly from their homes and with minimal burden. The Next Generation

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67 Naylor MD, Brooten D, Campbell R, et al. Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A Randomized Clinical Trial. JAMA. 1999;281(7):613-620.
68 Naylor, M. D., Brooten, D. A., Campbell, R. L., Maislin, G., McCauley, K. M. and Schwartz, J. S. (2004), Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. Journal of the American Geriatrics Society, 52: 675–684.
69 Stauffer BD, Fullerton C, Fleming N, et al. Effectiveness and Cost of a Transitional Care Program for Heart Failure: A Prospective Study with Concurrent Controls. Arch Intern Med. 2011;171(14):1238-1243.
70 Voss R, Gardner R, Baier R, Butterfield K, Lehrman S, Gravenstein S. The Care Transitions Intervention: Translating From Efficacy to Effectiveness. Arch Intern Med. 2011;171(14):1232-1237.
71 Report to the Congress: Medicare and the Health Care Delivery System. March 2013.

72 Joseph Kvedar, Molly Joel Coye and Wendy Everett, Connected Health: A Review Of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth, Health Affairs, 33, no.2 (2014):194-199.
73 Patrick T. Courneya, Kevin J. Palattao and Jason M. Gallagher. HealthPartners' Online Clinic For Simple Conditions Delivers Savings Of $88 Per Episode And High Patient Approval. Health Affairs, 32, no.2 (2013):385-392.
74 Mehrotra A, Paone S, Martich G, Albert SM, Shevchik GJ. A Comparison of Care at E-visits and Physician Office Visits for Sinusitis and Urinary Tract Infection. JAMA Intern Med. 2013;173(1):72-74.
75 UVA Health System, Tech Firm Collaborate to Reduce Hospital Readmission Rates. VHQC News. June 2014.
76 Shah MN, Gillespie SM, et al. High-Intensity Telemedicine-Enhanced Acute Care for Older Adults: An Innovative Healthcare Delivery Model. Journal of the American Geriatrics Society. 2003; 61(11):2000-2007.

Model seeks to allow ACOs flexibility in utilizing telehealth services to improve access to the most appropriate care for ACO beneficiaries.

1. Impact on Other Health Care Programs and Providers

We estimate that the Quality Payment Program Year 2 will not have a significant economic effect on eligible clinicians and groups and believe that MIPS policies, along with increasing participation in APMs over time may succeed in improving quality and reducing costs. This may in turn result in beneficial effects on both patients and some clinicians, and we intend to continue focusing on clinician-driven, patient-centered care.

We propose several policies for the Quality Payment Program Year 2 to reduce burden. These include raising the low volume threshold so that fewer clinicians in small practices are required to participate in the MIPS starting with the 2018 performance period; including bonus points for clinicians in small practices; adding a new significant hardship exception for the advancing care information performance category for MIPS eligible clinicians in small practices; implementing virtual groups; allowing MIPS eligible clinicians and groups to submit measures and activities using as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories; implementing a voluntary facility-based scoring mechanism for the 2018 performance period that aligns with the Hospital Value Based Purchasing (VBP) Program, and extending the ability of MIPS eligible clinicians and groups to use 2014 Edition CEHRT while providing bonus points for the use of the 2015 Edition of CEHRT. Additionally, for vendors, we believe the flexibility to use EHR technology certified to either the 2014 Edition or the 2015 Edition for the Quality Payment Program Year 2 is beneficial as vendors will have additional time to deploy the updated software to their customers, which are the clinicians and other providers. Clinicians will likewise have additional time to upgrade and implement the new functionalities.

In summary, the Quality Payment Program policies are designed to promote the delivery

of high-value care for individuals in all practices and areas with a particular focus on clinicians in small and solo practices. We believe each of these proposals will further reduce burdens on clinicians and practices and help increase successful participation. Further, the policies throughout this proposed rule will focus the Quality Payment Program in its second year on encouraging more complete data submission and educating clinicians. The proposed policies will continue a glide path, which began in the transition year, to more robust participation and performance in future years. 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.

2. Alternatives Considered

This proposed rule contains a range of policies, including many provisions related to specific statutory provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies where discretion has been exercised, presents our rationale for our proposed policies and, where relevant, analyzes alternatives that we considered. Comment is sought in section II.C.8.c. of this proposed rule on policies closely related to this Regulatory Impact Analysis, including the performance threshold. We view the performance threshold as one of the most important factors affecting the distribution of payment adjustments under the Program, and the alternatives that we considered focus on that policy.

For example, we discuss above that we modeled the effects of the proposed rule's policies using a 15-point performance threshold and a 70-point additional performance threshold. Additionally, we assumed a minimum 90 percent participation rate in each category of eligible clinicians. We displayed the results of that modeling in Table 86 along with subsequent tables.

We tested two additional models using a performance threshold of 6 points and a performance threshold of 33 points. In both of these cases, we again modeled a 70-point

additional performance threshold and a minimum 90 percent participation rate in each category of eligible clinicians in order to focus the results on the differing performance thresholds.

Under the 6-point performance threshold alternative, we estimated that we 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, we also estimated that slightly fewer eligible clinicians would receive negative payment adjustments than in the 15-point model described further above – approximately 3.1 percent in this alternative compared to approximately 3.9 percent in the 15-point model.

Under the 33-point performance threshold alternative, we estimated that we 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, we estimated that approximately 9.1 percent of eligible clinicians would receive a negative payment adjustment, compared to the approximately 3.9 percent that we estimated in the 15-point model.

3. Assumptions and Limitations

We would like to note several limitations to the analyses that estimated MIPS eligible clinicians' eligibility, negative MIPS payment adjustments, and positive payment adjustments for the 2020 MIPS payment year based on the data prepared to support the 2017 performance period

initial determination of clinician and special status eligibility (available via the NPI lookup on qpp.cms.gov), the preliminary version of the file used for the predictive qualifying APM participants analysis made available on qpp.cms.gov on June 2, 2017 and prepared using claims for services between January 1, 2016 through August 31, 2016 and 2014 and 2015 data from legacy programs, including the PQRS, CAHPS for PQRS, and the VM.

The scoring model cannot fully reflect MIPS eligible clinicians' behavioral responses to MIPS. The scoring model assumes higher participation in MIPS quality reporting than under the PQRS. Other potential behavioral responses are not addressed in our scoring model. The scoring model assumes that quality measures submitted and the distribution of scores on those measures would be similar under Quality Payment Program Payment in the 2020 MIPS payment year as they were under the 2015 PQRS program.

The scoring model does not reflect the growth in Advanced APM participation between 2017 and 2018. After applying the other MIPS exclusions, the scoring model excluded approximately 74,920 QPs using preliminary QP data for Quality Payment Program Year 2017, significantly lower than CMS' summary level projected QP counts for Quality Payment Program Year 2018 (180,000-245,000). The methods for the summary level estimates reflect the several new APMs that we anticipate will be Advanced APMs in CY 2018, and that some eligible clinicians will join the successors of APMs already active in early 2017.

There are additional limitations to our estimates. 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 90. Due the limitations above, there is considerable uncertainty around our estimates that is difficult to quantify in detail.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to

read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this proposed rule, we assume that the total number of commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we believe that the number of past commenters would be a fair estimate of the number of reviewers of this proposed rule. We welcome any public comments on the approach in estimating the number of entities that will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule. Therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the proposed rule. We are seeking public comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this proposed rule is $105.16 per hour, including overhead and fringe benefits, which we assume are 100 percent of the hourly wage (**https://www.bls.gov/oes/2016/may/naics4_621100.htm**). Assuming an average reading speed, we estimate 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, we estimate that the total cost of reviewing this proposed rule is $4,873,360 ($1209.34 x 4,000 reviewers). We estimate that the incremental costs of reviewing this proposed rule are the same as the CY 2017 Quality Payment Program final rule.

F. Accounting Statement

As required by OMB Circular A–4 (available at **http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf),** in Table 90 (Accounting Statement), we have prepared an accounting statement.

We have not attempted to quantify the benefits of this proposed rule because of the many uncertainties as to both clinician behaviors and resulting effects on patient health and cost reductions. For example, the applicable percentage for MIPS payment adjustments changes over time, increasing from 4 percent in 2019 to 9 percent in 2022 and subsequent years, and we are unable to estimate precisely how physicians will respond to the increasing payment adjustments. As noted above, in CY 2020, we estimate that we will distribute approximately $173 million in payment adjustments on a budget-neutral basis, which represents the applicable percent for 2020 required under section 1848(q)(6)(B)(i) of the Act and excludes $500 million in additional MIPS payment adjustments for exceptional performance.

Further, the addition of new Advanced APMs and growth in Advanced APM participation over time will affect the pool of MIPS eligible clinicians, and for those that are MIPS eligible clinicians, may change their relative performance. The $500 million available for exceptional performance and the 5 percent APM Incentive Payment for QPs are only available from 2019 through 2024. Beginning in 2026, Medicare PFS payment rates for services furnished by QPs will receive a higher update than for services furnished by non-QPs. However, we are unable to estimate the number of QPs in those years, as we cannot project the number or types of Advanced APMs that will be made available in those years through future CMS initiatives proposed and implemented in those years, nor the number of QPs for those future Advanced APMs.

The percentage of the final score attributable to each performance category will change over time and we will continue to refine our scoring rules. The improvement activities category represents a new category for measuring MIPS eligible clinicians' performance. We may also

propose policy changes in future years as we continue implementing MIPS and as MIPS eligible clinicians accumulate experience with the new system. Moreover, there are interactions between the MIPS and APM incentive programs and other shared savings and incentive programs that we cannot model or project. Nonetheless, even if ultimate savings and health benefits represent only low fractions of current experience, benefits are likely to be substantial in overall magnitude.

Table 90 includes our 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 90: Accounting Statement: Transfers

Category	Transfers
CY 2020 Annualized Monetized Transfers….	Estimated increase of between $1,263 and $ 1,473 million in payments for higher performance under MIPS and to QPs77.
From Whom to Whom?.....	Increased Federal Government payments to physicians, other practitioners and suppliers who receive payment under the Medicare Physician Fee Schedule.
Category	**Transfers**
CY 2020 Annualized Monetized Transfers….	Estimated decrease of $173 million for lower performance under MIPS.
From Whom to Whom?.....	Reduced Federal Government payments to physicians, other practitioners and suppliers who receive payment under the Medicare Physician Fee Schedule.

Note: These estimates are identical under both a 7 percent and 3 percent discount rate.

Based on National Health Expenditure data,78 total Medicare expenditures for physician and clinical services in 2015 reached $144.3 billion. Expenditures for physician and clinical services from all sources reached $634.9 billion. Table 90 shows that the

77 A range of estimates is provided due to uncertainty about the number of Advanced APM participants that will meet the QP threshold in 2016.

78 Physicians and Clinical Services Expenditures, **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html**.

aggregate negative MIPS payment adjustment for all MIPS eligible clinicians under MIPS is estimated at $173 million, which represents less than 0.2 percent of Medicare payments for physician and clinical services and less than 0.1 percent of payments for physician and clinician services from all sources. Table 90 also shows that the aggregate positive payment adjustment for MIPS eligible clinicians under MIPS is estimated at $673 million (including additional MIPS payment adjustments for exceptional performance), which represents less than 1 percent of Medicare expenditures for physician and clinician services and 0.2 percent of Medicare expenditures from all sources for physician and clinical services.

Table 91 summarizes the regulatory review costs discussed in section V.E. of this proposed rule, and the collection of information burden costs calculated in section III.N. of this proposed rule.

As noted above, we estimate the regulatory review costs of $4.8 million for this proposed rule. In Table 91, we have prepared our analysis of collection of information burden costs to be consistent with guidance in accordance with OMB's April 2017 guidance on EO13771. The Order's guidance directs agencies to measure certain costs, including costs associated with "Medicare quality performance tracking", using the estimates in the CY 2017 Quality Payment Program final rule as a baseline. The Order notes that regular updates to certain Medicare regulations make assessments of the incremental changes related to "performance tracking" included in a proposed regulation much more useful than a comparison against hypotheticals (such as a program's hypothetical discontinuation).

As shown in section III.N. of this proposed rule, we estimate that this proposed rule will result in approximately $857 million in collection of information-related burden. However, we estimate that the incremental collection of information-related burden associated with this proposed rule is an approximately $12.4 million reduction relative to the baseline burden of continuing the policies and information collections set forth in the CY

2017 Quality Program final rule into CY 2018. Our burden estimates reflect several proposed that would reduce burden, including the proposed reduction in the length of the CAHPS survey; our proposal to allow certain hospital-based clinicians to elect use facility-based measurements, thereby eliminating the need for additional quality data submission processes; and our proposal to allow MIPS eligible clinicians to form virtual groups, which would create efficiencies in data submission; and our proposal for significant hardship or other type of exception, including a new significant hardship exception for small practices for the advancing care information performance category.

TABLE 91: Additional Costs and Benefits

Category of Cost or Benefits	Costs/Benefits
Regulatory Review Costs	$4.8 million
Incremental Collection of Information/ Paperwork Reduction Act Burden Estimates	-$12.4 million
Benefits of Expanded Advanced and MIPS APM Participation	Improvements in quality, patient experience of care, readmission rates, access to appropriate care, and total cost of care
Benefits of MIPS	Improvements in quality, patient experience of care, and readmission rates.

Note: These estimates are identical under both a 7 percent and 3 percent discount rate. Incremental information collection costs are total information collection costs associated with this proposed rule minus costs associated with CY 2017 Quality Payment Program final rule.

Table 91 also shows the expected benefits associated with this proposed rule. We note that these expected benefits are qualitative in nature. We expect that the Quality Payment Program will result in quality improvements and improvements to the patients' experience of care as MIPS eligible clinicians respond to the incentives for high-quality care provided by the Program and implement care quality improvements in their clinical practices. While we cannot quantify these effects specifically at this time because we cannot project eligible clinicians' behavioral responses to the incentives offered under the Quality Payment Program, we nevertheless believe that changes to clinical care will result in care quality improvements for Medicare beneficiaries and other patients treated by eligible

clinicians.

List of Subjects

42 CFR Part 414

Administrative practice and procedure, Biologics, Drugs, Health facilities, Health professions, Diseases, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

2. Section 414.1305 is amended by--

a. Removing the definition of "Advanced APM Entity";

b. Revising the definition of "Affiliated practitioner";

c. Adding the definitions of "All-Payer QP Performance Period" and "Ambulatory Surgical Center (ASC)-based MIPS eligible clinician";

d. Revising the definitions of "APM Entity" and "Attributed beneficiary";

e. Amending the definition "Certified Electronic Health Record Technology (CEHRT)" by revising paragraphs (1) introductory text, (1)(iii), and (2) introductory text;

f. Adding the definition of "CMS Multi-Payer Model";

g. Revising the definition of "Final Score";

h. Adding the definitions of "Full TIN APM";

i. Revising the definition of "Hospital-based MIPS eligible clinician";

j. Adding the definitions of "Improvement scoring";

k. Revising the definitions of "Low-volume threshold", and "Medicaid APM";

l. Adding the definitions of "Medicare QP Performance Period";

m. Revising the definition of "Non-patient facing MIPS eligible clinician";

n. Adding the definition or "Other MIPS APM";

o. Revising the definition of "Other Payer Advanced APM";

p. Removing the definition of "QP Performance Period";

q. Revising the definition of "Rural areas"; and

r. Adding the definitions of "Virtual group".

The revisions and additions read as follows:

§414.1305 Definitions.

* * * * *

Affiliated practitioner means an eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the APM Entity for the purposes of supporting the APM Entity's quality or cost goals under the Advanced APM.

All-Payer QP Performance Period means the time period that CMS will use to assess the level of participation by an eligible clinician in Advanced APMs and Other Payer Advanced APMs under the All-Payer Combination Option for purposes of making a QP determination for the year as specified in §414.1440. The All-Payer QP Performance Period begins on January 1 and ends on June 30 of the calendar year that is 2 years prior to the payment year.

* * * * *

Ambulatory Surgical Center (ASC)-based MIPS eligible clinician means a MIPS eligible clinician who furnishes 75 percent 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 ambulatory surgical center setting based on claims for a period prior to the performance period as specified by CMS.

* * * * *

APM Entity means an entity that participates in an APM or other payer arrangement through a direct agreement with CMS or the payer or through Federal or State law or regulation.

* * * * *

Attributed beneficiary means a beneficiary attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of a QP determination.

* * * * *

Certified Electronic Health Record Technology (CEHRT) * * *

(1) For any calendar year before 2019, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets one of the following:

* * * * *

(iii) The definition for 2019 and subsequent years specified in paragraph (2) of this definition.

(2) For 2019 and subsequent years, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at 45 CFR 170.102) and has been certified to the 2015 Edition health IT certification criteria—

* * * * *

CMS Multi-Payer Model means 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.

* * * * *

Final score means a composite assessment (using a scoring scale of 0 to 100) for each MIPS eligible clinician for a performance period determined using the methodology for assessing the total performance of a MIPS eligible clinician according to performance standards for applicable measures and activities for each performance category.

* * * * *

Full TIN APM means 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.

* * * * *

Hospital-based MIPS eligible clinician means a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus-outpatient hospital, or emergency room setting based on claims for a period prior to the performance period as specified by CMS.

* * * * *

Improvement scoring means an assessment measuring improvement for each MIPS eligible clinician or group for a performance period using a methodology that compares improvement from one performance period to another performance period.

* * * * *

Low-volume threshold means an individual MIPS eligible clinician or group who, during the low-volume threshold determination period, has Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries.

* * * * *

Medicaid APM means a payment arrangement authorized by a State Medicaid program that meets the Other Payer Advanced APM criteria set forth in §414.1420.

* * * * *

Medicare QP Performance Period means the time period that CMS will use to assess the level of participation by an eligible clinician in Advanced APMs under the Medicare Option for

purposes of making a QP determination for the year as specified in §414.1425. The Medicare QP Performance Period begins on January 1 and ends on August 31 of the calendar year that is 2 years prior to the payment year.

* * * * *

Non-patient facing MIPS eligible clinician means an individual MIPS eligible clinician who 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 percent 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 non-patient facing determination period.

* * * * *

Other MIPS APM means a MIPS APM that does not require reporting through the CMS Web Interface.

Other Payer Advanced APM means an other payer arrangement that meets the Other Payer Advanced APM criteria set forth in §414.1420.

* * * * *

Rural areas means ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available.

* * * * *

Virtual group means a combination of two or more TINs composed of a solo practitioner (a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN) or a group (as defined at §414.1305) 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 of a year.

3. Section 414.1315 is added to read as follows:

§414.1315 Virtual Groups.

(a) *Eligibility*. A solo practitioner or a group of 10 or fewer eligible clinicians must make their election prior to the start of the applicable performance period and cannot change their election during the performance period. Virtual group participants may elect to be in 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.

(b) *Election Deadline*. A virtual group representative must make an election, on behalf of the members of a virtual group, regarding the formation of a virtual group for an applicable performance period, by December 1 of the calendar year preceding the applicable performance year.

(c) *Election Process*. The two-stage virtual group election process for the 2018 and 2019 performance years is as follows:

(1) *Stage 1: Virtual group eligibility determination*.

(i) Solo practitioners and groups with 10 or fewer eligible clinicians interested in forming or joining a virtual group have the option to contact their designated technical assistance representative or the Quality Payment Program Service Center, as applicable, in order to obtain information pertaining to virtual groups and/or determine whether or not they are eligible, as it relates to the practice size requirement of a solo practitioner or a group of 10 or fewer eligible clinicians, to participate in MIPS as a virtual group.

(ii) [Reserved]

(2) *Stage 2: Virtual group formation*.

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

(ii) On behalf of a virtual group, the official designated virtual group representative must submit an election by December 1 of the calendar year prior to the start of the applicable performance period.

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

(iv) Once an election is made, the virtual group representative must contact their designated CMS contact to update any election information that changed during a performance period one time prior to the start of an applicable submission period.

(3) *Agreement*. Virtual groups must execute a written formal and contractual agreement between each member of a virtual group that includes the following elements:

(i) Expressly state the only parties to the agreement are the TINs and NPIs of the virtual group.

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

(iii) Expressly require each member of the virtual group (including each NPI under each TIN) to agree to participate in the MIPS as a virtual group and comply with the requirements of the MIPS and all other applicable laws and regulations (including, but not limited to, federal criminal law, False Claims Act, anti-kickback statute, civil monetary penalties law, Health Insurance Portability and Accountability Act, and physician self-referral law).

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

(v) Set forth the NPI's rights and obligations in, and representation by, the virtual group, including without limitation, the reporting requirements and how participation in the MIPS as a virtual group affects the ability of the NPI to participate in the MIPS outside of the virtual group.

(vi) Describe how the opportunity to receive payment adjustments will encourage each member of the virtual group (including each NPI under each TIN) to adhere to quality assurance and improvement.

(vii) Require each member of the virtual group to update its Medicare enrollment information, including the addition and deletion of NPIs billing through a TIN that is part of a virtual group, on a timely basis in accordance with Medicare program requirements and to notify the virtual group of any such changes within 30 days after the change.

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

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

(d) *Virtual Group Reporting Requirements:* For TINs participating in MIPS at the virtual group level—

(1) 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.

(2) 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.

(3) 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.

(4) 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.

(5) Virtual groups would need to adhere to an election process established and required by CMS.

4. Section 414.1320 is amended by adding paragraphs (c) and (d) to read as follows:

§414.1320 MIPS performance period.

* * * * *

(c) For purposes of the 2021 MIPS payment year and future years, the performance period for:

(1) The quality and cost performance categories is the full calendar year (January 1 through December 31) that occurs 2 years prior to the applicable MIPS payment year.

(2) [Reserved]

(d) For purposes of the 2021 MIPS payment year, the performance period for:

(1) The advancing care information and improvement activities performance categories is a minimum of a continuous 90-day period within CY 2019, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

(2) [Reserved]

5. Section 414.1325 is amended by revising paragraphs (c)(6) and (d) to read as follows:

§414.1325 Data submission requirements.

* * * * *

(c) * * *

(6) A CMS-approved survey vendor for groups that elect to include the CAHPS for MIPS survey as a quality measure. Groups that elect to include the CAHPS for MIPS survey as a quality measure must select from the above data submission mechanisms to submit their other quality information.

(d) *Report measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories.* MIPS eligible clinicians and groups may elect to submit measures and activities, as available and applicable via multiple mechanisms; however, they must use the same identifier for all performance categories.

* * * * *

6. Section 414.1330 is amended by revising paragraph (b)(2) to read as follows:

§414.1330 Quality performance category.

* * * * *

(b) * * *

(2) 60 percent of a MIPS eligible clinician's final score for MIPS payment year 2020.

* * * * *

7. Section 414.1335 is amended by revising paragraph (a)(2)(i) to read as follows:

§414.1335 Data submission criteria for the quality performance category.

(a)* * *

(2)* * *

(i) Criteria applicable to groups of 25 or more eligible clinicians, report on all measures included in the CMS Web Interface. The group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module.

* * * * *

8. Section 414.1340 is amended by revising paragraphs (a)(2) and (b)(2) and adding paragraphs (a)(3) and (b)(3) to read as follows:

§414.1340 Data completeness criteria for the quality performance category.

(a) * * *

(2) At least 50 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the MIPS payment year 2020.

(3) At least 60 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment year 2021.

(b) * * *

(2) At least 50 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2020.

(3) At least 60 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2021.

* * * * *

9. Section 414.1350 is amended by revising paragraph (b)(2) to read as follows:

§414.1350 Cost performance category.

* * * * *

(b) * * *

(2) 0 percent of a MIPS eligible clinicians' final score for MIPS payment year 2020.

* * * * *

10. Section 414.1360 is amended by revising paragraph (a) introductory text to read as follows:

§414.1360 Data submission criteria for the improvement activities performance category.

(a) For purposes of the transition year of MIPS and future years MIPS eligible clinicians must submit data on MIPS improvement activities in one of the following manners:

* * * * *

11. Section 414.1370 is amended by—

a. Revising paragraphs (b)(4)(i); (e) and (f);

b. Adding paragraphs (g)(1)(i)(A) through (D), and (g)(1)(ii);

c. Revising paragraphs (g)(2), (g)(3)(i), (g)(4)(i) and (ii) introductory text, (h) introductory text, (h)(1), (h)(3), (h)(4); and

d. Adding paragraph (h)(5).

The revisions and additions read as follows:

§414.1370 APM scoring standard under MIPS.

* * * * *

(b) * * *

(4) * * *

(i) *New APMs*. An APM for which the first performance year begins after the first day of the APM scoring standard performance period for the year.

* * * * *

(e) *APM Entity group determination*. Except as provided in paragraph (e)(1) of this section, the APM Entity group is determined in the manner prescribed in §414.1425(b)(1).

(1) *Full TIN APM*. The APM Entity group includes an eligible clinician who is on a Participation List in a Full TIN APM on December 31 of the APM scoring standard performance period.

(2) [Reserved]

(f) *APM Entity group scoring under the APM scoring standard*. The MIPS final score calculated for the APM Entity is applied to each MIPS eligible clinician in the APM Entity

group. The MIPS payment adjustment is applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity group.

(1) If a Shared Savings Program ACO does not report data on quality measures as required by the Shared Savings Program under §425.508 of this chapter, each ACO participant TIN will be treated as a unique APM Entity for purposes of the APM scoring standard.

(2) *Virtual groups*. MIPS eligible clinicians who have elected to participate in a virtual group and who are also on a MIPS APM Participation List will be included in the assessment under MIPS for purposes of producing a virtual group score and under the APM scoring standard for purposes of producing an APM Entity score. The MIPS payment adjustment for these eligible clinicians is based solely on their APM Entity score.

(g) * * *

(1) * * *

(i) * * *

(A) *Quality Performance Category Score*. The MIPS Quality Performance category score for an APM scoring standard performance period is calculated for the APM Entity using the data submitted by the APM Entity through the CMS Web Interface according to the terms of the MIPS APM, including data on measures submitted through the CMS Web Interface and other measures specified by CMS for the APM scoring standard.

(B) *Quality Improvement Score*. Beginning in 2018, for an APM Entity for which we calculated a Total Quality Performance category score for the previous APM scoring standard performance period, CMS calculates a Quality Improvement Score for the APM Entity group as specified in §414.1380(b)(1)(xvi).

(C) *Total Quality Performance Category Score*. Beginning in 2018, the Total Quality Performance category score is the sum of the Quality Performance Category Score and the Quality Improvement Score.

(D) If a Shared Savings Program ACO does not report on quality measures on behalf of its participating eligible clinicians as required by the Shared Savings Program under §425.508 of this chapter, the ACO participant TINs may report data for the MIPS quality performance category according to the MIPS submission and reporting requirements.

(ii) *Other MIPS APMs*.

(A) *Quality Performance Category Score*. The MIPS Quality Performance category score for an APM scoring standard performance period is calculated for the APM Entity using the data submitted by the APM Entity based on measures that we specify through notice and comment rulemaking for each MIPS APM from among those used under the terms of the MIPS APM, and that are:

(*1*) Tied to payment;

(*2*) Available for scoring;

(*3*) Have a minimum of 20 cases available for reporting; and

(*4*) Have an available benchmark.

(B) *Quality Improvement Score*. Beginning in 2019, for an APM Entity for which we calculated a Total Quality Performance category score for the previous APM scoring standard performance period, CMS calculates a Quality Improvement Score for the APM Entity group, as specified in §414.1380(b)(1)(xvi).

(C) *Total Quality Performance Category Score*. Beginning in 2018, the Total Quality Performance category score is the sum of the Quality Performance category score and the Quality Improvement Score.

(2) *Cost*. The cost performance category weight is zero percent for APM Entities in MIPS APMs.

(3) * * *

(i) CMS assigns an improvement activities score for each MIPS APM for an APM scoring standard performance period based on the requirements of the MIPS APM. The assigned improvement activities score applies to each APM Entity group for the APM scoring standard performance period. In the event that the assigned score does not represent the maximum improvement activities score, an APM Entity may report additional activities.

* * * * *

(4) * * *

(i) Each Shared Savings Program ACO participant TIN must report data on the Advancing Care Information (ACI) Performance category separately from the ACO, as specified in §414.1375(b)(2). The ACO participant TIN scores are weighted according to the number of MIPS eligible clinicians in each TIN as a proportion of the total number of MIPS eligible clinicians in the APM Entity group, and then aggregated to determine an APM Entity score for the ACI Performance category.

(ii) For APM Entities in MIPS APMs other than the Shared Savings Program, CMS uses one score for each MIPS eligible clinician in the APM Entity group to derive a single average APM Entity score for the ACI Performance category. The score for each MIPS eligible clinician is the higher of either:

* * * * *

(h) *APM scoring standard performance category weights*. The performance category weights used to calculate the MIPS final score for an APM Entity group for the APM scoring standard performance period are:

(1) *Quality.*

(i) For MIPS APMs that require use of the CMS Web Interface: 50 percent.

(ii) For Other MIPS APMs, 0 percent for 2017, 50 percent beginning in 2018.

* * * * *

(3) *Improvement activities.*

(i) For MIPS APMs that require use of the CMS Web Interface: 20 percent.

(ii) For Other MIPS APMs, 25 percent for 2017, 20 percent beginning in 2018.

(4) *Advancing care information.*

(i) For MIPS APMs that require use of the CMS Web Interface: 30 percent.

(ii) For Other MIPS APMs, 25 percent for 2017, 30 percent beginning in 2018.

(5) *Reweighting the MIPS Performance categories for the APM scoring standard*. If CMS determines there are not sufficient measures or activities applicable and available to MIPS eligible clinicians, CMS will assign weights as follows:

(i) If CMS reweights the Quality Performance category to 0 percent, the Improvement Activities Performance category is reweighted to 25 percent and the Advancing Care Information Performance category is reweighted to 75 percent.

(ii) If CMS reweights the Advancing Care Information Performance category to 0 percent, the Quality Performance category is reweighted to 80 percent.

12. Section 414.1375 is amended by revising paragraphs (a) and (b)(2)(ii) to read as follows:

§414.1375 Advancing care information performance category.

* * * * *

(a) Final score. The advancing care information performance category comprises 25 percent of a MIPS eligible clinician's final score for the 2019 MIPS payment year and each

MIPS payment year thereafter, unless a different scoring weight is assigned by CMS.

(b) * * *

(2) * * *

(ii) May claim an exclusion for each measure that includes an option for an exclusion.

* * * * *

13. Section 414.1380 is revised to read as follows:

§414.1380 Scoring.

(a) *General.* MIPS eligible clinicians are scored under MIPS based on their performance on measures and activities in four performance categories. MIPS eligible clinicians are scored against performance standards for each performance category and receive a final score, composed of their scores on individual measures and activities, and calculated according to the final score methodology.

(1) *Measures and activities in the four performance categories are scored against performance standards.* (i) For the quality performance category, measures are scored between zero and 10 points. Performance is measured against benchmarks. Bonus points are available for both submitting specific types of measures and submitting measures using end-to-end electronic reporting. Starting with the 2020 MIPS payment year, improvement scoring is available in the quality performance category.

(ii) For the cost performance category, measures are scored between 1 and 10 points. Performance is measured against a benchmark. Starting with the 2020 MIPS payment year, improvement scoring is available in the cost performance category.

(iii) For the improvement activities performance category, each improvement activity is worth a certain number of points. The points for each reported activity are summed and scored against a total potential performance category score of 40 points.

(iv) For the advancing care information performance category, the performance category score is the sum of a base score, performance score, and bonus score.

(2) [Reserved]

(b) *Performance categories.* MIPS eligible clinicians are scored under MIPS in four performance categories.

(1) *Quality performance category.* For the 2017 and 2018 performance periods. MIPS eligible clinicians receive three to ten measure achievement points for each scored quality measure in the quality performance category based on the MIPS eligible clinician's performance compared to measure benchmarks. A quality measure must have a measure benchmark to be scored based on performance. Quality measures that do not have a benchmark will not be scored based on performance. Instead, these measures will receive 3 points for the 2017 MIPS performance period and either 1 or 3 points for the 2018 MIPS performance period in accordance with paragraph (b)(1)(vii) of this section.

(i) Measure benchmarks are based on historical performance for the measure based on a baseline period. Each benchmark must have a minimum of 20 individual clinicians or groups who reported the measure meeting the data completeness requirement and minimum case size criteria and performance greater than zero. Benchmark data are separated into decile categories based on a percentile distribution. We will restrict the benchmarks to data from MIPS eligible clinicians and comparable APM data, including data from QPs and Partial QPs.

(ii) As an exception, if there is no comparable data from the baseline period, CMS would use information from the performance period to create measure benchmarks, as described in paragraph (b)(1)(i) of this section, which would not be published until after the performance period. For the 2017 performance period, CMS would use information from CY 2017 during which MIPS eligible clinicians may report for a minimum of any continuous 90-day period.

(A) CMS Web Interface submission uses benchmarks from the corresponding reporting year of the Shared Savings Program.

(B) [Reserved]

(iii) Separate benchmarks are used for the following submission mechanisms:

(A) EHR submission options;

(B) QCDR and qualified registry submission options;

(C) Claims submission options;

(D) CMS Web Interface submission options;

(E) CMS-approved survey vendor for CAHPS for MIPS submission options; and

(F) Administrative claims submission options.

(iv) Minimum case requirements for quality measures are 20 cases, unless a measure is subject to an exception.

(v) As an exception, the minimum case requirements for the all-cause hospital readmission measure is 200 cases.

(vi) MIPS eligible clinicians failing to report a measure required under this category receive zero points for that measure.

(vii) Subject to paragraph (b)(1)(viii) of this section, MIPS eligible clinicians do not receive zero points if the expected measure is submitted but is unable to be scored because it does not meet the required case minimum or if the measure does not have a measure benchmark for MIPS payment years 2019 and 2020. Instead, these measures receive a score of 3 points in MIPS payment years 2019 and 2020. MIPS eligible clinicians do not receive zero points if the expected measure is submitted but is unable to be scored because it is below the data completeness requirement. Instead, these measures receive a score of 3 points in the 2019 MIPS payment year and a score of 1 point in the 2020 MIPS payment year, except if the measure is

submitted by a small practice. Measures below the data completeness requirement submitted by a small practice receive a score of 3 points in the 2020 MIPS payment year.

(viii) As an exception, the administrative claims-based measures and CMS Web Interface measures will not be scored if these measures do not meet the required case minimum. For CMS Web Interface measures, we will recognize the measure was submitted but exclude the measure from being scored. For CMS Web Interface measures: measures that do not have a measure benchmark and measures that have a measure benchmark but are redesignated as pay for reporting for all Shared Savings Program accountable care organizations by the Shared Savings Program, CMS will recognize the measure was submitted but exclude the measure from being scored as long as the data completeness requirement is met. CMS Web Interface measures that are below the data completeness requirement will be scored and receive 0 points.

(ix) Measures submitted by MIPS eligible clinicians are scored against measure benchmarks using a percentile distribution, separated by decile categories.

(x) For each set of benchmarks, CMS calculates the decile breaks for measure performance and assigns points based on which benchmark decile range the MIPS eligible clinician's measure rate is between.

(xi) CMS assigns partial points based on the percentile distribution.

(xii) MIPS eligible clinicians are required to submit measures consistent with §414.1335.

(A) MIPS eligible clinicians that submit measures via claims, qualified registry, EHR, or QCDR submission mechanisms, and submit more than the required number of measures are scored on the required measures with the highest measure achievement points. MIPS eligible clinicians that report a measure via more than one submission mechanism can be scored on only one submission mechanism, which will be the submission mechanism with the highest measure achievement points. Groups that submit via these submission options may also submit and be

scored on CMS-approved survey vendor for CAHPS for MIPS submission mechanisms.

(B) 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 mechanisms.

(xiii) Topped out quality measures will be identified on an annual basis and may be removed from the measure set for a submission mechanism after the third consecutive year that a given measure has been identified as topped out in connection with that submission mechanism. CMS will identify topped out measures in the benchmarks published for each Quality Payment Program year. Topped out measures that have been removed pursuant to this policy will not be available for reporting after removal.

(A) For the 2018 MIPS performance period (2020 MIPS payment year), selected topped out measures identified by CMS will receive no more than 6 measure achievement points, provided that the measure benchmarks for all submission mechanisms are identified as topped out in the benchmarks published for the 2018 MIPS performance period.

(B) Beginning with the 2019 MIPS performance period (2021 MIPS payment year), a measure, except for measures in the CMS Web Interface, whose benchmark is identified as topped out for 2 or more consecutive years will receive no more than 6 measure achievement points in the second consecutive year it is identified as topped out, and beyond.

(xiv) Measure bonus points are available for measures determined to be high priority measures when two or more high priority measures are reported.

(A) Measure bonus points are not available for the first reported high priority measure which is required to be reported. To qualify for measure bonus points, each measure must be reported with sufficient case volume to meet the required case minimum, meet the required data completeness criteria, and not have a zero percent performance rate. 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.

(B) Outcome and patient experience measures receive two measure bonus points.

(C) Other high priority measures receive one measure bonus point.

(D) Measure bonus points for high priority measures cannot exceed 10 percent of the total available measure achievement points for the 2019 and 2020 MIPS payment years.

(E) If the same high priority measure is submitted via two or more submission mechanisms, the measure will receive high priority measure bonus points only once for the measure.

(xv) One measure bonus point is also available for each measure submitted with end-to-end electronic reporting for a quality measure under certain criteria determined by the Secretary. Bonus points cannot exceed 10 percent of the total available measure achievement points for the 2019 and 2020 MIPS payment years. If the same measure is submitted via 2 or more submission mechanisms, the measure will receive measure bonus points only once for the measure.

(xvi) Improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to performance in the year immediately prior to the current MIPS performance period based on achievement.

(A) Improvement scoring is available when the data sufficiency standard is met, which means when data are available and a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period.

(1) Data must be comparable to meet the requirement of data sufficiency which means that the quality performance category achievement percent score is available for the current performance period and the previous performance period and quality performance category achievement percent scores can be compared.

(2) Quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods.

(3) If the identifier is not the same for 2 consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment. For group, virtual group, and APM Entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group.

(B) The improvement percent score may not total more than 10 percentage points.

(C) The improvement percent score is assessed at the performance category level for the quality performance category and included in the calculation of the quality performance category percent score as described in paragraph (b)(1)(xvii) of this section.

(*1*) The improvement percent score is awarded based on the rate of increase in the quality performance category achievement percent score of eligible clinicians from the current MIPS performance period compared to the year immediately prior to the current MIPS performance period.

(*2*) An improvement percent score is calculated by dividing the increase in the quality performance category achievement percent score from the prior performance period to the current performance period by the prior year quality performance category achievement percent score multiplied by 10 percent.

(*3*) An improvement percent score cannot be lower than zero percentage points.

(*4*) For the 2018 MIPS performance period, if a MIPS eligible clinician has a previous

year quality performance category achievement percent score less than or equal to 30 percent, then the 2018 performance will be compared to an assumed 2017 quality performance category achievement percent score of 30 percent.

(5) The improvement percent score is zero if the MIPS eligible clinician did not fully participate in the quality performance category for the current performance period.

(D) For the purpose of improvement scoring methodology, the term "quality performance category achievement percent score" means the total measure achievement points divided by the total available measure achievement points, without consideration of measure bonus points or improvement percent score.

(E) For the purpose of improvement scoring methodology, the term "improvement percent score" means the score that represents improvement for the purposes of calculating the quality performance category percent score as described in paragraph (b)(1)(xvii) of this section.

(F) For the purpose of improvement scoring methodology, the term "fully participate" means the MIPS eligible clinician met all requirements in §§414.1330 and 414.1340.

(xvii) A MIPS eligible clinician's quality performance category percent score is the sum of all the measure achievement points assigned for the measures required for the quality performance category criteria plus the measure bonus points in paragraph (b)(1)(xiv) of this section and measure bonus points in paragraph (b)(1)(xv) of this section. The sum is divided by the sum of total available measure achievement points. The improvement percent score in paragraph (b)(1)(xvi) of this section is added to that result. The quality performance category percent score cannot exceed 100 percentage points.

(xviii) Beginning with the 2018 MIPS performance period, measures significantly impacted by ICD-10 updates, as determined by CMS, will be assessed based only on the first 9 months of the 12-month performance period. For purposes of this paragraph, CMS will make a

determination as to whether a measure is significantly impacted by ICD-10 coding changes during the performance period. CMS will publish on the CMS website which measures require a 9-month assessment process by October 1st of the performance period if technically feasible, but by no later than the beginning of the data submission period at §414.1325(f)(1).

(2) *Cost performance category*. A MIPS eligible clinician receives one to ten achievement points for each cost measure attributed to the MIPS eligible clinician based on the MIPS eligible clinician's performance compared to the measure benchmark.

(i) Cost measure benchmarks are based on the performance period. Cost measures must have a benchmark to be scored.

(ii) A MIPS eligible clinician must meet the minimum case volume specified by CMS to be scored on a cost measure.

(iii) A MIPS eligible clinician cost performance category percent score is the sum of the following, not to exceed 100 percent:

(A) The total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points; and

(B) The cost improvement score, as determined under paragraph (iv).

(iv) Cost improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period.

(A) The cost improvement score is determined at the measure level for the cost performance category.

(B) The cost improvement score is calculated only when data sufficient to measure improvement is available. Sufficient data is available when a MIPS eligible clinician or group participates in MIPS using the same identifier in 2 consecutive performance periods and is

scored on the same cost measure(s) for 2 consecutive performance periods. If the cost improvement score cannot be calculated because sufficient data is not available, then the cost improvement score is zero.

(C) The cost improvement score is determined by comparing the number of measures with a statistically significant change (improvement or decline) in performance; a change is determined to be significant based on application of a t-test. The number of cost measures with a significant decline is subtracted from the number of cost measures with a significant improvement, with the result divided by the number of cost measures for which the MIPS eligible clinician or group was scored for two consecutive performance periods. The resulting fraction is then multiplied by the maximum improvement score.

(D) The cost improvement score cannot be lower than zero percentage points.

(E) The maximum cost improvement score for the 2020 MIPS payment year is zero percentage points.

(v) A cost performance category percent score is not calculated if a MIPS eligible clinician is not attributed any cost measures because the clinician or group has not met the case minimum requirements for any of the cost measures or a benchmark has not been created for any of the cost measures that would otherwise be attributed to the clinician or group.

(3) *Improvement activities performance category*. MIPS eligible clinicians and groups receive points for improvement activities based on patient-centered medical home or comparable specialty practice participation, APM participation, and improvement activities reported by the MIPS eligible clinician in comparison to the highest potential score (40 points) for a given MIPS year. For purposes of this paragraph, "full credit" means that the MIPS eligible clinician or group has met the highest potential score for the improvement activities performance category.

(i) CMS assigns credit for the total possible category score for each reported improvement activity based on two weights: Medium-weighted and high-weighted activities.

(ii) Improvement activities with a high weighting receive credit for 20 points, toward the total possible category score.

(iii) Improvement activities with a medium weighting receive credit for 10 points toward the total possible category score.

(iv) 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 for performance on the improvement activities performance category. A practice is certified or recognized as a patient-centered medical home if it meets any of the following criteria:

(A) The practice has received accreditation from one of four accreditation organizations that are nationally recognized;

(*1*) The Accreditation Association for Ambulatory Health Care;

(*2*) The National Committee for Quality Assurance (NCQA);

(*3*) The Joint Commission; or

(*4*) The Utilization Review Accreditation Commission (URAC).

(B) The practice is participating in a Medicaid Medical Home Model or Medical Home Model.

(C) The practice is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition.

(D) The practice is a participant or in a control group in the CPC+ model.

(E) The practice has received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by

the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following:

(*1*) Have a personal physician/clinician in a team-based practice.

(*2*) Have a whole-person orientation.

(*3*) Provide coordination or integrated care.

(*4*) Focus on quality and safety.

(*5*) Provide enhanced access.

(v) CMS compares the points associated with the reported activities against the highest potential category score of 40 points.

(vi) A MIPS eligible clinician or group's improvement activities category score is the sum of points for all of their reported activities, which is capped at 40 points, divided by the highest potential category score of 40 points.

(vii) Non-patient facing MIPS eligible clinicians and groups, small practices, and practices located in rural areas and geographic HPSAs receive full credit for improvement activities by selecting one high-weighted improvement activity or two medium-weighted improvement activities. Non-patient facing MIPS eligible clinicians and groups, small practices, and practices located in rural areas and geographic HPSAs receive half credit for improvement activities by selecting one medium-weighted improvement activity.

(viii) For the transition year, to receive full credit as a certified or recognized patient-centered medical home or comparable specialty a TIN that is reporting must include at least one practice site which is a certified patient-centered medical home or comparable specialty practice.

(ix) MIPS eligible clinicians participating in APMs that are not patient-centered medical homes for a performance period shall earn a minimum score of one-half of the highest potential score for the improvement activities performance category.

(x) For the 2018 MIPS performance period and future periods, to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice, CMS requires that at least 50 percent of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.

(4) *Advancing care information performance category*. (i) A MIPS eligible clinician's advancing care information performance category score equals the sum of the base score, performance score, and any applicable bonus scores. A MIPS eligible clinician cannot earn the performance score or base score until they have fulfilled the base score. The advancing care information performance category score will not exceed 100 percentage points.

(A) A MIPS eligible clinician earns a base score by reporting the numerator (of at least one) and denominator or a yes/no statement or an exclusion; as applicable, for each required measure.

(B) A MIPS eligible clinician earns a performance score by reporting on certain measures specified by CMS. MIPS eligible clinicians may earn up to 10 or 20 percentage points as specified by CMS for each measure reported for the performance score.

(C) A MIPS eligible clinician may earn the following bonus scores:

(1) A bonus score of 5 percentage points for reporting to one or more additional public health agencies or clinical data registries.

(2) A bonus score of 10 percentage points for attesting to completing one or more improvement activities specified by CMS using CEHRT.

(3) For the 2020 MIPS payment year, a bonus score of 10 percentage points for submitting data for the measures for the base score and the performance score generated solely from 2015 Edition CEHRT.

(c) *Final score calculation*. Each MIPS eligible clinician receives a final score of 0 to

100 points for a performance period for a MIPS payment year calculated per the following formula. If a MIPS eligible clinician is scored on fewer than 2 performance categories, he or she receives a final score equal to the performance threshold.

Final score = [(quality performance category percent score x quality performance category weight) + (cost performance category percent score x cost performance category weight) + (improvement activities performance category score x improvement activities performance category weight) + (advancing care information performance category score x advancing care information performance category weight)] x 100 + [the complex patient bonus + the small practice bonus], not to exceed 100 points.

(1) *Performance category weights.* The weights of the performance categories in the final score are as follows, unless a different scoring weight is assigned under paragraph (c)(2) of this section:

(i) Quality performance category weight is defined under §414.1330(b).

(ii) Cost performance category weight is defined under §414.1350(b).

(iii) Improvement activities performance category weight is defined under §414.1355(b).

(iv) Advancing care information performance category weight is defined under §414.1375(a).

(2) *Reweighting the performance categories.* A scoring weight different from the weights specified in paragraph (c)(1) of this section, will be assigned to a performance category, and its weight as specified in paragraph (c)(1) of this section, will be redistributed to another performance category or categories, in the following circumstances:

(i) CMS determines there are not sufficient measures and activities applicable and available to MIPS eligible clinicians pursuant to section 1848(q)(5)(F) of the Act.

(ii) CMS estimates that the proportion of eligible professionals who are meaningful EHR

users is 75 percent or greater pursuant to section 1848(q)(5)(E)(ii) of the Act.

(iii) A significant hardship exception or other type of exception is granted to a MIPS eligible clinician for the advancing care information performance category pursuant to section 1848(o)(2)(D) of the Act.

(3) *Complex patient bonus*. Provided that the MIPS eligible clinician, group, virtual group or APM entity submits data for at least one MIPS performance category during the applicable performance period, a complex patient bonus will be added to the final score for the 2020 MIPS payment year, as follows:

(i) For MIPS eligible clinicians and groups, the complex patient bonus is equal to the average HCC risk score assigned to beneficiaries (pursuant to the HCC risk adjustment model established by CMS pursuant to section 1853(a)(1) of the Act) seen by the MIPS eligible clinician or seen by clinicians in a group.

(ii) For MIPS APMs and virtual groups, the complex patient bonus is equal to the beneficiary weighted average HCC risk score for all MIPS eligible clinicians and TINs for models and virtual groups which rely on complete TIN participation within the APM entity or virtual group, respectively.

(iii) The complex patient bonus cannot exceed 3.0.

(4) *Small practice bonus*. A small practice bonus of 5 points will be added to the final score for the 2020 MIPS payment year for MIPS eligible clinicians, and for groups, virtual groups, and APM Entities that consist of 15 or fewer clinicians, that participate in the program by submitting data on at least one performance category in the 2018 MIPS performance period.

(d) *Scoring for APM Entities*. MIPS eligible clinicians in APM Entities that are subject to the APM scoring standard are scored using the methodology under §414.1370.

(e) *Scoring for Facility-Based Measurement*. MIPS eligible clinicians may elect to be

scored under the quality and cost performance categories using facility-based measures under the methodology described in in this paragraph.

(1) *General.* The facility-based measurement scoring standard is the MIPS scoring methodology applicable for MIPS eligible clinicians identified as meeting the requirements in paragraph (e)(2) and (3) of this section.

(i) For the 2018 MIPS performance period, the facility-based measures available are the measures adopted for the FY 2019 Hospital Value-Based Purchasing Program as authorized by section 1886(o) of the Act and codified in our regulations at §412.160 through §412.167.

(ii) For the 2020 MIPS payment year, the scoring methodology applicable for MIPS eligible clinicians electing facility-based measurement is the Total Performance Score methodology adopted for the Hospital Value-Based Purchasing Program.

(2) *Eligibility for facility-based measurement*. MIPS eligible clinicians are eligible for facility-based measurement for a MIPS payment year if they are determined facility-based as an individual clinician or as part of a group, as follows:

(i) *Facility-based individual determination*. A MIPS eligible clinician furnishes 75 percent or more of his or her covered professional services in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting based on claims for a period prior to the performance period as specified by CMS.

(ii) *Facility-based group determination*. A facility-based group is a group in which 75 percent or more of its MIPS eligible clinicians meet the requirements under paragraph (e)(2)(i) of this section.

(3) *Election of facility-based measurement*. MIPS eligible clinicians that meet the criteria described under paragraph (e)(2) of this section must elect participation in facility-based

measurement through attestation.

(4) *Data submission for facility-based measurement*. There are no data submission requirements for facility-based measurement other than electing the option through attestation as described in paragraph (e)(3) of this section.

(5) *Determination of applicable facility score*. A facility-based clinician or group receives a score under the facility-based measurement scoring standard derived from the value-based purchasing score for the facility at which the clinician or group provided services to the most Medicare beneficiaries. If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used.

(6) *MIPS performance category scoring under the facility-based measurement scoring standard*.

(i) *Measures*. The quality and cost measures are those adopted under the value-based purchasing program of the facility for the year specified.

(ii) *Benchmarks*. The benchmarks are those adopted under the value-based purchasing program of the facility program for the year specified.

(iii) *Performance Period*. The performance period for facility-based measurement is the performance period for the measures adopted under the value-based purchasing program of the facility program for the year specified.

(iv) *Quality*. The quality performance category percent score is established by determining the percentile performance of the facility in the value-based purchasing program for the specified year as described in paragraph (e)(5) of this section and awarding a score associated with that same percentile performance in the MIPS quality performance category percent score [for those clinicians who are not scored using facility-based measurement] for the MIPS payment year.

(v) *Cost*. The cost performance category percent score is established by determining the percentile performance of the facility in the value-based purchasing program for the specified year as described in paragraph (e)(5) of this section and awarding a score associated with that same percentile performance in the MIPS cost performance category percent score for those clinicians who are not scored using facility-based measurement for the MIPS payment year.

(A) *Other Cost Measures*. MIPS eligible clinicians who elect facility-based measurement are not scored on cost measures described in paragraph (b)(2) of this section.

(B) [Reserved]

14. Section 414.1390 is amended by adding paragraphs (b) through (d) to read as follows:

§414.1390 Data validation and auditing.

* * * * *

(b) *Certification*. All MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. Such certification must accompany the submission.

(c) *Reopening*. CMS may reopen and revise a MIPS payment determination in accordance with the rules set forth at §§405.980 through 405.986 of this chapter.

(d) *Record Retention*. 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.

15. Section 414.1395 is revised to read as follows:

§414.1395 Public reporting.

(a) *Public reporting of eligible clinician and group Quality Payment Program*

information. For each program year, CMS posts on Physician Compare, in an easily understandable format, information regarding the performance of eligible clinicians or groups under the Quality Payment Program.

(b) *Maintain existing public reporting standards*. With the exception of data that must be mandatorily reported on Physician Compare, for each program year, CMS relies on established public reporting standards to guide the information available for inclusion on Physician Compare. The public reporting standards require data included on Physician Compare to be statistically valid, reliable, and accurate; comparable across reporting mechanisms; and meet the reliability threshold. And, to be included on the public facing profile pages, the data must also resonate with website users, as determined by CMS.

(c) *First year measures*. For each program year, CMS does not publicly report any first year measure, meaning any measure in its first year of use in the quality and cost performance categories. After the first year, CMS reevaluates measures to determine when and if they are suitable for public reporting.

(d) *30-day preview period*. For each program year, CMS provides a 30-day preview period for any clinician or group with Quality Payment Program data before the data are publicly reported on Physician Compare.

16. Section 414.1400 is amended by—

a. Revising paragraph (a)(1) introductory text;

b. Adding paragraph (a)(5);

c. Revising paragraphs (b), (e) introductory text, (e)(3), (f) introductory text, (f)(1), (f)(2), (g), (i) and (j)(2).

The revisions and additions read as follows:

§414.1400 Third party data submission.

(a) * * *

(1) MIPS data may be submitted by third party intermediaries on behalf of a MIPS eligible clinician, group or virtual group by:

* * * * *

(5) 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. Such certification must accompany the submission.

(b) *QCDR self-nomination criteria.* For the 2018 performance period and future years of the program, QCDRs must self-nominate from September 1 of the prior year until November 1 of the prior year. Entities that desire to qualify as a QCDR for the purposes of MIPS for a given performance period will need to self-nominate for that performance period and provide all information requested by CMS at the time of self-nomination. Having qualified as a QCDR does not automatically qualify the entity to participate in subsequent MIPS performance periods. Beginning with the 2019 performance period existing QCDRs that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the upcoming performance period. CMS may allow existing QCDRs in good standing to submit minimal or substantial changes to their previously approved self-nomination form, from the previous year, during the annual self-nomination period, for CMS review and approval without having to complete the entire QCDR self-nomination application process.

* * * * *

(e) *Identifying QCDR quality measures.* For purposes of QCDRs submitting data for the MIPS quality performance category, CMS considers the following types of quality measures to be QCDR quality measures:

* * * * *

(3) CAHPS for MIPS survey. Although the CAHPS for MIPS survey is included in the MIPS measure set, we consider the changes that need to be made to the CAHPS for MIPS survey for reporting by individual MIPS eligible clinicians (and not as a part of a group) significant enough as to treat the CAHPS for MIPS survey as a QCDR quality measure for purposes of individual MIPS eligible clinicians reporting the CAHPS for MIPS survey via a QCDR.

(f) *QCDR measure specifications criteria*. A QCDR must provide specifications for each measure, activity, or objective the QCDR intends to submit to CMS. The QCDR must provide CMS descriptions and narrative specifications for each measure, activity, or objective no later than November 1of the applicable performance period for which the QCDR wishes to submit quality measures or other performance category (improvement activities and advancing care information) data starting with the 2018 performance period and in future program years.

(1) For QCDR quality measures, the quality measure specifications must include the following for each measure: name/title of measures, NQF number (if NQF-endorsed), descriptions of the denominator, numerator, and when applicable, denominator exceptions, denominator exclusions, risk adjustment variables, and risk adjustment algorithms. The narrative specifications provided must be similar to the narrative specifications we provide in our measures list.

(2) For MIPS quality measures, the QCDR only needs to submit the MIPS measure numbers or specialty-specific measure sets (if applicable). CMS expects that QCDRs reporting on MIPS measures, retain and use the MIPS measure specifications as they exist under the program year.

* * * * *

(g) *Qualified registry self-nomination criteria*. For the 2018 performance period and future years of the program, the qualified registry must self-nominate from September 1 of the

prior year until November 1 of the prior year. Entities that desire to qualify as a qualified registry for a given performance period must self-nominate and provide all information requested by CMS at the time of self-nomination. Having qualified as a qualified registry does not automatically qualify the entity to participate in subsequent MIPS performance periods. Beginning with the 2019 performance period, existing qualified registries that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the upcoming performance period. CMS may allow existing qualified registries in good standing to submit minimal or substantive changes to their previously approved self-nomination form from the previous year, during the annual self-nomination period, for CMS review and approval without having to complete the entire qualified registry self-nomination application process.

* * * * *

(i) *CMS-approved survey vendor application criteria*. Vendors are required to undergo the CMS approval process for each year in which the survey vendor seeks to transmit survey measures data to CMS. Applicants must adhere to any deadlines specified by CMS.

(j) * * *

(2) 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.

* * * * *

17. Section 414.1410 is amended by revising paragraph (b) to read as follows:

§414.1410 Advanced APM determination.

* * * * *

(b) *Advanced APM determination process*. CMS determines Advanced APMs in the following manner:

(1) CMS updates the Advanced APM list on its website at intervals no less than annually.

(2) CMS will include notice of whether a new APM is an Advanced APM in the first public notice of the new APM.

18. Section 414.1415 is amended by revising paragraphs (c) introductory text, (c)(2) introductory text, (c)(3)(i)(A) and (c)(4) to read as follows:

§414.1415 Advanced APM criteria.

* * * * *

(c) *Financial risk*. To be an Advanced APM, an APM must either meet the financial risk standard under paragraphs (c)(1) or (2) of this section and the nominal amount standard under paragraphs (c)(3) or (4) of this section or be an expanded Medical Home Model under Section 1115A(c) of the Act.

* * * * *

(2) *Medical Home Model financial risk standard*. The following standard applies only for APM Entities that are participating in Medical Home Models starting in the 2018 Medicare QP Performance Period, except for APM Entities participating in Round 1 of the Comprehensive Primary Care Plus (CPC+) Model. This standard applies for APM Entities that are owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities. APM Entities under this standard participate in a Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, which may include expected expenditures, does one or more of the following:

* * * * *

(3) * * *

(i) * * *

(A) For Medicare QP Performance Periods 2017, 2018, 2019, and 2020, 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; or

* * * * *

(4) *Medical Home Model nominal amount standard*. (i) For a Medical Home Model to be an Advanced APM, the total annual amount that an APM Entity potentially owes CMS or foregoes must be at least the following amounts:

(A) For Medicare QP Performance Period 2017, 2.5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(B) For Medicare QP Performance Period 2018, 2 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities;

(C) For Medicare QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(D) For Medicare QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(E) For Medicare QP Performance Periods 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(ii) [Reserved]

* * * * *

19. Section 414.1420 is amended by revising the section heading and paragraphs (a) introductory text, (a)(3)(i) and (ii), (c) introductory heading, (c)(2) introductory text, (c)(3), (d) introductory text, (d)(1) introductory text, (d)(3), and (4) to read as follows:

§414.1420 Other payer advanced APM criteria.

(a) *Other Payer Advanced APM criteria*. A payment arrangement with a payer other than Medicare is an Other Payer Advanced APM for an All-Payer QP Performance Period if CMS determines that the arrangement meets the following criteria during an All-Payer QP Performance Period:

* * * * *

(3) * * *

(i) Requires APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures as described in paragraph (d) of this section; or

(ii) Is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act as described in paragraph (d) of this section.

* * * * *

(c) *Use of quality measures*.

* * * * *

(2) At least one of the quality measures used in the payment arrangement must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

* * *

(3) To meet the quality measure use criterion, a payment arrangement must use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list.

(d) *Financial risk*. To be an Other Payer Advanced APM, a payment arrangement must meet either the financial risk standard under paragraphs (d)(1) or (2) of this section and the nominal amount standard under paragraphs (d)(3) or (4) of this section, make payment using a full capitation arrangement under paragraph (d)(6) of this section, or be a Medicaid Medical

Home Model with criteria comparable to an expanded Medical Home Model under section 1115A(c) of the Act.

(1) *Generally applicable financial risk standard*. Except for APM Entities to which paragraph (d)(2) of this section applies, to be an Other Payer Advanced APM, an APM Entity must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified period of performance do one or more of the following:

* * * * *

(3) *Generally applicable nominal amount standard*. Except for payment arrangements described in paragraph (d)(2) of this section, the total amount an APM Entity potentially owes or foregoes under a payment arrangement must be at least:

(i) 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity in the payment arrangement if financial risk is expressly defined in terms of revenue; or

(ii) At least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.

(4) *Medicaid Medical Home Model nominal amount standard*. For a Medicaid Medical Home Model to be an Other Payer Advanced APM, the total annual amount that an APM Entity potentially owes or foregoes must be at least the following amounts:

(i) For All-Payer QP Performance Period 2019, 3 percent of the APM Entity's total revenue under the payer.

(ii) For All-Payer QP Performance Period 2020, 4 percent of the APM Entity's total revenue under the payer.

(iii) For All-Payer QP Performance Periods 2021 and later, 5 percent of the APM Entity's total revenue under the payer.

* * * * *

20. Section 414.1425 is amended by--

a. Revising paragraphs (a), (b), (c)(3), and (c)(4)(i) and (c)(4)(ii);

b. Redesignating paragraph (c)(6) as paragraph (c)(4)(iii);

c. Revising newly redesignated paragraph (c)(4)(iii);

d. Adding a new paragraph (c)(6);

e. Revising paragraphs (d)(1) and (2); and

f. Removing paragraph (d)(4).

The revisions and addition read as follows:

§414.1425 Qualifying APM participant determination: In general.

* * * * *

(a) *List used for QP determination*. (1) For Advanced APMs in which all APM Entities may include eligible clinicians on a Participation List, the Participation List is used to identify the APM Entity group for purposes of QP determinations, regardless of whether the APM Entity also has eligible clinicians on an Affiliated Practitioner List.

(2) For Advanced APMs in which APM Entities do not include eligible clinicians on a Participation List but do include eligible clinicians on an Affiliated Practitioner List, the Affiliated Practitioner List is used to identify the eligible clinicians for purposes of QP determinations.

(3) For Advanced APMs in which some APM Entities may include eligible clinicians on a Participation List and other APM Entities may only include eligible clinicians on an Affiliated Practitioner List depending on the type of APM Entity, paragraph (a)(1) of this section applies to

APM Entities that may include eligible clinicians on a Participation List, and paragraph (a)(2) of this section applies to APM Entities that only include eligible clinicians on an Affiliated Practitioner List.

(b) *Group or individual determination under the Medicare Option. (1) APM Entity group determination*. Except for paragraphs (b)(2) and (3) of this section, for purposes of the QP determinations for a year, eligible clinicians are grouped and assessed through their collective participation in an APM Entity group that is in an Advanced APM. To be included in the APM Entity group for purposes of the QP determination, an eligible clinician's APM participant identifier must be present on a Participation List of an APM Entity group on one of the dates: March 31, June 30, or August 31 of the Medicare QP Performance Period. An eligible clinician included on a Participation List on any one of these dates is included in the APM Entity group even if that eligible clinician is not included on that Participation List at one of the prior or later listed dates. CMS performs QP determinations for the eligible clinicians in an APM entity group three times during the Medicare QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates: March 31, June 30, and August 31. An eligible clinician can only be determined to be a QP if the eligible clinician appears on the Participation List on a date (March 31, June 30, or August 31) CMS uses to determine the APM Entity group and to make QP determinations collectively for the APM Entity group based on participation in the Advanced APM.

(2) *Affiliated practitioner individual determination under the Medicare Option*. For Advanced APMs described in paragraph (a)(2) of this section, QP determinations are made individually for each eligible clinician. To be assessed as an Affiliated Practitioner, an eligible clinician must be identified on an Affiliated Practitioner List on one of the dates: March 31, June 30, or August 31 of the Medicare QP Performance Period. An eligible clinician included on an

Affiliated Practitioner List on any one of these dates is assessed as an Affiliated Practitioner even if that eligible clinician is not included on the Affiliated Practitioner List at one of the prior or later listed dates. For such eligible clinicians, CMS performs QP determinations during the Medicare QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates that the eligible clinician is on the Affiliated Practitioner List: March 31, June 30, and August 31.

(3) *Individual eligible clinician determination under the All-Payer Combination Option*. Eligible clinicians are assessed under the All-Payer Combination Option as set forth in §414.1440.

(c) * * *

(3) An eligible clinician is a QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that Medicare QP Performance Period as described in §414.1430(a)(1) and (3). An eligible clinician is a QP for the year under the All-Payer Combination Option if the individual eligible clinician achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that All-Payer QP Performance Period as described in §414.1430(b)(1) and (3).

(4) * * *

(i) The eligible clinician is included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the QP payment amount threshold or the QP patient count threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the QP payment amount threshold or the QP patient count threshold; unless

(iii) Any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period.

* * * * *

(6) *Advanced APMs that Start or End During the Medicare QP Performance Period*. (i) Notwithstanding paragraph (a) of this section and §§414.1435 and 414.1440, and except as provided in paragraph (c)(6)(ii) of this section, CMS makes QP determinations and Partial QP determinations for the APM Entity group or individual eligible clinician under §414.1425(b) for Advanced APMs that start or end during the Medicare QP Performance Period and that are actively tested for 60 or more continuous days during the Medicare QP Performance Period using claims data for services furnished during those dates on which the Advanced APM is actively tested. For Advanced APMs that start active testing during the Medicare QP Performance Period, CMS performs QP and Partial QP determinations during the Medicare QP Performance Period using claims data for services furnished from the start of active testing of the Advanced APM through each of the QP determination dates that occur on or after the Advanced APM has been actively tested for 60 or more continuous days: March 31, June 30, and August 31. For Advanced APMs that end active testing during the Medicare QP Performance Period, CMS performs QP and Partial QP determinations using claims data for services furnished from January 1 or the start of active testing, whichever occurs later, through the final day of active testing of the Advanced APM for each of the QP determination dates that occur on or after the

Advanced APM has been actively tested for 60 or more continuous days during that Medicare QP Performance Period: March 31, June 30, and August 31.

(ii) For QP determinations specified under paragraph (c)(4) of this section and Partial QP determinations under paragraph (d)(2) of this section, QP determinations are made using claims data for the full Medicare QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the Medicare QP Performance Period.

(d) * * *

(1) An eligible clinician is a Partial QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that Medicare QP Performance Period as described in §414.1430(a)(2) and (4). An eligible clinician is a Partial QP for the year under the All-Payer Combination Option if the individual eligible clinician achieves a Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that All-Payer QP Performance Period as described in §414.1430(b)(2) and (4).

(2) Notwithstanding paragraph (d)(1) of this section, an eligible clinician is a Partial QP for a year if:

(i) The eligible clinician is included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the corresponding QP or Partial QP threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the corresponding Partial QP Threshold; unless

(iii) Any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period.

* * * * *

21. Section 414.1435 is amended by revising paragraphs (a) introductory text, (a)(1), (2), (b)(1) through (4), (c)(3), and (d) to read as follows:

§414.1435 Qualifying APM participant determination: Medicare option.

(a) *Payment amount method*. The Threshold Score for an APM Entity or eligible clinician is calculated as a percent by dividing the value described under paragraph (a)(1) of this section by the value described under paragraph (a)(2) of this section.

(1) *Numerator*. The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to attributed beneficiaries during the Medicare QP Performance Period.

(2) *Denominator*. The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to all attribution-eligible beneficiaries during the Medicare QP Performance Period.

* * * * *

(b) * * *

(1) *Numerator*. The number of attributed beneficiaries to whom the APM Entity group furnishes Medicare Part B covered professional services or is furnished services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the Medicare QP Performance Period.

(2) *Denominator*. The number of attribution-eligible beneficiaries to whom the APM Entity group or eligible clinician furnishes Medicare Part B covered professional services or is

furnished services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the Medicare QP Performance Period.

(3) *Unique beneficiaries*. For each APM Entity group, a unique Medicare beneficiary is counted no more than one time for the numerator and no more than one time for the denominator.

(4) *Beneficiaries count multiple times*. Based on attribution under the terms of an Advanced APM, a single Medicare beneficiary may be counted in the numerator or denominator for multiple different APM Entity groups.

(c) * * *

(3) When it is not operationally feasible to use the final attributed beneficiary list, the attributed beneficiary list will be taken from the Advanced APM's most recently available attributed beneficiary list at the end of the Medicare QP Performance Period.

(d) *Use of methods*. CMS calculates Threshold Scores for an APM Entity or eligible clinician as provided by §414.1425(b) under both the payment amount and patient count methods for each Medicare QP Performance Period. CMS then assigns to the eligible clinicians included in the APM Entity group or to the eligible clinician the score that results in the greater QP status. QP status is greater than Partial QP status, and Partial QP status is greater than no QP status.

22. Section 414.1440 is amended by revising paragraphs (a)(2), (b), (c), and (d) and adding paragraphs (e), (f), and (g) to read as follows:

§414.1440 Qualifying APM participant determination: All-payer combination option.

(a) * * *

(2) Payments and associated patient counts under paragraph (a)(1) of this section, are included in the numerator and denominator as specified in paragraphs (b)(2) and (3) of this section for an eligible clinician if CMS determines that there is at least one Medicaid APM or

Medicaid Medical Home Model that is an Other Payer Advanced APM available in the county where the eligible clinician sees the most patients during the All-Payer QP Performance Period, and that the eligible clinician is eligible to participate in the Other Payer Advanced APM based on their specialty.

(b) *Payment amount method*. (1) *In general*. The Threshold Score for an eligible clinician will be calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (b)(2) and (3) of this section.

(2) *Numerator*. The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, attributable to the eligible clinician under the terms of Advanced APMs and Other Payer Advanced APMs during the All-Payer QP Performance Period. CMS calculates Medicare Part B covered professional services under the All-Payer Combination Option at the eligible clinician level.

(3) *Denominator*. The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, made to the eligible clinician during the All-Payer QP Performance Period. CMS calculates Medicare Part B covered professional services under the All-Payer Combination Option at the eligible clinician level.

(c) *Patient count method*. (1) *In general*. The Threshold Score for an eligible clinician is calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (c)(2) and (3) of this section.

(2) *Numerator*. The number of unique patients to whom the eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other Payer Advanced APMs during the All-Payer QP Performance Period.

(3) *Denominator*. The number of unique patients to whom the eligible clinician furnishes services under all non-excluded payers during the All-Payer QP Performance Period.

(d) *QP Determinations under the All-Payer Combination Option*. (1) Eligible clinicians are assessed under the All-Payer Combination Option at the individual level only. CMS performs QP determinations following the All-Payer QP Performance Period using payment amount and patient count information submitted to CMS by APM Entities or eligible clinicians for January 1 through March 31 and January 1 through June 30.

(2) If the Medicare Threshold Score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the individual eligible clinician, CMS makes the QP determination under the All-Payer Combination Option using a weighted Medicare Threshold Score that will be factored into an All-Payer Combination Option Threshold Score calculated at the individual eligible clinician level.

(e) *Information used to calculate Threshold Scores under the All-Payer Combination Option*. (1) To request a QP determination under the All-Payer Combination Option, an APM Entity or eligible clinician may request that we evaluate whether a payment arrangement meets the Other Payer Advanced APM criteria as set forth in §414.1445(b)(2) and may demonstrate participation in an Other Payer Advanced APM determined as a result of requests made in §414.1445(a) and (b)(1) in a form and manner specified by CMS.

(2) To request a QP determination under the All-Payer Combination Option, for each payment arrangement submitted as set forth in paragraph (e)(1), the APM Entity or eligible clinician must include the amount of revenue for services furnished through the payment arrangement, the total revenue received from the all payers except those excluded as provided in paragraph (a)(2) of this section, the number of patients furnished any service through the

arrangement, and the total number of patients furnished any services, except those excluded as provided in paragraph (a)(2) of this section, during the All-Payer QP Performance Period.

(f) *Requirement to submit sufficient information*. (1) CMS makes a QP determination with respect to the eligible clinician under the All-Payer Combination Option only if the APM Entity or eligible clinician submits the information required under paragraphs (e)(1) and (2) of this section sufficient for CMS to assess the eligible clinician under either the payment amount or patient count as described in paragraphs (b) and (c) of this section.

(2) *Certification*. The APM Entity or eligible clinician who submits information to request a QP determination under the All-Payer Combination Option must certify that the information submitted to CMS is true, accurate, and complete. Such certification must accompany the submission. In the case of information submitted by an APM Entity, the certification must be made by an individual with the authority to bind the APM Entity.

(g) *Notification of QP determination*. CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable after QP calculations are conducted.

23. Section 414.1445 is revised to read as follows:

§414.1445 Determination of other payer advanced APMs.

(a) *Determination of Medicaid APMs*. Beginning in 2018, at a time determined by CMS, a state, APM Entity, or eligible clinician may request, in a form and manner specified by CMS, that CMS determine whether a payer arrangement authorized under Title XIX is either a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria prior to the All-Payer QP Performance Period.

(b) *Determination of Other Payer Advanced APMs*. (1) *Determination prior to the All-Payer QP Performance Period*. Beginning in 2018, a payer with a Medicare Health Plan payment arrangement or a payment arrangement in a CMS Multi-Payer Model may request, in a

form and manner specified by CMS, that CMS determine whether a payment arrangement meets the Other Payer Advanced APM criteria under §414.1420 prior to the All-Payer QP Performance Period.

(2) *Determination following the All-Payer QP Performance Period*. Beginning in 2019, an APM Entity or eligible clinician may request, in a form and manner specified by CMS, that CMS determine whether a payment arrangement meets the Other Payer Advanced APM criteria under §414.1420 following the All-Payer QP Performance Period.

(i) CMS will not determine that a payment arrangement is a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria after the end of the All-Payer QP Performance Period.

(ii) [Reserved]

(c) *Information Required for Determination*. (1) For a payer, APM Entity, or eligible clinician to request that CMS determine whether a payment arrangement is an Other Payer Advanced APM, Medicaid APM, or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria, a payer, APM Entity, or eligible clinician must submit payment arrangement information necessary to assess the payment arrangement on the Other Payer Advanced APM criteria under §414.1420. If the payer, APM Entity, or eligible clinician fails to submits all of the information required under this section or does not supplement information if the need to do so as identified by CMS, then CMS will not determine whether the payment arrangement is an Other Payer Advanced APM.

(2) If an eligible clinician submits information showing that a payment arrangement requires that the eligible clinician must use CEHRT as defined in §414.1305 to document and communicate clinical care, CMS will presume that CEHRT criterion in §414.1420(b) is satisfied for that payment arrangement.

(3) If a payment arrangement has no outcome measure, the payer, APM Entity, or eligible clinician submitting payment arrangement information to request a determination of whether a payment arrangement meets the Other Payer Advanced APM criteria must certify that there is no available or applicable outcome measure on the MIPS list of quality measures.

(d) *Certification*. A payer, APM Entity, or eligible clinician that submits information pursuant to paragraph (c) of this section must certify that the information it submitted to CMS is true, accurate, and complete. Such certification must accompany the submission. In case of information submitted by an APM Entity, the certification must be made by an individual with the authority to bind the APM Entity.

(e) *Timing of Other Payer Advanced APM determinations*. CMS makes Other Payer Advanced APM determinations prior to making QP determinations under §414.1440.

(f) *Notification of Other Payer Advanced APM determinations*. CMS makes final Other Payer Advanced APM determinations and notifies the requesting payer, APM Entity, or eligible clinician of such determinations as soon as practicable following the relevant submission deadline.

24. Section 414.1460 is amended by revising paragraphs (a) through (e) to read as follows:

§414.1460 Monitoring and program integrity.

(a) *Vetting eligible clinicians*. Prior to payment of the APM Incentive Payment, CMS determines if eligible clinicians were in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APMs in which they participated during the Medicare QP Performance Period. A determination under this provision is not binding for other purposes.

(b) *Rescinding QP Determinations*. CMS may rescind a QP determination if:

(1) Any of the information CMS relied on in making the QP determination was inaccurate or misleading.

(2) The QP is terminated from an Advanced APM or Other Payer Advanced APM during the Medicare QP Performance Period, All-Payer QP Performance Period or Incentive Payment Base Period; or

(3) The QP is found to be in violation of the terms of the relevant Advanced APM or any Federal, State, or tribal statute or regulation during the Medicare QP Performance Period, All-Payer Performance Period or Incentive Payment Base Period.

(c) *Information submitted for All-Payer Combination Option*. Information submitted by payers, APM Entities, or eligible clinicians for purposes of the All-Payer Combination Option may be subject to audit by CMS.

(d) *Reducing, Denying, and Recouping of APM Incentive Payments*.

(1) CMS may reduce or deny an APM Incentive Payment to an eligible clinician

(i) Who CMS determines is not in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APM in which they participate during the Medicare QP Performance Period, All-Payer QP Performance Period, or Incentive Payment Base Period;

(ii) Who is terminated by an APM or Advanced APM during the Medicare QP Performance Period, All-Payer QP Performance Period, or Incentive Payment Base Period; or

(iii) Whose APM Entity is terminated by an APM or Advanced APM for non-compliance with any Medicare condition of participation or the terms of the relevant Advanced APM in which they participate during the Medicare QP Performance Period, All-Payer QP Performance Period, or Incentive Payment Base Period.

(2) CMS may reopen, revise, and recoup an APM Incentive Payment that was made in error in accordance with procedures similar to those set forth at §§405.980 through §405.986 and §§405.370 through 405.379 of this chapter or as established under the relevant APM.

(e) *Maintenance of records*. (1) A payer that submits information to CMS under §414.1445 for assessment under the All-Payer Combination Option must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination. Such information and supporting documentation must be maintained for a period of 10 years after submission.

(2) An APM Entity or eligible clinician that submits information to CMS under §414.1445 for assessment under the All-Payer Combination Option or §414.1440 for QP determinations must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination, QP determinations, and the accuracy of APM Incentive Payments for a period of 10 years from the end of the All-Payer QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless;

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the APM Entity or eligible clinician at least 30 days before the formal disposition date; or

(ii) There has been a termination, dispute, or allegation of fraud or similar fault against the APM Entity or eligible clinician, in which case the APM Entity or eligible clinician must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

(3) A payer, APM Entity or eligible clinician that submits information to CMS under §§414.1440 or 414.1445 must provide such information and supporting documentation to CMS

upon request.

* * * * *

Dated: June 7, 2017.

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Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: June 13, 2017.

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Thomas E. Price,

Secretary,

Department of Health and Human Services.

BILLING CODE 4120-01-P

APPENDIX

NOTE: For previously finalized MIPS quality measures, we refer readers to Table A in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77558). For previously finalized MIPS specialty measure sets, we refer readers to Table E in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77686). Except as otherwise proposed below, previously finalized measures and specialty measure sets would continue to apply for the Quality Payment Program year 2 and future years.

TABLE Group A: New Quality Measures Proposed for Inclusion in MIPS for the 2018 Performance Period

A.1. Average Change in Back Pain following Lumbar Discectomy / Laminotomy

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	The average change (preoperative to three months postoperative) in back pain for patients 18 years of age or older who had lumbar discectomy / laminotomy procedure.
Measure Steward:	MN Community Measurement
Numerator:	This measure is not a proportion or rate, and as such, does not have a numerator and denominator, but has an eligible population with a calculated result. The calculated result is: The average change (preoperative to three months postoperative) in back pain for all eligible patients.
Denominator:	Patients 18 years of age or older as of January 1 of the measurement period who had a lumbar discectomy / laminotomy procedure for a diagnosis of disc herniation performed by an eligible provider in an eligible specialty during the measurement period and whose back pain was measured by the Visual Analog Scale (VAS) within three months preoperatively AND at three months (6 to 20 weeks) postoperatively.
Exclusions:	Patient who has had any additional spine procedures performed on the same date as the lumbar discectomy / laminotomy.
Measure Type:	Outcome
Measure Domain:	Person and Caregiver-Centered Experience and Outcomes
High priority measure:	Yes (Patient Experience)
Data Submission Method:	Qualified Registry
Rationale:	CMS proposes to include this measure because it is outcomes focused and provides measurements related to the variations in improvement after spine surgery. This measure is useful for patients in evaluating what outcomes can be expected from surgery and clinicians who can conduct comparisons across results. The MAP has made a recommendation of conditional support, with the conditions of submission to NQF for endorsement and verification that testing supports implementation at the individual clinician level (https://www.qualityforum.org/map/)

A.2. Average Change in Back Pain following Lumbar Fusion

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	The average change (preoperative to one year postoperative) in back pain for patients 18 years of age or older who had lumbar spine fusion surgery.
Measure Steward:	MN Community Measurement
Numerator:	This measure is not a proportion or rate, and as such, does not have a numerator and denominator, but has an eligible population with a calculated result. The calculated result is: The average change (preoperative to one year postoperative) in back pain for all eligible patients.
Denominator:	Patients 18 years of age or older as of January 1 of the measurement period who had a lumbar spine fusion surgery performed by an eligible provider in an eligible specialty during the measurement period and whose back pain was measured by the Visual Analog Scale (VAS) within three months preoperatively AND at one year (+/- 3 months) postoperatively.
Exclusions:	None
Measure Type:	Outcome
Measure Domain:	Person and Caregiver-Centered Experience and Outcomes
High priority measure:	Yes (Patient Experience)
Data Submission Method:	Qualified Registry
Rationale:	CMS proposes to include this measure because it is outcomes focused and provides measurements related to the variations in improvement after spine surgery in patients. This measure is an example of quality measurement as the results can be used in evaluating whether the patient's pain was reduced as a result of the lumbar fusion. The MAP has made a recommendation of conditional support, with the conditions of submission to NQF for endorsement and verification that testing supports implementation at the individual clinician level.(https://www.qualityforum.org/map/)

A.3. Average Change in Leg Pain following Lumbar Discectomy / Laminotomy

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	The average change (preoperative to three months postoperative) in leg pain for patients 18 years of age or older who had lumbar discectomy / laminotomy procedure.
Measure Steward:	MN Community Measurement
Numerator:	The average change (preoperative to three months postoperative) in leg pain for all eligible patients.
Denominator:	Patients 18 years of age or older as of January 1 of the measurement period who had a lumbar discectomy and/or laminotomy procedure for a diagnosis of disc herniation performed by an eligible provider in an eligible specialty during the measurement period and whose leg pain was measured by the Visual Analog Scale (VAS) within three months preoperatively AND at three months (6 to 20 weeks) postoperatively.
Exclusions:	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/ laminotomy.
Measure Type:	Outcome
Measure Domain:	Person and Caregiver-Centered Experience and Outcomes
High priority measure:	Yes (Patient Experience)
Data Submission Method:	Qualified Registry
Rationale:	CMS proposes to include this measure because it is outcomes focused and provides measurements related to the variations in improvement after spine surgery. This measure is useful for clinicians who can conduct comparisons across results. The MAP has made a recommendation of conditional support, with the conditions of submission to NQF for endorsement and verification that testing supports implementation at the individual clinician level.(https://www.qualityforum.org/map/)

A.4. Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.
Measure Steward:	Oregon Urology Institute
Numerator:	Patients with a bone density evaluation within the two years prior to the start of or less than three months after the start of ADT treatment.
Denominator:	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater.
Exclusions:	None
Measure Type:	Process
Measure Domain:	Effective Clinical Care
High priority measure:	No
Data Submission Method:	EHR
Rationale:	CMS proposes to include this measure as there are no quality measures that currently address patients with prostate cancer and a diagnosis of osteoporosis. This measure will result in better care, reduced fractures, and reduced bone density loss. The MAP has made a recommendation of conditional support, with the condition for the completion of NQF endorsement. (https://www.qualityforum.org/map/)

A.5. Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics)

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	Percentage of patients aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.
Measure Steward:	American Society of Anesthesiologists
Numerator:	Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.
Denominator:	All patients, aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for POV.
Exclusions:	Cases in which an inhalational anesthetic is used only for induction. Organ Donors as designated by ASA Physical Status 6
Measure Type:	Process
Measure Domain:	Effective Clinical Care
High priority measure:	No
Data Submission Method:	Qualified Registry
Rationale:	CMS proposes to include this measure because it recognizes the difference in therapy required for the pediatric population with regards to the prevention of post-operative vomiting; furthermore, the American Society of Anesthesiologists have verified that testing supports the implementation of the measure at the individual clinician level. The MAP has made a recommendation of conditional support, with the conditions of submission to NQF for endorsement and verification that testing supports implementation at the individual clinician level.(https://www.qualityforum.org/map/)

A.6. Otitis Media with Effusion (OME): Systemic Antimicrobials - Avoidance of Inappropriate Use

Category	Description
NQF #:	657
Quality #:	To Be Determined (TBD)
Description:	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.
Measure Steward:	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)
Numerator:	Patients who were not prescribed systemic antimicrobials.
Denominator:	All patients aged 2 months through 12 years with a diagnosis of OME.
Exclusions:	Documentation of medical reason(s) for prescribing systemic antimicrobials.
Measure Type:	Process
Measure Domain:	Patient Safety, Efficiency and Cost Reduction
High priority measure:	Yes (Appropriate Use)
Data Submission Method:	Qualified Registry
Rationale:	CMS proposes to include this measure as it promotes the practice of appropriate prescription and usage of medications in the care of all beneficiaries to facilitate health and promote well-being. The MAP has made a recommendation of support for this NQF endorsed measure. (https://www.qualityforum.org/map/)

A.7. Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries

Category	Description
NQF #:	Not Applicable (NA)
Quality #:	To Be Determined (TBD)
Description:	Documentation of angiographic endpoints of embolization AND the documentation of embolization strategies in the presence of unilateral or bilateral absent uterine arteries.
Measure Steward:	Society of Interventional Radiology
Numerator:	Number of patients undergoing uterine artery embolization for symptomatic leiomyomas and/or adenomyosis in whom embolization endpoints are documented separately for each embolized vessel AND ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy. Embolization endpoints: Complete stasis (static contrast column for at least 5 heartbeats) / Near-stasis (not static, but contrast visible for at least 5 heartbeats) / Slowed flow (contrast visible for fewer than 5 heartbeats) / Normal velocity flow with pruning of distal vasculature / Other [specify] / Not documented Embolization strategy options for variant uterine artery anatomy: Ovarian artery angiography, Ovarian artery embolization, Abdominal Aortic angiography, None
Denominator:	All patients undergoing uterine artery embolization for symptomatic leiomyomas and/or adenomyosis.
Exclusions:	SIR Guidance: Any patients that should be excluded from reporting either in the eligible population (denominator) or from both numerator and denominator (if patient experiences outcome then exclude from denominator and numerator; if not then include in denominator). Method to risk adjust measure.
Measure Type:	Process
Measure Domain:	Patient Safety
High priority measure:	Yes (Patient Safety)
Data Submission Method:	Qualified Registry
Rationale:	The MAP has made a recommendation of refine and resubmit based on lack of test data. CMS proposes to include this measure, as field testing has been completed and there are currently no applicable uterine artery embolization technique measures in CMS quality programs. (https://www.qualityforum.org/map/)

A.8. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Category	Description
NQF #:	1516
Quality #:	To Be Determined (TBD)
Description:	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.
Measure Steward:	National Committee for Quality Assurance
Numerator:	Children who received at least one well-child visit with a PCP during the measurement year. The measurement year (12 month period).
Denominator:	Children 3-6 years of age during the measurement year.
Exclusions:	Numerator Exclusions: Do not include services rendered during an inpatient or ED visit. Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
Measure Type:	Process
Measure Domain:	Community/Population Health
High priority measure:	No
Data Submission Method:	Qualified Registry
Rationale:	This pediatric measure fulfills an important measurement gap for pediatric patients in the 3 through 6 year olds age range; therefore, CMS is proposing its inclusion in the Pediatric specialty measure set.

A.9. Developmental Screening in the First Three Years of Life

Category	Description
NQF #:	1448
Quality #:	To Be Determined (TBD)
Description:	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
Measure Steward:	Oregon Health & Science University
Numerator:	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators. Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday. Numerator 2: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their second birthday. Numerator 3: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their third birthday. Numerator 4: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday.
Denominator:	Children who meet the following eligibility requirement: Age: Children who turn 1, 2 or 3 years of age between January 1 and December 31 of the measurement year. Continuous Enrollment: Children who are enrolled continuously for 12 months prior to child's 1st, 2nd or 3rd birthday. Allowable Gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Exclusions:	None
Measure Type:	Process
Measure Domain:	Community/Population Health

Category	Description
High priority measure:	No
Data Submission Method:	Qualified Registry
Rationale:	This pediatric measure fulfills an important measurement gap related to developmental screening for pediatric patients in the 1 through 3 year olds age range; therefore, CMS is proposing its inclusion in the Pediatric specialty measure set.

TABLE Group B: Proposed New and Modified MIPS Specialty Measure Sets for the 2018 Performance Period

Note: CMS has proposed to modify the specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies. Existing measures with proposed substantive changes are noted with an asterisk (*), core measures as agreed upon by Core Quality Measure Collaborative (CQMC) are noted with the symbol (§), high priority measures are noted with an exclamation point (!), and high priority measures that are appropriate use measures are noted with a double exclamation point (!!) in the column.

B.1. Allergy/Immunology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title And Description	Measure Steward
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
§	0405	160	52v6	EHR	Process	Effective Clinical Care	**HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis Jiroveci Pneumonia (PCP) prophylaxis.	National Committee for Quality Assurance

B.1. Allergy/Immunology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	0022	238	156v6	Registry, EHR	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.1. Allergy/Immunology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	2082	338	N/A	Registry	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
	2079	340	N/A	Registry	Process	Efficiency and Cost Reduction	**HIV Medical Visit Frequency:** Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between medical visits.	Health Resources and Services Administration
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.2. Anesthesiology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0236	044	N/A	Registry	Process	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery:** Percentage of isolated Coronary Artery Bypass Graft (CABG) surgeries for patients aged 18 years and older who received a beta-blocker within 24 hours prior to surgical incision.	Centers for Medicare & Medicaid Services

B.2. Anesthesiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	076	N/A	Claims, Registry	Process	Patient Safety	**Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	American Society of Anesthesiologists
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.2. Anesthesiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
!	N/A	404	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Anesthesiology Smoking Abstinence:** The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure.	American Society of Anesthesiologists

B.2. Anesthesiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	2681	424	N/A	Registry	Outcome	Patient Safety	**Perioperative Temperature Management:** Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.	American Society of Anesthesiologists
!	N/A	426	N/A	Registry	Process	Communication and Care Coordination	**Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU):** Percentage of patients, regardless of age, who are under the care of an anesthesia practitioner and are admitted to a PACU in which a post-anesthetic formal transfer of care protocol or checklist which includes the key transfer of care elements is utilized.	American Society of Anesthesiologists

B.2. Anesthesiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	427	N/A	Registry	Process	Communication and Care Coordination	**Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU):** Percentage of patients, regardless of age, who undergo a procedure under anesthesia and are admitted to an Intensive Care Unit (ICU) directly from the anesthetizing location, who have a documented use of a checklist or protocol for the transfer of care from the responsible anesthesia practitioner to the responsible ICU team or team member.	American Society of Anesthesiologists
!	N/A	430	N/A	Registry	Process	Patient Safety	**Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy:** Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two prophylactic pharmacologic antiemetic agents of different classes preoperatively or intraoperatively.	American Society of Anesthesiologists
	N/A	TBD	N/A	Registry	Process	Effective Clinical Care	**Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics):** Percentage of patients aged 3 through 17 years of age, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.	American Society of Anesthesiologists

B.3. Cardiology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0081	005	135v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	Registry	Process	Effective Clinical Care	**Chronic Stable Coronary Artery Disease: Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
§	0070	007	145v6	Registry, EHR	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0083	008	144v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
§	0066	118	N/A	Registry	Process	Effective Clinical Care	**Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	American Heart Association

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0068	204	164v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.	National Committee for Quality Assurance
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0018	236	165v6	Claims, Registry, EHR, Web Interface	Inter-mediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.	National Committee for Quality Assurance

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	0022	238	156v6	Registry, EHR	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	0643	243	N/A	Registry	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP).	Centers for Medicare & Medicaid Services
!!	N/A	322	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients:** Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period.	American College of Cardiology

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	323	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI):** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status.	American College of Cardiology
!!	N/A	324	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment.	American College of Cardiology
§	1525	326	N/A	Claims, Registry	Process	Effective Clinical Care	**Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism.	American College of Cardiology

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	344	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2.	Society for Vascular Surgeons
!	N/A	345	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS):** Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital.	Society for Vascular Surgeons
	N/A	373	65v7	EHR	Intermediate Outcome	Effective Clinical Care	**Hypertension: Improvement in Blood Pressure:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	Registry	Process	Population/ Community	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI)

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	N/A	438	347v1	Web Interface, Registry, EHR	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**: Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services

B.3. Cardiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	441	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) • Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm Hg • And Most recent tobacco status is Tobacco Free • And Daily Aspirin or Other Antiplatelet Unless Contraindicated And Statin Use.	Wisconsin Collaborative for Healthcare Quality (WCHQ)
§	0071	442	N/A	Registry	Process	Effective Clinical Care	**Persistent Beta Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance

B.3a. Electrophysiology Cardiac Specialist (Subspecialty Set of B.3 Cardiology)

Note: Each subspecialty set is effectively a separate specialty set. In instances where an Individual MIPS eligible clinician or group reports on specialty or subspecialty set, if the set has less than six measures that is all the clinician is required to report.

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	348	N/A	Registry	Outcome	Patient Safety	**HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate:** Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD.	The Heart Rhythm Society
!	2474	392	N/A	Registry	Outcome	Patient Safety	**HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation:** Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation This measure is reported as four rates stratified by age and gender: • Reporting Age Criteria 1: Females less than 65 years of age • Reporting Age Criteria 2: Males less than 65 years of age • Reporting Age Criteria 3: Females 65 years of age and older • Reporting Age Criteria 4: Males 65 years of age and older.	The Heart Rhythm Society
!	N/A	393	N/A	Registry	Outcome	Patient Safety	**HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision:** Infection rate following CIED device implantation, replacement, or revision.	The Heart Rhythm Society

B.4. Gastroenterology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.4. Gastroenterology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	0659	185	N/A	Claims, Registry	Process	Communication and Care Coordination	**Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use:** Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy.	Gastroenterological Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	271	N/A	Registry	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment:** Percentage of patients aged 18 years and older with an inflammatory bowel disease encounter who were prescribed prednisone equivalents greater than or equal to 10 mg/day for 60 or greater consecutive days or a single prescription equating to 600mg prednisone or greater for all fills and were documented for risk of bone loss once during the reporting year or the previous calendar year.	American Gastro-enterologial Association

B.4. Gastroenterology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	275	N/A	Registry	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy.	American Gastro-enterological Association
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
§ !!	0658	320	N/A	Claims, Registry	Process	Communicat ion and Care Coordination	**Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients:** Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	American Gastroenterol ogical Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology
§ !	N/A	343	N/A	Registry	Outcome	Effective Clinical Care	**Screening Colonoscopy Adenoma Detection Rate Measure:** The percentage of patients age 50 years or older with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.	American College of Gastro-enterology
* !	N/A	374	50v6	Registry, EHR	Process	Communicat ion and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.4. Gastroenterology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	390	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment.	American Gastro-enterological Association/ Physician Consortium for Performance Improvement
§	N/A	401	N/A	Registry	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis**: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period.	American Gastro-enterological Association/ Physician Consortium for Performance Improvement

B.4. Gastroenterology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	402	N/A	Registry	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	N/A	425	N/A	Claims, Registry	Process	Effective Clinical Care	**Photodocumentation of Cecal Intubation:** The rate of screening and surveillance colonoscopies for which photo documentation of landmarks of cecal intubation is performed to establish a complete examination.	American Society for Gastrointestinal Endoscopy
	2152	431	N/A	Registry	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ !!	N/A	439	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Age Appropriate Screening Colonoscopy:** The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.	American Gastro-enterological Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology

B.5. Dermatology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0650	137	N/A	Registry	Structure	Communication and Care Coordination	**Melanoma: Continuity of Care – Recall System:** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12-month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment.	American Academy of Dermatology
!	N/A	138	N/A	Registry	Process	Communication and Care Coordination	**Melanoma: Coordination of Care:** Percentage of patients visits, regardless of age, with a new occurrence of melanoma, who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	American Academy of Dermatology
!!	0562	224	N/A	Registry	Process	Efficiency and Cost Reduction	**Melanoma: Overutilization of Imaging Studies in Melanoma:** Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered.	American Academy of Dermatology

B.5. Dermatology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	N/A	265	N/A	Registry	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician.	American Academy of Dermatology
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	N/A	337	N/A	Registry	Process	Effective Clinical Care	**Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	American Academy of Dermatology

B.5. Dermatology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
!	N/A	410	N/A	Registry	Outcome	Person and Caregiver Centered Experience and Outcomes	**Psoriasis: Clinical Response to Oral Systemic or Biologic Medications :** Percentage of psoriasis patients receiving oral systemic or biologic therapy who meet minimal physician- or patient-reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control as measured by physician- and/or patient-reported outcomes will increase patient satisfaction with and adherence to treatment.	American Academy of Dermatology
	N/A	440	N/A	Registry	Process	Communication and Care Coordination	**Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma: Biopsy Reporting Time – Pathologist to Clinician:** Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC) (including in situ disease) in which the pathologist communicates results to the clinician within 7 days of biopsy date.	American Academy of Dermatology

B.6. Emergency Medicine

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	066	146v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology-Head and Neck Surgery
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
	0104	107	161v6	EHR	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ !!	0058	116	N/A	Registry	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	National Committee for Quality Assurance
	N/A	187	N/A	Registry	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Thrombolytic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well.	American Heart Association

B.6. Emergency Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0651	254	N/A	Claims, Registry	Process	Effective Clinical Care	**Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain:** Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location.	American College of Emergency Physicians
	N/A	255	N/A	Claims, Registry	Process	Effective Clinical Care	**Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure:** Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED).	American College of Emergency Physicians
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
!!	N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology-Head and Neck Surgery
!!	N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery

B.6. Emergency Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology - Head and Neck Surgery
!	N/A	415	N/A	Claims, Registry	Efficiency	Efficiency and Cost Reduction	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older:** Percentage of emergency department visits for patients aged 18 years and older who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.	American College of Emergency Physicians
!!	N/A	416	N/A	Claims, Registry	Efficiency	Efficiency and Cost Reduction	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years:** Percentage of emergency department visits for patients aged 2 through 17 years who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury.	American College of Emergency Physicians

B.7. Family Medicine

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0059	001	122v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0081	005	135v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	Registry	Process	Effective Clinical Care	**Chronic Stable Coronary Artery Disease: Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
§	0070	007	145v6	Registry, EHR	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0083	008	144v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	105	009	128v6	EHR	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. Two rates are reported a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	National Committee for Quality Assurance
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
	0046	039	N/A	Claims, Registry	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	048	N/A	Claims, Registry	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
!	N/A	050	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experienc e and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance
!!	0069	065	154v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months through 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
!!	N/A	066	146v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology - Head and Neck Surgery

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0104	107	161v6	EHR	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	N/A	109	N/A	Claims, Registry	Process	Person and Caregiver Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
§	2372	112	125v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 -74 years of age who had a mammogram to screen for breast cancer.	National Committee for Quality Assurance
* §	0034	113	130v6	Claims, Web Interface, Registry, EHR EHREHR	Process	Effective Clinical Care	**Colorectal Cancer Screening:** Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance
§ !!	0058	116	N/A	Registry	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0055	117	131v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	National Committee for Quality Assurance
§	0062	119	134v4	Registry, EHR	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance
	0417	126	N/A	Registry	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy –Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0418	134	2v77	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0056	163	123v6	EHR	Process	Effective Clinical Care	**Comprehensive Diabetes Care: Foot Exam:** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.	National Committee for Quality Assurance
!	NA	181	N/A	Claims, Registry	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services
§	0068	204	164v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	0022	238	156v6	Registry, EHR	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	0643	243	N/A	Registry	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0004	305	137v6	EHR	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	National Committee for Quality Assurance
§	0032	309	124v6	EHR	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	National Committee for Quality Assurance
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* § !	0005 & 0006	321	N/A	CMS-approved Survey Vendor	Patient Engagement/Experience	Person and Caregiver-Centered Experience and Outcomes	**CAHPS for MIPS Clinician/Group Survey:** Summary Survey Measures may include: • 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.	Agency for Healthcare Research & Quality (AHRQ)
§	1525	326	N/A	Claims, Registry	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism.	American College of Cardiology
!!	N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology -Head and Neck Surgery
!!	N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery
!!	N/A	334	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery
	N/A	337	N/A	Registry	Process	Effective Clinical Care	**Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	American Academy of Dermatology
§ !	2082	338	N/A	Registry	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
!	N/A	342	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Pain Brought Under Control Within 48 Hours:** Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0710	370	159v6	Web Interface, Registry, EHR	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	MN Community Measurement
	0712	371	160v6	EHR	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** Patients age 18 and older with the diagnosis of major depression or dysthymia who have a Patient Health Questionnaire (PHQ-9) tool administered at least once during a 4-month period in which there was a qualifying visit.	MN Community Measurement
	N/A	373	65v7	EHR	Intermediate Outcome	Effective Clinical Care	**Hypertension: Improvement in Blood Pressure:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	377	90v7	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessments for Congestive Heart Failure:** Percentage of patients 65 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Centers for Medicare & Medicaid Services

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	1879	383	N/A	Registry	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	National Committee for Quality Assurance
	N/A	387	N/A	Registry	Process	Effective Clinical Care	**Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** Percentage of patients regardless of age who are active injection drug users who received screening for HCV infection within the 12 month reporting period	Physician Consortium for Performance Improvement Foundation (PCPI®)
	1407	394	N/A	Registry	Process	Community / Population Health	**Immunizations for Adolescents:** The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	National Committee for Quality Assurance
!	N/A	398	N/A	Registry	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.	MN Community Measurement
§	N/A	400	N/A	Registry	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	N/A	401	N/A	Registry	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period.	American Gastroenterological Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology
	N/A	402	N/A	Registry	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAPPSOAPP-R) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0053	418	N/A	Claims, Registry	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
	2152	431	N/A	Registry	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	438	347v1	Web Interface, Registry, EHR	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	Centers for Medicare & Medicaid Services

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	441	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) • Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm Hg • And Most recent tobacco status is Tobacco Free • And Daily Aspirin or Other Antiplatelet Unless Contraindicated • And Statin Use.	Wisconsin Collaborative for Healthcare Quality (WCHQ)
§	0071	442	N/A	Registry	Process	Effective Clinical Care	**Persistent Beta Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance
§ !!	N/A	443	N/A	Registry	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age screened unnecessarily for cervical cancer.	National Committee for Quality Assurance
§ !	1799	444	N/A	Registry	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma (MMA):** The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance

B.7. Family Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	N/A	447	N/A	Registry	Process	Community/ Population Health	**Chlamydia Screening and Follow-up:** The percentage of female adolescents 16 years of age who had a chlamydia screening test with proper follow-up during the measurement period.	National Committee for Quality Assurance
	0657	TBD	N/A	Registry	Process	Patient Safety, Efficiency and Cost Reduction	**Otitis Media with Effusion (OME): Systemic Antimicrobials- Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)

B.8. Internal Medicine

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0059	001	122v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
§	0081	005	135v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	Registry	Process	Effective Clinical Care	**Chronic Stable Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
§	0070	007	145v6	Registry, EHR	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0083	008	144v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium For Performance Improvement
	0105	009	128v6	EHR	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. Two rates are reported a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	National Committee for Quality Assurance
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0046	039	N/A	Claims, Registry	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Claims, Registry	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
!	N/A	050	N/A	Claims, Registry	Process	Person and Caregiver Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology -Head and Neck Surgery
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology -Head and Neck Surgery
§	0055	117	131v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Diabetes: Eye Exam**: Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	National Committee for Quality Assurance
§	0062	119	134v6	Registry, EHR	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0417	126	N/A	Registry	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0056	163	123v6	EHR	Process	Effective Clinical Care	**Comprehensive Diabetes Care: Foot Exam:** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.	National Committee for Quality Assurance
!	N/A	181	N/A	Claims, Registry	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0068	204	164v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.	National Committee for Quality Assurance

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	0022	238	156v6	EHR, Registry	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	0643	243	N/A	Registry	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0004	305	137v6	EHR	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	National Committee for Quality Assurance
§	0032	309	124v6	EHR	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:	National Committee for Quality Assurance

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
							• Women age 21–64 who had cervical cytology performed every 3 years • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* § !	0005 & 0006	321	N/A	CMS-approved Survey Vendor	Patient Engagement/Experience	Person and Caregiver-Centered Experience and Outcomes	**CAHPS for MIPS Clinician/Group Survey:** Summary Survey Measures may include: • 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.	Agency for Healthcare Research & Quality (AHRQ)
§	1525	326	N/A	Claims, Registry	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism.	American College of Cardiology

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology-Head and Neck Surgery
!!	N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery
!!	N/A	334	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery
	N/A	337	N/A	Registry	Process	Effective Clinical Care	**Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	American Academy of Dermatology
§ !	2082	338	N/A	Registry	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
!	N/A	342	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Pain Brought Under Control Within 48 Hours:** Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0710	370	159v6	Web Interface, Registry, EHR	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	MN Community Measurement
	0712	371	160v6	EHR	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** Patients age 18 and older with the diagnosis of major depression or dysthymia who have a Patient Health Questionnaire (PHQ-9) tool administered at least once during a 4-month period in which there was a qualifying visit.	MN Community Measurement
	N/A	373	65v7	EHR	Intermediate Outcome	Effective Clinical Care	**Hypertension: Improvement in Blood Pressure:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	377	90v7	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessments for Congestive Heart Failure:** Percentage of patients 65 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Centers for Medicare & Medicaid Services

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	1879	383	N/A	Registry	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	National Committee for Quality Assurance
	N/A	387	N/A	Registry	Process	Effective Clinical Care	**Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** Percentage of patients regardless of age who are active injection drug users who received screening for HCV infection within the 12 month reporting period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	N/A	398	N/A	Registry	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.	Minnesota Community Measurement
§	N/A	400	N/A	Registry	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	401	N/A	Registry	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period.	American Gastro-enterological Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology

B.8. Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
	0053	418	N/A	Claims, Registry	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
	2152	431	N/A	Registry	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.8 Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	N/A	438	347v1	Web Interface, Registry, EHR	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients: all considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical athero-sclerotic cardiovascular disease(ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services
!	N/A	441	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):** The IVD All-or- None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) • Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm Hg • And Most recent tobacco status is Tobacco Free • And Daily Aspirin or Other Antiplatelet Unless Contraindicated And Statin Use.	Wisconsin Collaborative for Healthcare Quality (WCHQ)
§	0071	442	N/A	Registry	Process	Effective Clinical Care	**Persistent Beta Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance

B.8 Internal Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	N/A	443	N/A	Registry	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age screened unnecessarily for cervical cancer.	National Committee for Quality Assurance
§ !	1799	444	NA	Registry	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma (MMA):** The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance
§	N/A	447	N/A	Registry	Process	Community / Population Health	**Chlamydia Screening and Follow-up:** The percentage of female adolescents 16 years of age who had a chlamydia screening test with proper follow-up during the measurement period.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Claims, Registry	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
!	N/A	050	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	2372	112	125v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community / Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services
	0419	130	68v7	Claims, Registry, EHR,	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ !	0018	236	165v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	National Committee for Quality Assurance
!	N/A	265	N/A	Registry	Process	Communication and Care Coordination	**Biopsy Follow Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician.	American Academy of Dermatology
§	0032	309	124v6	EHR	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	National Committee for Quality Assurance
	0033	310	153v6	EHR	Process	Community / Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	N/A	369	158v6	EHR	Process	Effective Clinical Care	**Pregnant women that had HBsAg testing:** This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	OptumInsight
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	0053	418	N/A	Claims, Registry	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
	2063	422	N/A	Claims, Registry	Process	Patient Safety	**Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury:** Percentage of patients who undergo cystoscopy to evaluate for lower urinary tract injury at the time of hysterectomy for pelvic organ prolapse.	American Urogynecological Society

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	428	N/A	Registry	Process	Effective Clinical Care	**Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence:** Percentage of patients undergoing appropriate preoperative evaluation of stress urinary incontinence prior to pelvic organ prolapse surgery per ACOG/AUGS/AUA guidelines.	American Urogynecologic Society
	N/A	429	N/A	Claims, Registry	Process	Patient Safety	**Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy:** Percentage of patients who are screened for uterine malignancy prior to vaginal closure or obliterative surgery for pelvic organ prolapse.	American Urogynecologic Society
	2152	431	N/A	Registry	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	432	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing any surgery to repair pelvic organ prolapse who sustains an injury to the bladder recognized either during or within 1 month after surgery.	American Urogynecologic Society
!	N/A	433	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bowel Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing surgical repair of pelvic organ prolapse that is complicated by a bowel injury at the time of index surgery that is recognized intraoperatively or within 1 month after surgery.	American Urogynecologic Society
!	N/A	434	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining A Ureter Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the ureter recognized either during or within 1 month after surgery.	American Urogynecologic Society

B.9. Obstetrics/Gynecology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	N/A	443	N/A	Registry	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age screened unnecessarily for cervical cancer.	National Committee for Quality Assurance
§	N/A	447	N/A	Registry	Process	Community/ Population Health	**Chlamydia Screening and Follow-up:** The percentage of female adolescents 16 years of age who had a chlamydia screening test with proper follow-up during the measurement period.	National Committee for Quality Assurance
§ !	0567	448	N/A	Registry	Process	Patient Safety	**Appropriate Work Up Prior to Endometrial Ablation:** Percentage of women, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results documented before undergoing an endometrial ablation.	Health Benchmarks-IMS Health

B.10. Ophthalmology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0086	012	143v6	Claims, Registry, EHR	Process	Effective Clinical Care	**Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0087	014	N/A	Claims, Registry	Process	Effective Clinical Care	**Age-Related Macular Degeneration (AMD): Dilated Macular Examination:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.	American Academy of Ophthalmology

B.10. Ophthalmology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0088	018	167v6	EHR	Process	Effective Clinical Care	**Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	0089	019	142v6	Claims, Registry, EHR	Process	Communication and Care Coordination	**Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0055	117	131v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	National Committee for Quality Assurance
	0419	130	68v7	Claims, Registry, EHR,	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.10. Ophthalmology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0566	140	N/A	Claims, Registry	Process	Effective Clinical Care	**Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD.	American Academy of Ophthalmology
!	0563	141	N/A	Claims, Registry	Outcome	Communication and Care Coordination	**Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months.	American Academy of Ophthalmology
!	0565	191	133v6	Registry, EHR	Outcome	Effective Clinical Care	**Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	Physician Consortium for Performance Improvement Foundation (PCPI®
!	0564	192	132v6	Registry, EHR	Outcome	Patient Safety	**Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.10. Ophthalmology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	1536	303	N/A	Registry	Outcome	Person Caregiver-Centered Experience and Outcomes	**Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.	American Academy of Ophthalmology
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
!	N/A	384	N/A	Registry	Outcome	Effective Clinical Care	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery:** Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment who did not require a return to the operating room within 90 days of surgery.	American Academy of Ophthalmology

B.10. Ophthalmology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	385	N/A	Registry	Outcome	Effective Clinical Care	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery:** Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.	American Academy of Ophthalmology
!	N/A	388	N/A	Registry	Outcome	Patient Safety	**Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy:** Percentage of patients aged 18 years and older who had cataract surgery performed and had an unplanned rupture of the posterior capsule requiring vitrectomy.	American Academy of Ophthalmology
!	N/A	389	N/A	Registry	Outcome	Effective Clinical Care	**Cataract Surgery: Difference Between Planned and Final Refraction:** Percentage of patients aged 18 years and older who had cataract surgery performed and who achieved a final refraction within +/- 0.5 diopters of their planned (target) refraction.	American Academy of Ophthalmology
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.11. Orthopedic Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxi to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0097	046	N/A	Claims, Web Interface, Registry	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	109	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons
* §	0421	128	69v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0420	131	N/A	Claims, Registry	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
	N/A	178	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.	American College of Rheumatology

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	179	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.	American College of Rheumatology
	N/A	180	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Glucocorticoid Management** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.	American College of Rheumatology
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	0101	318	139v6	EHR, Web Interface	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	350	N/A	Registry	Process	Communication and Care Coordination	**Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** Percentage of patients regardless of age undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g. nonsteroidal anti-inflammatory drugs (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure.	American Association of Hip and Knee Surgeons
!	N/A	351	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation:** Percentage of patients regardless of age undergoing a total knee replacement who are evaluated for the presence or absence of venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), Myocardial Infarction (MI), Arrhythmia and Stroke).	American Association of Hip and Knee Surgeons
!	N/A	352	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet:** Percentage of patients regardless of age undergoing a total knee replacement who had the prophylactic antibiotic completely infused prior to the inflation of the proximal tourniquet.	American Association of Hip and Knee Surgeons
!	N/A	353	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report:** Percentage of patients regardless of age undergoing a total knee replacement whose operative report identifies the prosthetic implant specifications including the prosthetic implant manufacturer, the brand name of the prosthetic implant and the size of each prosthetic implant.	American Association of Hip and Knee Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American Association of Hip and Knee Surgeons

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
* !	N/A	375	66v6	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Knee Replacement:** Changes to the measure description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
!	N/A	376	56v6	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Hip Replacement:** Percentage of patients 18 years of age and older with who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committe e for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record	American Academy of Neurology
	0053	418	N/A	Claims, Registry	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture	National Committee for Quality Assurance
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Discectomy / Laminotomy:** The average change (preoperative to three months postoperative) in back pain for patients 18 years of age or older who had lumbar discectomy /laminotomy procedure	MN Community Measurement
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Fusion:** The average change (preoperative to one year postoperative) in back pain for patients 18 years of age or older who had lumbar spine fusion surgery	MN Community Measurement
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Leg Pain Following Lumbar Discectomy / Laminotomy:** The average change (preoperative to three months postoperative) in leg pain for patients 18 years of age or older who had lumbar discectomy / laminotomy procedure	MN Community Measurement

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
!!	0069	065	154v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months through 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode	National Committee for Quality Assurance

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations	American Academy of Otolaryngology Head and Neck Surgery
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy	American Academy of Otolaryngology Head and Neck Surgery
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	National Committee for Quality Assurance
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	N/A	265	N/A	Registry	Process	Communication and Care Coordination	**Biopsy Follow Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician	American Academy of Dermatology
	N/A	276	N/A	Registry	Process	Effective Clinical Care	**Sleep Apnea: Assessment of Sleep Symptoms:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of sleep symptoms, including presence or absence of snoring and daytime sleepiness	American Academy of Sleep Medicine

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	277	N/A	Registry	Process	Effective Clinical Care	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis	American Academy of Sleep Medicine
	N/A	278	N/A	Registry	Process	Effective Clinical Care	**Sleep Apnea: Positive Airway Pressure Therapy Prescribed:** Percentage of patients aged 18 years and older with a diagnosis of moderate or severe obstructive sleep apnea who were prescribed positive airway pressure therapy	American Academy of Sleep Medicine
	N/A	279	N/A	Registry	Process	Effective Clinical Care	**Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured	American Academy of Sleep Medicine
	N/A	317	22v6	Registry	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
!!	N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms	American Academy of Otolaryngology-Head and Neck Surgery

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis	American Academy of Otolaryngology-Head and Neck Surgery
!!	N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis	American Academy of Otolaryngology-Head and Neck Surgery
!!	N/A	334	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis	American Academy of Otolaryngology-Head and Neck Surgery
!	N/A	357	N/A	Registry	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI)	American College of Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons

B.12. Otolaryngology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
!	N/A	398	N/A	Registry	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools	Minnesota Community Measurement
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
	2152	431	N/A	Registry	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0657	TBD	N/A	Registry	Process	Patient Safety, Efficiency and Cost Reduction	**Otitis Media with Effusion (OME): Systemic Antimicrobials- Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)

B.13. Pathology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0391	099	N/A	Claims, Registry	Process	Effective Clinical Care	**Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade:** Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade	College of American Pathologists
	0392	100	N/A	Claims, Registry	Process	Effective Clinical Care	**Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade:** Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade	College of American Pathologists
	1854	249	N/A	Claims, Registry	Process	Effective Clinical Care	**Barrett's Esophagus:** Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia	College of American Pathologists
§	1853	250	N/A	Claims, Registry	Process	Effective Clinical Care	**Radical Prostatectomy Pathology Reporting:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status	College of American Pathologists
	1855	251	N/A	Claims, Registry	Structure	Effective Clinical Care	**Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients:** This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the current ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer	College of American Pathologists

B.13. Pathology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	395	N/A	Claims, Registry	Process	Communication and Care Coordination	**Lung Cancer Reporting (Biopsy/ Cytology Specimens):** Pathology reports based on biopsy and/or cytology specimens with a diagnosis of primary nonsmall cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report	College of American Pathologists
!	N/A	396	N/A	Claims, Registry	Process	Communication and Care Coordination	**Lung Cancer Reporting (Resection Specimens):** Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer, histologic type	College of American Pathologists
!	N/A	397	N/A	Claims, Registry	Process	Communication and Care Coordination	**Melanoma Reporting:** Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate	College of American Pathologists

B.14. Pediatrics

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0069	065	154v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months through 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
!!	N/A	066	146v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis External (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations	American Academy of Otolaryngology -Head and Neck Surgery

B.14. Pediatrics (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy	American Academy of Otolaryngology-Head and Neck Surgery
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Centers for Medicare & Medicaid Services
§	0405	160	52v6	EHR	Process	Effective Clinical Care	**HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis Jiroveci Pneumonia (PCP) prophylaxis	National Committee for Quality Assurance
§	0409	205	N/A	Registry	Process	Effective Clinical Care	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	National Committee for Quality Assurance

B.14. Pediatrics (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0024	239	155v6	EHR	Process	Community / Population Health	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition • Percentage of patients with counseling for physical activity	National Committee for Quality Assurance
	0038	240	117v6	EHR	Process	Community / Population Health	**Childhood Immunization Status:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday	National Committee for Quality Assurance
	0004	305	137v6	EHR	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	National Committee for Quality Assurance
	0033	310	153v6	EHR	Process	Community / Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period	National Committee for Quality Assurance

B.14. Pediatrics (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0108	366	136v7	EHR	Process	Effective Clinical Care	**ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	National Committee for Quality Assurance
	N/A	379	74v7	EHR	Process	Effective Clinical Care	**Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period	Centers for Medicare & Medicaid Services
!	1365	382	177v6	EHR	Process	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.14. Pediatrics (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0576	391	N/A	Registry	Process	Communication/Care Coordination	**Follow-up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge	National Committee for Quality Assurance
	1407	394	N/A	Registry	Process	Community/ Population Health	**Immunizations for Adolescents:** The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday	National Committee for Quality Assurance
!	N/A	398	N/A	Registry	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools	MN Community Measurement
	N/A	402	NA	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
§ !	1799	444	N/A	Registry	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma (MMA):** The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance
§	N/A	447	N/A	Registry	Process	Community/ Population Health	**Chlamydia Screening and Follow-up:** The percentage of female adolescents 16 years of age who had a chlamydia screening test with proper follow-up during the measurement period	National Committee for Quality Assurance

B.14. Pediatrics (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0657	TBD	N/A	Registry	Process	Patient Safety, Efficiency and Cost Reduction	**Otitis Media with Effusion (OME): Systemic Antimicrobials-Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)
	1516	TBD	N/A	Registry	Process	Community/Population Health	**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life:** The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	National Committee for Quality Assurance
	1448	TBD	N/A	Registry	Process	Community/Population Health	**Developmental Screening in the First Three Years of Life:** The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	Oregon Health & Science University

B.15. Physical Medicine

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
!	N/A	109	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	American Academy of Orthopedic Surgeons
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services

B.15. Physical Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0420	131	N/A	Claims, Registry	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	National Committee for Quality Assurance

B.15. Physical Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	National Committee for Quality Assurance
!	2624	182	N/A	Claims, Registry	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention C. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.15. Physical Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record	American Academy of Neurology
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record	American Academy of Neurology

B.15. Physical Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	2152	431	N/A	Registry	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.16. Plastic Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons

B.16. Plastic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP)	Centers for Medicare & Medicaid Services
!	N/A	355	N/A	Registry	Outcome	Patient Safety	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period	American College of Surgeons

B.16. Plastic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	356	N/A	Registry	Outcome	Effective Clinical Care	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure	American College of Surgeons
!	N/A	357	N/A	Registry	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI)	American College of Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons

B.17. Preventive Medicine

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0059	001	122v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	National Committee for Quality Assurance
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication	National Committee for Quality Assurance

B.17. Preventive Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0046	039	N/A	Claims, Registry	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Claims, Registry	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	National Committee for Quality Assurance
!	N/A	109	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	American Academy of Orthopedic Surgeons
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
§	2372	112	125v6	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer	National Committee for Quality Assurance
* §	0034	113	130v66	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	**Colorectal Cancer Screening:** Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance

B.17. Preventive Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	0058	116	N/A	Registry	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	National Committee for Quality Assurance
§	0062	119	134v6	Registry, EHR	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	National Committee for Quality Assurance
	0417	126	N/A	Registry	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy –Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.17. Preventive Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	National Committee for Quality Assurance
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.17. Preventive Medicine (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	NA	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
	2152	431	NA	Registry	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	438	347v1	Web Interface, Registry, EHR	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**: Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services

B.18. Neurology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.18. Neurology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	National Committee for Quality Assurance
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	1814	268	N/A	Claims, Registry	Process	Effective Clinical Care	**Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy:** All female patients of childbearing potential (12 - 44 years old) diagnosed with epilepsy who were counseled or referred for counseling for how epilepsy and its treatment may affect contraception OR pregnancy at least once a year	American Academy of Neurology

B.18.Neurology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	N/A	281	149v6	EHR	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	282	N/A	Registry	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12-month period	American Academy of Neurology
	N/A	283	N/A	Registry	Process	Effective Clinical Care	**Dementia: Neuro-psychiatric Symptom Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12-month period	American Academy of Neurology
!	N/A	286	N/A	Registry	Process	Patient Safety	**Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety screening * in two domains of risk: dangerousness to self or others and environmental risks; and if screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Academy of Neurology
!	N/A	288	N/A	Registry	Process	Communication and Care Coordination	**Dementia: Caregiver Education and Support:** Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional sources for support within a 12-month period	American Academy of Neurology

B.18. Neurology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	290	N/A	Registry	Process	Effective Clinical Care	**Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease:** All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric symptoms (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) in the last 12 months	American Academy of Neurology
	N/A	291	N/A	Registry	Process	Effective Clinical Care	**Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment:** All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction in the last 12 months	American Academy of Neurology
!	N/A	293	N/A	Registry	Process	Communication and Care Coordination	**Parkinson's Disease: Rehabilitative Therapy Options:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed in the last 12 months	American Academy of Neurology
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.18. Neurology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
!	N/A	386	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences:** Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (e.g. advance directives, invasive ventilation, hospice) at least once annually	American Academy of Neurology
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record	American Academy of Neurology
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record	American Academy of Neurology

B.18. Neurology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	419	N/A	Claims, Registry	Efficiency	Efficiency and Cost Reduction	**Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination:** Percentage of patients with a diagnosis of primary headache disorder whom advanced brain imaging was not ordered	American Academy of Neurology
	2152	431	N/A	Registry	Process	Population/ Community	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI)
!	N/A	435	N/A	Claims, Registry	Outcome	Effective Clinical Care	**Quality Of Life Assessment For Patients With Primary Headache Disorders:** Percentage of patients with a diagnosis of primary headache disorder whose health related quality of life (HRQoL) was assessed with a tool(s) during at least two visits during the 12 month measurement period AND whose health related quality of life score stayed the same or improved	American Academy of Neurology
	N/A	TBD	N/A	Registry	Process	Patient Safety	**Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety screening * in two domains of risk: dangerousness to self or others and environmental risks; and if screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Academy of Neurology

B.19. Mental/Behavioral Health

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	105	009	128v6	EHR	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. Two rates are reported: a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)	National Committee for Quality Assurance
	0104	107	161v6	EHR	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services

B.19. Mental/Behavioral Health (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Centers for Medicare & Medicaid Services
!	N/A	181	N/A	Claims, Registry	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder mal-treatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.19. Mental/Behavioral Health (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	N/A	281	149v6	EHR	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	282	N/A	Registry	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12-month period	American Academy of Neurology
	N/A	283	N/A	Registry	Process	Effective Clinical Care	**Dementia: Neuropsychiatric Symptom Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12-month period	American Academy of Neurology
!	N/A	286	N/A	Registry	Process	Patient Safety	**Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety screening * in two domains of risk: dangerousness to self or others and environmental risks; and if screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Academy of Neurology
!	N/A	288	N/A	Registry	Process	Communication and Care Coordination	**Dementia: Caregiver Education and Support:** Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional sources for support within a 12-month period	American Academy of Neurology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
!	N/A	325	N/A	Registry	Process	Communication/ Care Coordination	**Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions:** Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition	American Psychiatric Association
	0108	366	136v7	EHR	Process	Effective Clinical Care	**ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	National Committee for Quality Assurance

B.19. Mental/Behavioral Health (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	367	169v6	EHR	Process	Effective Clinical Care	**Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use:** Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use	Center for Quality Assessment and Improvement in Mental Health
§ !	0710	370	159v6	Web Interface, Registry, EHR	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	MN Community Measurement
	0712	371	160v6	EHR	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** Patients age 18 and older with the diagnosis of major depression or dysthymia who have a Patient Health Questionnaire (PHQ-9) tool administered at least once during a 4-month period in which there was a qualifying visit	MN Community Measurement
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
!	1365	382	177v5	EHR	Process	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.19. Mental/Behavioral Health (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	1879	383	N/A	Registry	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months)	National Committee for Quality Assurance
!	0576	391	N/A	Registry	Process	Communication/Care Coordination	**Follow-up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge	National Committee for Quality Assurance
	N/A	402	NA	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
!	0711	411	N/A	Registry	Outcome	Effective Clinical Care	**Depression Remission at Six Months:** Adult patients age 18 years and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator	MN Community Measure-ment

B.19. Mental/Behavioral Health (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	2152	431	N/A	Registry	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	TBD	N/A	Registry	Process	Patient Safety	**Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety screening in two domains of risk: dangerousness to self or others and environmental risks; and if screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Academy of Neurology

B.20a. Diagnostic Radiology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	145	N/A	Registry	Process	Patient Safety	**Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy:** Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)	American College of Radiology
!	0508	146	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening:** Percentage of final reports for screening mammograms that are classified as "probably benign"	American College of Radiology

B.20a. Diagnostic Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	147	N/A	Claims, Registry	Process	Communication and Care Coordination	**Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy:** Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed	Society of Nuclear Medicine and Molecular Imaging
	0507	195	N/A	Claims, Registry	Process	Effective Clinical Care	**Radiology: Stenosis Measurement in Carotid Imaging Reports:** Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement	American College of Radiology
	0509	225	N/A	Registry, Claims	Structure	Communication and Care Coordination	**Radiology: Reminder System for Screening Mammograms:** Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram	American College of Radiology
!	N/A	359	N/A	Registry	Process	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging:** Percentage of computed tomography (CT) imaging reports for all patients, regardless of age, with the imaging study named according to a standardized nomenclature and the standardized nomenclature is used in institution's computer systems.	American College of Radiology

B.20a. Diagnostic Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	360	N/A	Registry	Process	Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies:** Percentage of computed tomography (CT) and cardiac nuclear medicine (myocardial perfusion studies) imaging reports for all patients, regardless of age, that document a count of known previous CT (any type of CT) and cardiac nuclear medicine (myocardial perfusion) studies that the patient has received in the 12-month period prior to the current study.	American College of Radiology
!	N/A	361	N/A	Registry	Structure	Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry:** Percentage of total computed tomography (CT) studies performed for all patients, regardless of age, that are reported to a radiation dose index registry that is capable of collecting at a minimum selected data elements	American College of Radiology
!	N/A	362	N/A	Registry	Structure	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes:** Percentage of final reports for computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study	American College of Radiology

B.20a. Diagnostic Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	363	N/A	Registry	Structure	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive:** Percentage of final reports of computed tomography (CT) studies performed for all patients, regardless of age, which document that a search for Digital Imaging and Communications in Medicine (DICOM) format images was conducted for prior patient CT imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure, authorized, media free, shared archive prior to an imaging study being performed	American College of Radiology
!!	N/A	364	N/A	Registry	Process	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines:** Percentage of final reports for computed tomography (CT) imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidentally detected pulmonary nodules (e.g., follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors	American College of Radiology
	N/A	405	N/A	Claims, Registry	Process	Effective Clinical Care	**Appropriate Follow-up Imaging for Incidental Abdominal Lesions:** Percentage of final reports for abdominal imaging studies for asymptomatic patients aged 18 years and older with one or more of the following noted incidentally with follow- up imaging recommended: • Liver lesion ≤ 0.5 cm • Cystic kidney lesion < 1.0 cm • Adrenal lesion ≤ 1.0 cm	American College of Radiology

B.20a. Diagnostic Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	406	N/A	Claims, Registry	Process	Effective Clinical Care	**Appropriate Follow-Up Imaging for Incidental Thyroid Nodules in Patients:** Percentage of final reports for computed tomography (CT), magnetic resonance imaging (MRI) or magnetic resonance angiogram (MRA) studies of the chest or neck or ultrasound of the neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally with follow-up imaging recommended	American College of Radiology
	N/A	436	N/A	Claims, Registry	Process	Effective Clinical Care	**Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques:** Percentage of final reports for patients aged 18 years and older undergoing CT with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control • Adjustment of the mA and/or kV according to patient size • Use of iterative reconstruction technique	American College of Radiology/American Medical Association-Physician Consortium for Performance Improvement/ National Committee for Quality Assurance

B.20b. Interventional Radiology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	076	N/A	Claims, Registry	Process	Patient Safety	**Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	American Society of

B.20b. Interventional Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	145	N/A	Claims, Registry	Process	Patient Safety	**Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy:** Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)	American College of Radiology
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	409	N/A	Registry	Outcome	Effective Clinical Care	**Clinical Outcome Post Endovascular Stroke Treatment:** Percentage of patients with a mRs score of 0 to 2 at 90 days following endovascular stroke intervention	Society of Interventional Radiology
	N/A	413	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Door to Puncture Time for Endovascular Stroke Treatment:** Percentage of patients undergoing endovascular stroke treatment who have a door to puncture time of less than two hours	Society of Interventional Radiology
	N/A	420‡	N/A	Registry	Outcome	Effective Clinical Care	**Varicose Vein Treatment with Saphenous Ablation: Outcome Survey:** Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.	Society of Interventional Radiology
	N/A	421	N/A	Registry	Process	Effective Clinical Care	**Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal:** Percentage of patients in whom a retrievable IVC filter is placed who, within 3 months post-placement, have a documented assessment for the appropriateness of continued filtration, device removal or the inability to contact the patient with at least two attempts.	Society of Interventional Radiology

B.20b. Interventional Radiology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	437	N/A	Claims, Registry	Outcome	Patient Safety	**Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure:** Inpatients assigned to endovascular treatment for obstructive arterial disease, the percent of patients who undergo unplanned major amputation or surgical bypass within 48 hours of the index procedure.	Society of Interventional Radiology
	N/A	TBD	N/A	Registry	Process	Patient Safety	**Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries:** Documentation of angiographic endpoints of embolization AND the documentation of embolization strategies in the presence of unilateral or bilateral absent uterine arteries	Society of Interventional Radiology

B.21. Nephrology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0059	001	122v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
§ !	0097	046	N/A	Claims, Web Interface, Registry	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance

B.21. Nephrology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
*	0041	110	147v7	Claims, Web Interface, Registry, EHI	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHI	Process	Community/ Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
§	0062	119	134v6	Registry, EHR	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	National Committee for Quality Assurance
	N/A	122	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Adult Kidney Disease: Blood Pressure Management:** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) with a blood pressure < 140/90 mmHg OR ≥ 140/90 mmHg with a documented plan of care	Renal Physicians Association

B.21. Nephrology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0419	130	68v7	Claims, Registry, EHR,	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	2624	182	N/A	Claims, Registry	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	Centers for Medicare & Medicaid Services
	N/A	317	22v6	Claims, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	0101	318	139v6	EHR, Web Interface	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance

B.21. Nephrology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	327	N/A	Registry	Process	Effective Clinical Care	**Pediatric Kidney Disease: Adequacy of Volume Management:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist	Renal Physicians Association
!	1667	328	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL.	Renal Physicians Association
	N/A	329	N/A	Registry	Outcome	Effective Clinical Care	**Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated	Renal Physicians Association
	N/A	330	N/A	Registry	Outcome	Patient Safety	**Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter	Renal Physicians Association

B.21. Nephrology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	400	N/A	Registry	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection	Physician Consortium for Performance Improvement
	N/A	403	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Adult Kidney Disease: Referral to Hospice:** Percentage of patients aged 18 years and older with a diagnosis of ESRD who withdraw from hemodialysis or peritoneal dialysis who are referred to hospice care	Renal Physicians Association

B.22. General Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons

B.22. General Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0097	046	N/A	Claims, Web Interface, Registry	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services

B.22. General Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.22. General Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	355	N/A	Registry	Outcome	Patient Safety	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period	American College of Surgeons
!	N/A	356	N/A	Registry	Outcome	Effective Clinical Care	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure	American College of Surgeons
!	N/A	357	N/A	Registry	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI)	American College of Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop:** Receipt of Specialist Report Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance

B.23. Vascular Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services

B.23. Vascular Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0018	236	165v6	Claims, Registry, EHR, Web Interface	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	National Committee for Quality Assurance
	1519	257	N/A	Registry	Process	Effective Clinical Care	**Statin Therapy at Discharge after Lower Extremity Bypass (LEB):** Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge	Society for Vascular Surgeons

B.23. Vascular Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	258	N/A	Registry	Outcome	Patient Safety	**Rate of Open Elective Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7):** Percent of patients undergoing open repair of small or moderate sized non-ruptured infrarenal abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7)	Society for Vascular Surgeons
!	N/A	259	N/A	Registry	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged at Home by Post-Operative Day #2):** Percent of patients undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)	Society for Vascular Surgeons
!	N/A	260	N/A	Registry	Outcome	Patient Safety	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2)	Society for Vascular Surgeons
	N/A	317	22v6	Claims, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.23. Vascular Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	344	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2	Society for Vascular Surgeons
!	N/A	345	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS):** Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Society for Vascular Surgeons
!	1540	346	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA):** Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital.	Society for Vascular Surgeons
!	1534	347	N/A	Registry	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital:** Percent of patients undergoing endovascular repair of small or moderate infrarenal abdominal aortic aneurysms (AAA) who die while in the hospital	Society for Vascular Surgeons
!	N/A	357	N/A	Registry	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI)	American College of Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons

B.23. Vascular Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance
	1523	417	N/A	Registry	Outcome	Patient Safety	**Rate of Open Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive:** Percentage of patients undergoing open repair of small or moderate abdominal aortic aneurysms (AAA) who are discharged alive	Society for Vascular Surgeons
	N/A	420‡	N/A	Effective Clinical Care	Registry	Outcome	**Varicose Vein Treatment with Saphenous Ablation: Outcome Survey:** Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.	Society of Interventional Radiology
	0465	423	N/A	Registry, Claims	Process	Effective Clinical Care	**Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy:** Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery	Society for Vascular Surgeons

B.23. Vascular Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	441441	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) • Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm Hg • And Most recent tobacco status is Tobacco Free • And Daily Aspirin or Other Antiplatelet Unless Contraindicated • And Statin Use.	Wisconsin Collaborative for Healthcare Quality (WCHQ)

B.24. Thoracic Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons

B.24. Thoracic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0134	043	N/A	Registry	Process	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who received an IMA graft.	Society of Thoracic Surgeons
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0129	164	N/A	Registry	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Prolonged Intubation:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours	American Thoracic Society
!	0130	165	N/A	Registry	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention	American Thoracic Society

B.24. Thoracic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0131	166	N/A	Registry	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Stroke:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours	American Thoracic Society
!	0114	167	N/A	Registry	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis	American Thoracic Society
!	0115	168	N/A	Registry	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason	Society of Thoracic Surgeons
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0018	236	165v6	Claims, Registry, EHR, Web Interface	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	National Committee for Quality Assurance

B.24. Thoracic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance

B.24.Thoracic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	441	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) • Using the IVD denominator optimal results include: Most recent blood pressure (BP) measurement is less than 140/90 mm Hg • And Most recent tobacco status is Tobacco Free • And Daily Aspirin or Other Antiplatelet Unless Contraindicated And Statin Use.	Wisconsin Collaborative for Healthcare Quality (WCHQ)
	0119	445	N/A	Registry	Outcome	Effective Clinical Care	**Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG):** Percent of patients aged 18 years and older undergoing isolated CABG who die, including both all deaths occurring during the hospitalization in which the CABG was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure	Society of Thoracic Surgeons

B.25. Urology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	0389	102	129v7	Registry, EHR	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0390	104	N/A	Registry	Process	Effective Clinical Care	**Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or very High Risk Prostate Cancer:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist	American Urological Association Education and Research
§	0062	119	134v6	Registry, EHR	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	National Committee for Quality Assurance
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community / Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services

B.25. Urology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Claims, Registry	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	National Committee for Quality Assurance
!	N/A	050	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Assessment of Presence or Absence Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	National Committee for Quality Assurance

B.25. Urology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0420	131	N/A	Claims, Registry	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Centers for Medicare & Medicaid Services
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	N/A	265	N/A	Registry	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician	American Academy of Dermatology

B.25. Urology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	American College of Surgeons
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	428	N/A	Registry	Process	Effective Clinical Care	**Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence:** Percentage of patients undergoing appropriate preoperative evaluation of stress urinary incontinence prior to pelvic organ prolapse surgery per ACOG/AUGS/AUA guidelines.	American Urogynecologic Society
	N/A	429	N/A	Claims, Registry	Process	Patient Safety	**Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy:** Percentage of patients who are screened for uterine malignancy prior to vaginal closure or obliterative surgery for pelvic organ prolapse.	American Urogynecologic Society
	2152	431	N/A	Registry	Process	Community /Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Physician Consortium for Performance Improvement

B.25. Urology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	432	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing any surgery to repair pelvic organ prolapse who sustains an injury to the bladder recognized either during or within 1 month after surgery	American Urogynecologic Society
	N/A	433	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing surgical repair of pelvic organ prolapse that is complicated by a bowel injury at the time of index surgery that is recognized intraoperatively or within 1 month after surgery	American Urogynecologic Society
	N/A	434	N/A	Registry	Outcome	Patient Safety	**Proportion of Patients Sustaining a Ureter Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the ureter recognized either during or within 1 month after surgery	American Urogynecologic Society
	N/A	TBD	645v1	EHR	Process	Effective Clinical Care	**Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Oregon Urology Institute

B.26. Oncology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
§ !!	0389	102	129v7	Registry, EHR	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
§ !	0384	143	157v6	Registry, EHR	Process	Person and Caregiver Centered Experience and Outcome	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Physician Consortium for Performance Improvement Foundation (PCPI®

B.26. Oncology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0383	144	N/A	Registry	Process	Person and Caregiver Centered Experience and Outcome	**Oncology: Medical and Radiation – Plan of Care for Pain:** Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	American Society of Clinical Oncology
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	1853	250	N/A	Claims, Registry	Process	Effective Clinical Care	**Radical Prostatectomy Pathology Reporting:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.	College of American Pathologists
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.26. Oncology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	402	N/A	Registry	Process	Community/Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	Registry	Process	Population/ Community	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI)
§ !!	1857	449	N/A	Registry	Process	Efficiency and Cost Reduction	**HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies:** Proportion of female patients (aged 18 years and older) with breast cancer who are human epidermal growth factor receptor 2 (HER2)/neu negative who are not administered HER2-targeted therapies	American Society of Clinical Oncology
§ !!	1858	450	N/A	Registry	Process	Efficiency and Cost Reduction	**Trastuzumab Received By Patients With AJCC Stage I (T1c) –III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy:** Proportion of female patients (aged 18 years and older) with AJCC stage I (T1c) – III, human epidermal growth factor receptor 2 (HER2) positive breast cancer receiving adjuvant chemotherapy who are also receiving trastuzumab	American Society of Clinical Oncology
§	1859	451	N/A	Registry	Process	Effective Clinical Care	**KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy::** Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom KRAS gene mutation testing was performed.	American Society of Clinical Oncology

B.26. Oncology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	1860	452	N/A	Registry	Process	Patient Safety	**Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal: Antibodies:** Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-EGFR monoclonal antibodies.	American Society of Clinical Oncology
§ !!	0210	453	N/A	Registry	Process	Effective Clinical Care	**Proportion Receiving Chemotherapy in the Last 14 Days of life:** Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life.	American Society of Clinical Oncology
§ !!	0211	454	N/A	Registry	Outcome	Effective Clinical Care	**Proportion of Patients who Died from Cancer with more than One Emergency Department Visit in the Last 30 Days of Life:** Proportion of patients who died from cancer with more than one emergency room visit in the last 30 days of life.	American Society of Clinical Oncology
§ !!	0213	455	N/A	Registry	Outcome	Effective Clinical Care	**Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life:** Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life.	American Society of Clinical Oncology
§ !!	0215	456	N/A	Registry	Process	Effective Clinical Care	**Proportion Not Admitted to Hospice:** Proportion of patients who died from cancer not admitted to hospice.	American Society of Clinical Oncology
§ !!	0216	457	N/A	Registry	Outcome	Effective Clinical Care	**Proportion Admitted to Hospice for less than 3 days:** Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there.	American Society of Clinical Oncology
	N/A	TBD	645v1	EHR	Process	Effective Clinical Care	**Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Oregon Urology Institute

B.26a. Radiation Oncology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !!	0389	102	129v7	Registry, EHR	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ !	0384	143	157v6	Registry, EHR	Process	Person and Caregiver Centered Experience and Outcome	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	0383	144	N/A	Registry	Process	Person and Caregiver Centered Experience and Outcome	**Oncology: Medical and Radiation – Plan of Care for Pain:** Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	American Society of Clinical Oncology
!!	0382	156	N/A	Claims, Registry	Process	Patient Safety	**Oncology: Radiation Dose Limits to Normal Tissues:** Percentage of patients, regardless of age, with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues	American Society for Radiation Oncology

B.27. Hospitalists

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§	0081	005	135v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0083	008	144v6	Registry, EHR	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	Physician Consortium for Performance Improvement Foundation (PCPI®)
!	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance

B.27. Hospitalists (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	076	N/A	Claims, Registry	Process	Patient Safety	**Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed	American Society of Anesthesiologists
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!!	N/A	407‡	N/A	Claims, Registry	Process	Effective Clinical Care	**Appropriate Treatment of MSSA Bacteremia:** Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. nafcillin, oxacillin or cefazolin) as definitive therapy.	Infectious Disease Society of America

B.28. Rheumatology

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication	National Committee for Quality Assurance
	0046	039	N/A	Claims, Registry	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance

B.28. Rheumatology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
!	0420	131	N/A	Claims, Registry	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Centers for Medicare & Medicaid Services
	N/A	176	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Tuberculosis Screening:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).	American College of Rheumatology
	N/A	177	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity within 12 months.	American College of Rheumatology

B.28. Rheumatology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	178	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months	American College of Rheumatology
	N/A	179	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months	American College of Rheumatology
	N/A	180	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Glucocorticoid Management:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months	American College of Rheumatology
* §	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.28. Rheumatology (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0018	236	165v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period	National Committee for Quality Assurance
*	0022	238	156v6	Registry, EHR	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 6565 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.29. Infectious Disease

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0069	065	154v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months--18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode	National Committee for Quality Assurance
!!	N/A	066	146v6	Registry, EHR	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
!!	0653	091	N/A	Claims, Registry	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology-Head and Neck Surgery
!!	0654	093	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
*	0041	110	147v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0043	111	127v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
§ !!	0058	116	N/A	Registry	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	National Committee for Quality Assurance

B.29. Infectious Disease (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
	N/A	176	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Tuberculosis Screening:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).	American College of Rheumatology
§	0409	205	N/A	Registry	Process	Effective Clinical Care	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	National Committee for Quality Assurance

B.29. Infectious Disease (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	275	N/A	Registry	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy.	American Gastro-enterological Association
!!	N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms	American Academy of Otolaryngology-Head and Neck Surgery
!!	N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis	American Academy of Otolaryngology-Head and Neck Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis	American Academy of Otolaryngology-Otolaryngology-Head and Neck Surgery
!!	N/A	334	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis	American Academy of Otolaryngology-Otolaryngology-Head and Neck Surgery
	N/A	337	N/A	Registry	Process	Effective Clinical Care	**Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test	American Academy of Dermatology
§ !	2082	338	N/A	Registry	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Health Resources and Services Administration
	2079	340	N/A	Registry	Process	Efficiency and Cost Reduction	**HIV Medical Visit Frequency:** Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between medical visits	Health Resources and Services Administration
	N/A	387	N/A	Registry	Process	Effective Clinical Care	**Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12 month reporting period	Physician Consortium for Performance Improvement

B.29. Infectious Disease (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	390	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment	American Gastroenterological Association
	1407	394	N/A	Registry	Process	Community /Population Health	**Immunizations for Adolescents:** The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday	National Committee for Quality Assurance
§	N/A	400	N/A	Registry	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	401	N/A	Registry	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period	American Gastro-enterological Association/ American Society for Gastro-intestinal Endoscopy/ American College of Gastro-enterology

B.29. Infectious Disease (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward

!!	N/A	407‡	N/A	Claims, Registry	Process	Effective Clinical Care	**Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia:** Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. nafcillin, oxacillin or cefazolin) as definitive therapy.	Infectious Diseases Society of America
§	N/A	447	N/A	Registry	Process	Community / Population Health	**Chlamydia Screening and Follow Up:** The percentage of female adolescents 16 years of age who had a chlamydia screening test with proper follow-up during the measurement period	National Committee for Quality Assurance
	0657	TBD	N/A	Registry	Process	Patient Safety, Efficiency and Cost Reduction	**Otitis Media with Effusion (OME): Systemic Antimicrobials- Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)

B.30. Neurosurgical

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxi to be given within 24 hours prior to incision time or within 24 hours after surgery end time	American Society of Plastic Surgeons

B.30. Neurosurgical (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
	N/A	187	N/A	Registry	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Thrombolytic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well	American Heart Association
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.30. Neurosurgical (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	1543	345	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS):** Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Society for Vascular Surgeons
!	1540	346	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA):** Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital.	Society for Vascular Surgeons
	N/A	409	N/A	Registry	Outcome	Effective Clinical Care	**Clinical Outcome Post Endovascular Stroke Treatment:** Percentage of patients with a mRs score of 0 to 2 at 90 days following endovascular stroke intervention	Society of Interventional Radiology
	N/A	413	N/A	Registry	Intermediate Outcome	Effective Clinical Care	**Door to Puncture Time for Endovascular Stroke Treatment:** Percentage of patients undergoing endovascular stroke treatment who have a door to puncture time of less than two hours	Society of Interventional Radiology
	N/A	TBD	N/A	Registry	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Discectomy and/or Laminotomy:** The average change (preoperative to three months postoperative) in back pain for patients 18 years of age or older who had lumbar discectomy laminotomy procedure	MN Community Measurement
	N/A	TBD	N/A	Registry	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Fusion:** The average change (preoperative to one year postoperative) in back pain for patients 18 years of age or older who had lumbar spine fusion surgery	MN Community Measurement
	N/A	TBD	N/A	Registry	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy:** The average change (preoperative to three months postoperative) in leg pain for patients 18 years of age or older who had lumbar discectomy laminotomy procedure	MN Community Measurement

B.31. Podiatry

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	0417	126	N/A	Registry	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy –Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
	0416	127	N/A	Registry	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention-Evaluation of Footwear:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.	American Podiatric Medical Association
* §	0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	National Committee for Quality Assurance

B.31. Podiatry (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
*	0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.32. Dentistry

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	378	75v6	EHR	Outcome	Community /Population Health	**Children Who Have Dental Decay or Cavities:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period	Centers for Medicare & Medicaid Services
	N/A	379	74v7	EHR	Process	Effective Clinical Care	**Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Centers for Medicare & Medicaid Services

TABLE C.1: Proposed MIPS Measures Removed Only from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
0059	001	122v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	National Committee for Quality Assurance	Emergency Medicine
N/A	032	N/A	Claims, Registry	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed an antithrombotic therapy at discharge.	American Academy of Neurology	Neurosurgical Neurology Hospitalists
0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance	Emergency Medicine Mental/Behavioral Health Ophthalmology Plastic Surgery

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
0421	128	69v6	Claims, Registry, EHR, Web Interface	Process	Community / Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services	Hospitalist Neurology Plastic Surgery
0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	Anesthesiology Emergency Medicine

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
0028	226	138v6	Claims, Registry, EHR, Web Interface	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	Emergency Medicine Hospitalist
0018	236	165v6	Claims, Registry, EHR, Web Interface	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	National Committee for Quality Assurance	Preventative Medicine
N/A	259	N/A	Registry	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of patients undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)	Society for Vascular Surgeons	Interventional Radiology

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
N/A	265	N/A	Registry	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician	American Academy of Dermatology	Interventional Radiology
	284	N/A	Registry	Process	Effective Clinical Care	**Dementia: Management of Neuropsychiatric Symptoms:** Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12-month period	American Academy of Neurology	Neurology Mental/ Behavioral Health
N/A	294	N/A	Registry	Process	Communication and Care Coordination	**Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually	American Academy of Neurology	Neurology
N/A	304	N/A	Registry	Outcome	Person Caregiver-Centered Experience and Outcomes	**Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey	American Academy of Ophthalmology	Ophthalmology

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
N/A	312	166v7	EHR	Process	Efficiency and Cost Reduction	**Use of Imaging Studies for Low Back Pain:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis	National Committee for Quality Assurance	Family Medicine Internal Medicine Orthopedic Surgery Physical Medicine
N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services	Ophthalmology Hospitalist
N/A	331	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms	American Academy of Otolaryngology-Head and Neck Surgery	Allergy/Immunology
N/A	332	N/A	Registry	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulante, as a first line antibiotic at the time of diagnosis	American Academy of Otolaryngology-Head and Neck Surgery	Allergy/Immunology

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
N/A	333	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis	American Academy of Otolaryngology - Head and Neck Surgery	Allergy/Immunology
N/A	334	N/A	Registry	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis	American Academy of Otolaryngology - Head and Neck Surgery	Allergy/Immunology
N/A	337	N/A	Registry	Process	Effective Clinical Care	**Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test	American Academy of Dermatology	Rheumatology
N/A	344	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2	Society for Vascular Surgeons	Interventional Radiology

TABLE C.1: Proposed MIPS Measures Removed from Specialty Sets for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets below based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
1543	345	N/A	Registry	Outcome	Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS):** Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Society for Vascular Surgeons	Interventional Radiology
N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services	Emergency Medicine Plastic Surgery Hospitalist
N/A	398	N/A	Registry	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation	MN Community Measure-ment	Allergy/ Immunology
N/A	402	N/A	Registry	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	National Committee for Quality Assurance	Emergency Medicine Hospitalist Plastic Surgery Urology
2152	431	N/A	Registry	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use:** Screening & Brief Counseling: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	Emergency Medicine Hospitalist

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Specialty Set Proposed to be Removed From
1799	444	N/A	Registry	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma:** The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance	Allergy/ Immunology

TABLE C.2: Proposed Quality Measures Removed from Merit-Based Incentive Payment System Program for the 2018 Performance Period

Note: CMS proposed removal of measures within specific specialty measure sets based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies. Measure specific removal rationale is provided in the table below. For example, this measure has been proposed for removal because of outdated measure specifications based on current clinical guidelines.

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	032	N/A	Claims, Registry	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed an antithrombotic therapy at discharge.	American Academy of Neurology	CMS proposes the removal of the measure "Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy" as a quality measure from the MIPS program, due to the measure steward no longer maintaining the measure since there are similar existing measures being maintained by other measure stewards. We request comment on the removal of this measure from the Merit-Based Incentive Payment System (MIPS) program.
N/A	284	N/A	Registry	Process	Effective Clinical Care	**Dementia: Management of Neuropsychiatric Symptoms:** Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12-month period	American Academy of Neurology	CMS proposes the removal of the measure "Dementia: Management of Neuropsychiatric Symptoms" as a quality measure from the MIPS program, due to the measure steward no longer maintaining the measure since it was combined with Q283 Dementia: Neuro-Psychiatric Symptom Assessment. We request comment on the removal of this measure from MIPS.

TABLE C.2: Proposed Quality Measures Removed from Merit-Based Incentive Payment System Program for the 2018 Performance Period

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	294	N/A	Registry	Process	Communication and Care Coordination	**Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed:**	American Academy of Neurology	CMS proposes the removal of the measure "Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed" as a quality measure

						All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually		from the MIPS program, due to the measure steward no longer maintaining the measure. We request comment on the removal of this measure from the Merit-Based Incentive Payment System (MIPS) program.

TABLE C.2: Proposed Quality Measures Removed from Merit-Based Incentive Payment System Program for the 2018 Performance Period

NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	312	166v7	EHR	Process	Efficiency and Cost Reduction	**Use of Imaging Studies for Low Back Pain:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis	National Committee for Quality Assurance	CMS proposes the removal of the measure "Use of Imaging Studies for Low Back Pain" as a quality measure from the MIPS program, due to the age cut off as stated in the current measure description. The American College of Radiology's current guidelines suggest that imaging be performed in adults older than 50 years of age who present with lower back pain. CMS had provided the measure steward with the opportunity to update the age range, in order to retain the measure within the program however, no changes

								have been made to the measure description. We request comment on the removal of this measure from the Merit-Based Incentive Payment System (MIPS) program.

TABLE D: 2018 Proposed Cross-Cutting Measures

Note: The table of cross-cutting measures is intended to provide clinicians with a list of measures that are broadly applicable to all clinicians regardless of the clinician's specialty. Even though it is not required to report on cross-cutting measures, it is provided as a reference to clinicians who are looking for additional measures to report outside their specialty.

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward
!	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421	128	69v669v6	Claims, Web Interface, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	Centers for Medicare & Medicaid Services
!	0419	130	68v768v7	Claims, Registry, EHR	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

TABLE D: 2018 Proposed Cross-Cutting Measures

Note: The table of cross-cutting measures is intended to provide clinicians with a list of measures that are broadly applicable to all clinicians regardless of the clinician's specialty. Even though it is not required to report on cross-cutting measures, it is provided as a reference to clinicians who are looking for additional measures to report outside their specialty.

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ !	0018	236	165v6	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period	National Committee for Quality Assurance
	N/A	317	22v6	Claims, Registry, EHR	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated	Centers for Medicare & Medicaid Services

TABLE E: Measures with Substantive Changes Proposed for MIPS Reporting in 2018

E.1. CAHPS for MIPS Clinician/Group Survey

Category	Description
NQF #:	0005 & 0006
Quality#:	321
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	CMS Approved Survey Vendor
Current Measure Description:	The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Clinician/Group Survey is comprised of 12 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice.
Proposed Substantive Change:	The proposed survey would eliminate 2 SSMs (Helping You to Take Medication as Directed and Between Visit Communication)
Steward:	Agency for Healthcare Research & Quality (AHRQ)
High Priority Measure:	Yes (Patient Experience)
Rationale:	For the Quality Payment Program Year 2 and beyond, CMS proposes to remove two SSMs, "Helping You to Take Medication as Directed" due to low reliability and "Between Visit Communication" as this SSM currently contains only one question. This question could also be considered related to other SSMs entitled: "Care Coordination" or "Courteous and Helpful Office Staff," but does not directly overlap with any of the questions under that SSM. However, we are proposing to remove this SSM in order to maintain consistency with the Medicare Shared Savings Program that utilizes the CAHPS Survey for Accountable Care Organizations (ACOs). The SSM entitled "Between Visit Communication" has never been a scored measure with the Medicare Shared Savings Program CAHPS Survey for ACOs. Please refer to section II.C.6.b.(3)(a)(iii) of this proposed rule for additional details on the removal of the two SSMs.

E.2. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Category	Description
NQF #:	0028
Quality#:	226
CMS E-Measure ID:	138v6138v6
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	EHR, Claims, Web Interface, Qualified Registry
Current Measure Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Proposed Substantive Change:	We are proposing to restructure the measure more similarly to its original construct to make it more apparent where potential gaps in care exist and how performance can be improved. Instead of being comprised of just 1 performance rate (Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user), it is now comprised of the 3 components below: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	This measure was originally developed as a two-part measure: the first part assessed whether a patient had been screened for tobacco use within the past 24 months; the second part assessed whether those who had been screened and identified as tobacco users in the first part of the measure also received tobacco cessation intervention (either counseling and/or pharmacotherapy). The two parts were eventually combined into one performance rate. That performance rate is collective and does not show the difference in performance with respect to how well clinicians adhere to performing tobacco use screenings and how well clinicians follow the guidelines to provide tobacco cessation interventions. As written, the measure has had a continuously high performance rate. The performance rate currently does not differentiate between smokers and non-smokers with regards to counseling, thereby demonstrating a potential inaccurately high performance rate. To address this, based on discussions with CMS' Million Hearts program as well as the technical expert panel (TEP) recently convened by our measure development contractor, the measure has been updated to more accurately reflect the intended quality action. Accordingly, the measure will look to assess tobacco use, the percentage of patients who use tobacco and were counseled to quit and the overall percentage of patients who received counseling.

E.3. Dementia: Cognitive Assessment

Category	Description
NQF #:	N/A
Quality #:	281
CMS E-Measure ID:	149v6
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period
Proposed Substantive Change:	The measure currently allows for medical exceptions, including diagnosis of severe dementia, palliative care, or other medical reasons, from numerator compliance.
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	The technical expert panel convened by our measure development contractor recommended removing these exceptions as cognitive assessment is especially important for planning the care of patients who are very sick or have advanced-stage dementia. The denominator identifies patients with dementia. Prior to this change, patients with severe dementia, palliative care, and medical reasons were removed from the denominator. While the denominator seeks patients with dementia, the number of patients with severe dementia is likely non-trivial and could impact performance rates. It is recognized that patients with perceived severe dementia still need an objective assessment of their cognition to appropriately care for them.

E.4. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Category	Description
NQF #:	0421
Quality #:	128
CMS E-Measure ID:	69v6
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	Claims, Web Interface, Registry, EHR
Current Measure Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2
Proposed Substantive Change:	Change the frequency of documenting BMI from 6 to 12 months.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	No
Rationale:	Based on current evidence, the expert work group for the measure recommended revising the time frame for frequency of documenting BMI from 6 to 12 months. This proposed change doubles the time frame for numerator compliance, providing additional opportunities for meeting measure criteria. Extending the timeframe for numerator compliance will decrease the burden on the clinician, and can also potentially impact the performance rates.

E.5. Preventive Care and Screening: Influenza Immunization

Category	Description
NQF #:	0041
Quality #:	110
CMS E-Measure ID:	147v7
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	Claims, Web Interface, Registry, EHR
Current Measure Description:	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Proposed Substantive Change:	Remove encounter count requirement from initial population. This change applies to the Registry and EHR data submission methods only.
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	The technical expert panel (TEP) convened by our measure development contractor recommended removing the 2-visit requirement from CMS147. The TEP suggests the measure should encourage clinicians to take advantage of every opportunity to administer the flu vaccination. CMS agrees with the TEP's recommendation and believes that each patient contact during the flu season is an opportunity to ensure that the patient received proper vaccination. This will reduce the number of missed opportunities for vaccination. We believe this proposed change allows clinicians to take advantage of every opportunity to administer the flu vaccination. In light of this change, the Initial Population language and the Initial Population logic need to be modified.

E.6. Use of High-Risk Medications in the Elderly

Category	Description
NQF #:	0022
Quality #:	238
CMS E-Measure ID:	156v6
National Quality Strategy Domain:	Patient Safety
Current Data Submission Method:	Registry, EHR
Current Measure Description:	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.
Proposed Substantive Change:	The change is proposed in rate b, which will be going from two different medications to two instances of the same medication. This new change aligns with Beers criteria.
Steward:	National Committee for Quality Assurance (NCQA)
High Priority Measure:	Yes (Patient Safety)
Rationale:	The American Geriatrics Society has established the Beers criteria, inclusive of a list of medications considered to be inappropriate for elderly patients. The Beers criteria is important because it involves closer monitoring of drug use, application of real-time interventions, and better patient outcomes. The parent measure requires that the patients have two or more dispensing events (any days supply) on different dates of services during the measurement year. The dispensing events should be for the same drug (as identified by the drug ID in the HEDIS NDC code list).

E.7. Functional Status Assessment for Total Knee Replacement

Category	Description
NQF #:	N/A
Quality #:	375
CMS E-Measure ID:	66v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments
Proposed Substantive Change:	Aligning the initial population more closely with the measurement period. The overall duration of period remains the same. Changes to the measure description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.

E.8. Functional Status Assessment for Total Hip Replacement

Category	Description
NQF #:	N/A
Quality #:	376
CMS E-Measure ID:	56v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported functional status assessments
Proposed Substantive Change:	Revise timing to identify initial population, to align more closely with the measurement period. The overall duration of period remains the same. Changes to the measure descriptions: Percentage of patients 18 years of age and older with who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.

E.9. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Category	Description
NQF #:	N/A
Quality #:	438
CMS E-Measure ID:	347v1
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	Web Interface, Registry
Current Measure Description:	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.
Proposed Substantive Change:	We propose to offer this measure as an eCQM for the 2018 performance period.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	No
Rationale:	To provide eligible clinicians with an additional reporting option that can be used to report for the measure.

E.10. Closing the Referral Loop: Receipt of Specialist Report

Category	Description
NQF #:	N/A
Quality #:	374
CMS E-Measure ID:	50v650v6
National Quality Strategy Domain:	Communication and Care Coordination
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
Proposed Substantive Change:	We propose to offer this measure as a registry measure for the 2018 performance period.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Care Coordination)
Rationale:	To provide eligible clinicians with an additional reporting option that can be used to report for the measure.

E.11. Dementia: Counseling Regarding Safety Concerns

Category	Description
NQF #:	N/A
Quality #:	286
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Data Submission Method:	Qualified Registry
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period
Proposed Substantive Change:	We propose to update the title, description and numerator of this measure to further specify the safety screening required and documentation of mitigation recommendations, consistent with updates from the measure steward.
Steward:	American Academy of Neurology
High Priority Measure:	Yes (Patient Safety)
Rationale:	CMS proposes to update this measure consistent with updates from the measure steward, as it will provide a more comprehensive assessment from which the results may provide additional insight about the patient's condition and alterations needed in the treatment plan therefore making this a more robust measure.

E.12. Dementia: Neuro-Psychiatric Symptom Assessment

Category	Description
NQF #:	N/A
Quality #:	283
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	Qualified Registry
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12-month period
Proposed Substantive Change:	The measure was updated to change 'Functional Status Assessment and Results Reviewed' to 'Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management' Symptoms screening is for three domains 'activity disturbances', 'mood disturbances' and 'thought and perceptual disturbances' including depression. To meet the measure, a documented behavioral and psychiatric symptoms screen inclusive of at least one or more symptom from each of three defined domains AND documented symptom management recommendations if safety concerns screening is positive within the last 12 months.
Steward:	American Academy of Neurology
High Priority Measure:	No
Rationale:	The measure steward updated the measure to combine it with Q284: Dementia: Management of Neuropsychiatric Symptoms (proposed for removal), to make the measure more robust to include assessment of neuropsychiatric symptoms modified to include depression screening and the management of those symptoms.

Appendices—Improvement Activities Table

NOTE: For previously finalized improvement activities, we refer readers to the Finalized Improvement Activities Inventory in Table H in the Appendix of the CY 2017 Quality Payment Program final rule (81 FR 77817). Except as otherwise proposed below, previously finalized improvement activities would continue to apply for the Quality Payment Program year 2 and future years.

TABLE F: Proposed New Improvement Activities for the Quality Payment Program Year 2 and Future Years

Activity ID:	**IA_AHE_XX**
Subcategory:	Achieving Health Equity
Activity Title:	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
Activity Description:	MIPS eligible clinician leadership in clinical trials, research alliances or community-based participatory research (CBPR) that identify tools, research or processes that can focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_AHE_XX**
Subcategory:	Achieving Health Equity
Activity Title:	Provide Education Opportunities for New Clinicians
Activity Description:	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_BMH_XX**
Subcategory:	Behavioral and Mental Health
Activity Title:	Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients
Activity Description:	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the 2018 performance period, and 75 percent for the Quality Payment Program Year 2 and future years, of their ambulatory care patients are screened for unhealthy alcohol use.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_CC_XX**
Subcategory:	Care Coordination

Activity Title:	PSH Care Coordination
Activity Description:	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_CC_XX**
Subcategory:	Care Coordination
Activity Title:	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
Activity Description:	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes, if accomplished with CEHRT
Activity ID:	**IA_EPA_XX**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)
Activity Description:	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provided substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_PM_XX**
Subcategory:	Population Management
Activity Title:	Participation in Population Health Research
Activity Description:	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.

Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_PM_XX**
Subcategory:	Population Management
Activity Title:	Provide Clinical-Community Linkages
Activity Description:	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes, if accomplished with CEHRT
Activity ID:	**IA_PM_XX**
Subcategory:	Population Management
Activity Title:	Glycemic Screening Services
Activity Description:	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 75 percent of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_PM_XX**
Subcategory:	Population Management
Activity Title:	Glycemic Referring Services
Activity Description:	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 75 percent of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_PM_XX**
Subcategory:	Population Management
Activity Title:	Advance Care Planning
Activity Description:	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to

	address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain
Activity Description:	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_ PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Completion of CDC Training on Antibiotic Stewardship
Activity Description:	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_ PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Initiate CDC Training on Antibiotic Stewardship
Activity Description:	Completion of greater than 50 percent of the modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No

Activity ID:	**IA_ PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Cost Display for Laboratory and Radiographic Orders
Activity Description:	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event
Activity Description:	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_ PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Invasive Procedure or Surgery Anticoagulation Medication Management
Activity Description:	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment

Activity Title:	Completion of an Accredited Safety or Quality Improvement Program
Activity Description:	Completion of an accredited performance improvement continuing medical education program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Activity ID:	**IA_PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging
Activity Description:	Clinicians attest that they are consulting specified applicable appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. This activity is for clinicians that are early adopters of the Medicare AUC program (e.g., 2018 performance year) and for clinicians that begin the Medicare AUC program in future years will be required by §414.94 (authorized by the Protecting Access to Medicare Act of 2014). Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Activity ID:	**IA_PSPA_XX**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	PCI Bleeding Campaign
Activity Description:	Participation in the PCI Bleeding Campaign which is a national quality improvement program that provides infrastructure for a learning network and offers evidence-based resources and tools to reduce avoidable bleeding associated with patients who receive a percutaneous coronary intervention (PCI). The program uses a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for PCI patients by implementing quality improvement strategies: • Radial-artery access, • Bivalirudin, and • Use of vascular closure devices.

Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No

We propose to include these additional improvement activities in the Improvement Activities Inventory for the Quality Payment Program Year 2 and future years based on guidelines discussed in the CY 2017 Quality Payment Program final rule at (81 FR 77190) and proposed in section II.C.6.e.(7)(b) of this proposed rule. These may include one or more of the following criteria:

- 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 advancing care information bonus;
- Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care);
- Feasible to implement, recognizing importance in minimizing burden, especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA;
- CMS is able to validate the activity; or
- Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.

TABLE G: Proposed Improvement Activities with Changes for the Quality Payment Program Year 2 and Future Years

Activity ID:	**IA_AHE_1**
Subcategory:	Achieving Health Equity
Activity Title:	Engagement of New Medicaid Patients and Follow-up
Current Activity Description:	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.
Rationale:	We propose to revise the wording of this improvement activity to clarify the meaning of "a timely manner."
Activity ID:	**IA_AHE_3**
Subcategory:	Achieving Health Equity
Activity Title:	Leveraging a QCDR to Promote Use of PRO Tools
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Change Activity Title to: Promote Use of Patient-Reported Outcome Tools Change Activity Description to: Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PQH-2 or PHQ-9, PROMIS instruments, patient reported Wound Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening Change Weight to: High Proposed change to eligibility for advancing care information bonus: Change to "yes" for eligible for advancing care information bonus. We believe MIPS eligible clinicians may utilize EHR to capture this information to include standardized data capture and incorporating patient generated health data.
Rationale:	We propose to revise this improvement activity to expand its application to include employing the PRO tools and corresponding collection of PRO data. In addition, we propose to provide additional examples of activities that may be appropriate for this improvement activity.
Activity ID:	**IA_BE_14**
Subcategory:	Beneficiary Engagement
Activity Title:	Engage Patients and Families to Guide Improvement in the System of Care
Current Activity Description:	Engage patients and families to guide improvement in the system of care.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes

Proposed Change:	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.
Rationale:	Proposed activity description: We believe that the use of digital technologies that provide either one-way or two-way data between MIPS eligible clinicians and patients is valuable, including for the purposes of promoting patient self-management, enabling remote monitoring, and detecting early indicators of treatment failure. Proposed weight: Change to high because of increased cost and time considerations for digital tools for ongoing guidance and assessment outside of encounter. Proposed change to eligibility for advancing care information bonus: Change to "yes" for eligible for advancing care information bonus. We believe MIPS eligible clinicians will use health IT including providing patients access to health information and educational resources as well as incorporating PGHD for this activity to include standardized data capture and incorporating patient generated health data.
Activity ID:	**IA_BE_15**
Subcategory:	Beneficiary Engagement
Activity Title:	Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
Current Activity Description:	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified electronic health record (EHR) technology.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.
Rationale:	We propose to remove the requirement that the EHR technology be certified.

	We do not believe this improvement activity should be limited to certified EHR technology, however, when certified technology is used, eligible clinicians may qualify for the advancing care information bonus.
Activity ID:	**IA_BE_21**
Subcategory:	Beneficiary Engagement
Activity Title:	Improved Practices that Disseminate Appropriate Self-Management Materials
Current Activity Description:	Provide self-management materials at an appropriate literacy level and in an appropriate language.
Weighting:	Medium
Current Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	We propose to correct the "eligible for advancing care information bonus" for this improvement activity to "No."
Rationale:	This improvement activity contains an error and should not include an advancing care information bonus indicator.
Activity ID:	**IA_BE_22**
Subcategory:	Beneficiary Engagement
Activity Title:	Improved Practices that Engage Patients Pre-Visit
Current Activity Description:	Provide a pre-visit development of a shared visit agenda with the patient.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.
Rationale:	We propose to clarify the type of actions that qualify for this improvement activity.
Activity ID:	**IA_BMH_7**
Subcategory:	Behavioral and Mental Health
Activity Title:	Implementation of Integrated Patient Centered Behavioral Health Model
Current Activity Description:	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one or more of the following: • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; and/or integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. The services could include one or more of the following: • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between MIPS eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; and/or integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible. • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance.
Rationale:	We propose to revise the wording of this improvement activity to clarify that the list of chronic illnesses is not limited to these examples.
Activity ID:	**IA_CC_1**
Subcategory:	Care Coordination
Activity Title:	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
Current Activity Description:	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Rationale:	We propose to remove the requirement that the EHR technology be certified. We do not believe this improvement activity should be limited to certified EHR technology, however, when certified technology is used, eligible clinicians may qualify for the advancing care information bonus.
Activity ID:	**IA_CC_4**
Subcategory:	Care Coordination
Activity Title:	TCPI Participation

Current Activity Description:	Participation in the CMS Transforming Clinical Practice Initiative
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	We propose to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years.
Rationale:	We designated this activity as a high-weighted activity for the transition year of MIPS. However, we note that MIPS eligible clinicians that participate in the CMS Transforming Clinical Practice Initiative (TCPI)—which is an APM (as defined in section 1833(z)(3)(C) of the Act)—will automatically earn a minimum score of one-half of the highest potential score for this performance category, as required by section 1848(q)(5)(C)(ii) of the Act. In addition, we anticipate that most MIPS eligible clinicians that are fully active TCPI participants will participate in additional practice improvement activities and will be able to select additional improvement activities to achieve the improvement activities highest score.
Activity ID:	**IA_CC_9**
Subcategory:	Care Coordination
Activity Title:	Implementation of practices/processes for developing regular individual care plans
Current Activity Description:	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.
Rationale:	We propose this revision because by having an open conversation on care, we believe patients and MIPS eligible clinicians can work together to evaluate care options and opportunities that are based on an individual patient's values and priorities.
Activity ID:	**IA_CC_13**
Subcategory:	Care Coordination
Activity Title:	Practice Improvements for Bilateral Exchange of Patient Information
Current Activity Description:	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or • Use structured referral notes.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Ensure that there is bilateral exchange of necessary patient information to guide patient care, such as Open Notes, that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or

	• Use structured referral notes.
Rationale:	We propose to provide additional examples of activities that would qualify for this improvement activity.
Activity ID:	**IA_CC_14**
Subcategory:	Care Coordination
Activity Title:	Practice Improvements that Engage Community Resources to Support Patient Health Goals
Current Activity Description:	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or provide a guide to available community resources.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; • Including through the use of tools that facilitate electronic communication between settings; • Screen patients for health-harming legal needs; • Screen and assess patients for social needs using tools that are preferably health IT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or • Provide a guide to available community resources.
Rationale:	We propose to add screening patients for health harming legal needs to this activity, as such screening can help MIPS eligible clinicians address the social determinants that contribute to the most challenging problems related to coordinating care. In addition, we propose to change the eligible for advancing care information bonus to "yes." We believe MIPS eligible clinicians may use EHR to communicate with community-based resources including secure messaging, sending and receiving summary of care records, and incorporating data from a non-clinical setting.
Activity ID:	**IA_EPA_1**
Subcategory:	Expanded Practice Access
Activity Title:	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
Current Activity Description:	• Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);

	• Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	We propose to change the weight of this improvement activity from high to medium for MIPS Year 2 and future years. In addition, we are proposing to change the language to this improvement activity as follows: • Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (for example, eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (for example, coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by individual MIPS eligible clinicians and groups, such as telehealth, phone visits, group visits, home visits and alternate locations (for example, senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.
Rationale:	We designated this activity as a high-weighted activity for the transition year of MIPS. However, we are seeking comment on why this activity should either maintain the current weight or why the weighting should be decreased to medium.
Activity ID:	**IA_PM_1**
Subcategory:	Population Management
Activity Title:	Participation in Systematic Anticoagulation Program
Current Activity Description:	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in the transition year and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).

Rationale:	We propose to clarify that the 75 percent performance target extends into future years.
Activity ID:	**IA_PM_2**
Subcategory:	Population Management
Activity Title:	Anticoagulant Management Improvements
Current Activity Description:	MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance year, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these clinical practice improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care*, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; and/or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. MIPS eligible clinicians would attest that, 60 percent for the transition year or 75 percent for the second year, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.
Weighting:	High
Eligible for Advancing Care Information Bonus:	Yes
Proposed Change:	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, 75 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient

	communication of results and dosing decisions; and/or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Rationale:	We propose to clarify which actions qualify for this improvement activity for the Quality Payment Program Year 2 and future years.
Activity ID:	**IA_PM_8**
Subcategory:	Population Management
Activity Title:	Participation in CMMI models such as the Million Hearts Campaign
Current Activity Description:	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Delete activity from the improvement activities inventory.
Rationale:	We do not believe participants in an APM, who have already automatically received 50% credit in the improvement activity performance category, should be provided additional credit for this improvement activity based solely on their participation in a single APM.
Activity ID:	**IA_PM_11**
Subcategory:	Population Management
Activity Title:	Regular Review Practices in Place on Targeted Patient Population Needs
Current Activity Description:	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.
Rationale:	We propose to provide additional examples of activities that would qualify for this improvement activity.
Activity ID:	**IA_PM_13**
Subcategory:	Population Management
Activity Title:	Chronic Care and Preventative Care Management for Empaneled Patients
Current Activity Description:	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic

	conditions; and advance care planning; • Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; • Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools (registry functionality) to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; or • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or Routine medication reconciliation.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions; • Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; • Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools (registry functionality) to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; or • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.
Rationale:	We propose to remove the advance care planning portion of this improvement activity. We are proposing to create a new improvement activity focused on advance care planning.
Activity ID:	**IA_PSPA_2**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participation in MOC Part IV
Current Activity Description:	Participation in Maintenance of Certification (MOC) Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of monthly activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No

Proposed Change:	Participation in Maintenance of Certification (MOC) Part IV, such as the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or ASA Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of monthly activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.
Rationale:	We propose to provide additional examples of activities that would qualify for this improvement activity.
Activity ID:	**IA_PSPA_3**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity
Current Activity Description:	For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.
Rationale:	We propose to revise this improvement activity to clarify that other MOC programs are eligible for this improvement activity.
Activity ID:	**IA_PSPA_4**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Administration of the AHRQ Survey of Patient Safety Culture
Current Activity Description:	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html).
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html). Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

Rationale:	We propose to revise the wording of this improvement activity to specify that it may be selected once every 4 years to achieve the performance category score.
Activity ID:	**IA_PSPA_6**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Consultation of the Prescription Drug Monitoring Program
Current Activity Description:	Clinicians would attest that 60 percent for the first year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.
Weighting:	High
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Rationale:	We propose to clarify that in the transition year, clinicians would attest to 60 percent review of applicable patient's history. In the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.
Activity ID:	**IA_PSPA_8**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Use of Patient Safety Tools
Current Activity Description:	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the surgical risk calculator.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator, evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings, (https://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html), predictive algorithms, or other such tools.
Rationale:	We propose to include additional examples of tools that may be utilized to assist specialty practices in tracking specific measures that are meaningful to their practice, including evidence based protocols such as Enhanced Recovery After Surgery (ERAS) protocols, the CDC Guide for Infection Prevention for Outpatient Settings and the use of tools and protocols that promote appropriate use criteria.
Activity ID:	**IA_PSPA_14**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Participation in Bridges to Excellence or Other Similar Programs
Current Activity Description:	Participation in other quality improvement programs such as Bridges to Excellence.

Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Proposed Activity Title: Participation in Quality Improvement Initiatives Proposed Activity Description: Participation in other quality improvement programs such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.
Rationale:	We propose to revise the wording of this improvement activity to clarify that other programs are eligible for this improvement activity.
Activity ID:	**IA_PSPA_15**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Implementation of an ASP
Current Activity Description:	Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall hospital strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with hospital compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and hospital personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the hospital, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line.
Rationale:	We propose to provide additional examples of activities that may be appropriate for this improvement activity.
Activity ID:	**IA_PSPA_18**

Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Measurement and Improvement at the Practice and Panel Level
Current Activity Description:	Measure and improve quality at the practice and panel level that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No
Proposed Change:	Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
Rationale:	We propose to provide additional examples of activities that may be appropriate for this improvement activity.
Activity ID:	**IA_PSPA_19**
Subcategory:	Patient Safety & Practice Assessment
Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Current Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.
Weighting:	Medium
Eligible for Advancing Care Information Bonus:	No

Proposed Change:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.
Rationale:	We propose to provide additional examples of activities that would qualify for this improvement activity.

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