(*2*) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;

(*3*) Implemented in a manner that allowed for timely access by patients to their electronic health information; and

(*4*) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and health IT vendors.

(C) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

§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.

(ii) For the cost performance category, measures are scored between one and 10 points. Performance is measured against a benchmark.

(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 performance period. MIPS eligible clinicians receive three to ten 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 MIPS quality measure must have a measure benchmark to be scored based on performance. MIPS 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 performance period.

(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. 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, 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) 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 year 2019. Instead, these measures as well as measures that are below the data completeness requirement receive a score of 3 points in MIPS payment year 2019.

(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 will also not be scored, although we will recognize that the measure was submitted, and measures that are below the data completeness requirement receive 0 points.

(ix) Measures submitted by MIPS eligible clinicians are scored 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.

(xiii) Bonus points are available for measures determined to be high priority measures when two or more high priority measures are reported.

(A) Bonus points are not available for the first reported high priority measure which is required to be reported. To qualify for bonus points, each measure must be reported with sufficient case volume to the meet the required case minimum and the required data completeness criteria and does not have a zero percent performance rate, regardless of whether it is included in the calculation of the quality performance category score.

(B) Outcome and patient experience measures receive two bonus points.

(C) Other high priority measures receive one bonus point.

(D) Bonus points for high priority measures cannot exceed 10 percent of the total possible points for MIPS payment year 2019 and 2020.

(xiv) One 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 possible points for MIPS payment year 2019 and 2020.

(xv) A MIPS eligible clinician's quality performance category score is the sum of all the points assigned for the measures required for the quality performance category criteria plus the bonus points in paragraph (b)(1)(xiii) of this section and bonus points in paragraph (b)(1)(xiv) of this section. The sum is divided by the sum of total possible points. The quality performance category score cannot exceed the total possible points for the quality performance category.

(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's cost performance category score is the equally-weighted average of all scored cost measures.

(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.

(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 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 this paragraph (b)(3)(iv), ''full credit'' means that the MIPS eligible clinician or group has met the highest potential score of 40 points. A practice is certified 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 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) To receive full credit as a certified patient-centered medical home or comparable specialty practice requires that a TIN that is reporting includes at least one practice 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.

(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, Public Health and Clinical Data Registry bonus score and completing improvement activities using CEHRT bonus 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 yes/no statement or null value 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 earn a bonus of five percentage points for reporting any measures beyond than the Immunization Registry Reporting measure for the Public Health and Clinical Data Registry objective.

(D) A MIPS eligible clinician earns a bonus of 10 percentage points for attesting to completing one or more improvement activities specified by CMS using CEHRT.

(ii) [Reserved]

(c) *Final score calculation.* Each MIPS eligible clinician receives a final score of 0 to 100 points equal to the sum of each of the products of each performance category score and each performance category's assigned weight, multiplied by 100.

(1) *Performance category weights.* Subject to CMS's authority to reweight, performance category weights under section 1848(q)(5)(F) of the Act:

(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.* If CMS determines there are not sufficient measures and activities applicable and available to MIPS eligible clinicians, CMS will assign weights to the performance categories that are different from the weights specified in § 414.1380(c)(1).

(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.

§ 414.1385 Targeted review and review limitations.

(a) *Targeted review.* 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. The process for targeted reviews is:

(1) MIPS eligible clinicians and groups have a 60-day period to submit a request for targeted review, which begins on the day CMS makes 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 CMS.

(2) CMS will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted.

(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 CMS requests additional information from the MIPS eligible clinician or group, it must be provided and received by CMS within 30 days of the request. Non-responsiveness to the request for additional information may