

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.

(b) *Limitations on review.* Except as specified in paragraph (a)(4) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of—

(1) The methodology used to determine the amount of the MIPS payment adjustment factor and the amount of the additional MIPS payment adjustment factor and the determination of such amounts;

(2) The establishment of the performance standards and the performance period;

(3) The identification of measures and activities specified for a MIPS performance category and information made public or posted on the Physician Compare Internet Web site of the CMS; and

(4) The methodology developed that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

§414.1390 Data validation and auditing.

(a) *General.* CMS 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 CMS establishes:

(1) Comply with data sharing requests, providing all data as requested by CMS or our designated entity. All data must be shared with CMS or our designated entity within 45 days of the data sharing request, or an alternate timeframe that is agreed to by CMS and the MIPS eligible clinician or group. Data will be submitted via email, facsimile, or an electronic method via a secure Web site maintained by CMS.

(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.

(b) [Reserved]

§414.1395 Public reporting.

(a) *Public reporting of a MIPS eligible clinician's MIPS data.* For each program year, CMS will post on a public Web site, in an easily understandable format, information regarding the performance of MIPS eligible clinicians or groups under the MIPS.

(b) [Reserved]

§414.1400 Third party data submission.

(a) *General.* (1) MIPS data may be submitted by third party intermediaries on behalf of a MIPS eligible clinician or group by:

(i) A qualified registry;

(ii) A QCDR;

(iii) A health IT vendor or other authorized third party that obtains data from a MIPS eligible clinician's CEHRT; or

(iv) A CMS-approved survey vendor.

(2) Qualified registries, QCDRs, and health IT vendors or other authorized third parties may submit data on measures, activities, or objectives for any of the following MIPS performance categories:

(i) Quality;

(ii) Improvement activities; or

(iii) Advancing care information, if the MIPS eligible clinician or group is using CEHRT.

(3) CMS-approved survey vendors may submit data for the CAHPS for MIPS survey under the MIPS quality performance category.

(4) Third party intermediaries must meet all the criteria specified by CMS to qualify and be approved as a third party intermediary for purposes of MIPS, including, but not limited to, the following criteria:

(i) For measures, activities, and objectives under the quality, advancing care information, and improvement activities performance categories, if the data is derived from CEHRT, the

QCDR, qualified registry, or health IT vendor must be able to indicate its data source.

(ii) All submitted data must be submitted in the form and manner specified by CMS.

(b) *QCDR self-nomination criteria.* QCDRs must self-nominate, for the 2017 performance period, from November 15, 2016 until January 15, 2017. For future years of the program, starting with the 2018 performance period, 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.

(c) *Establishment of a QCDR entity.* For an entity to become qualified for a given performance period as a QCDR, the entity must:

(1) Be in existence as of January 1 of the performance period for which the entity seeks to become a QCDR.

(2) Have at least 25 participants by January 1 of the performance period.

(d) *Collaboration of entities to become a QCDR.* In situations where an entity may not meet the criteria of a QCDR solely on its own but can do so in conjunction with another entity, the entity must also comply with the following:

(1) An entity that uses an external organization for purposes of data collection, calculation, or transmission may meet the definition of a QCDR as long as the entity has a signed, written agreement that specifically details the relationship and responsibilities of the entity with the external organization effective as of September 1 the year prior to the year for which the entity seeks to become a QCDR.

(2) [Reserved]

(e) *Identifying non-MIPS quality measures.* For purposes of QCDRs submitting data for the MIPS quality performance category, CMS considers the following types of quality measures to be non-MIPS quality measures:

(1) A measure that is not contained in the annual list of MIPS quality measures for the applicable performance period.

(2) A measure that may be in the annual list of MIPS quality measures but has substantive differences, as determined by the Secretary, in the manner it is reported by the QCDR.

(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 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 non-MIPS 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 January 15 of the applicable performance period for which the QCDR wishes to submit quality measures or other performance category (improvement activities and advancing care information) data. In future years, starting with the 2018 performance period, those specifications must be provided to CMS by no later than November 1 prior to the applicable performance period for which the QCDR wishes to submit quality measures or other performance category (improvement activities and advancing care information) data.

(1) For non-MIPS 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. CMS will consider all non-MIPS quality measures submitted by the QCDR but the measures

must address a gap in care and outcome or other high priority measures are preferred. Documentation or “check box” measures are discouraged. Measures that have very high performance rates already or address extremely rare gaps in care (thereby allowing for little or no quality distinction between eligible clinicians) are also unlikely to be approved for inclusion.

(2) For MIPS quality measures, the QCDR only needs to submit the MIPS measure numbers or specialty-specific measure sets (if applicable).

(3) The QCDR must publicly post the measure specifications (no later than 15 days following CMS approval of the measure specifications) for each non-MIPS quality measure it intends to submit for MIPS. The QCDR may use any public format it prefers. Immediately following posting of the measures specification, the QCDR must provide CMS with the link to where this information is posted.

(g) *Qualified registry self-nomination criteria.* Qualified registries must self-nominate, for the 2017 performance period from November 15, 2016 until January 15, 2017. For future years of the program, starting with the 2018 performance period, 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.

(h) *Establishment of a qualified registry entity.* For an entity to become qualified for a given performance period as a qualified registry, the entity must:

(1) Be in existence as of January 1 of the performance period for which the entity seeks to become a qualified registry.

(2) Have at least 25 participants by January 1 of the performance period.

(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. All CMS-approved survey vendor applications and materials will be due by April 30 of the performance period.

(j) *Auditing of entities submitting MIPS data.* 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 CMS 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 CMS for MIPS for a minimum of 10 years.

(3) For the purposes of auditing, CMS may request any records or data retained for the purposes of MIPS for up to 6 years and 3 months.

(k) *Probation and disqualification of a third party intermediary.* (1) 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 and approval, CMS may place the third party intermediary on probation for the current performance period or the following performance period, as applicable.

(2) For purposes of this section, probation means that, for the applicable performance period, the third party intermediary must meet all applicable criteria for qualification and approval and must submit a corrective action plan for remediation or correction of any deficiencies identified by CMS that resulted in the probation.

(3) CMS requires a corrective action plan from the third party intermediary to address any deficiencies or issues and prevent them from recurring. The corrective action plan must be received and accepted by CMS within 14 days of the CMS notification to the third party intermediary of the deficiency or probation. If the corrective action plan is not received and accepted by CMS

within the specified time, CMS may disqualify the third party intermediary from the MIPS program for the subsequent performance period.

(4) 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, such inaccuracies will trigger paragraph (k)(3) of this section and may result in this information being posted on the CMS Web site.

(5) If the third party intermediary does not reduce their data error rate below 3 percent for the subsequent performance period, the third party intermediary will continue to be on probation and have their listing on the CMS Web site continue to note the poor quality of the data they are submitting for MIPS for one additional year. After 2 years on probation, the third party intermediary will be disqualified for the subsequent performance period.

(6) Before placing the third party intermediary on probation; CMS would notify the third party intermediary of the identified issues, at the time of discovery of such issues.

(7) If the third party intermediary does not submit an acceptable corrective action plan within 14 days of notification of deficiencies, and correct the deficiencies within 30 days or before the submission deadline—whichever is sooner, CMS may disqualify the third party intermediary from participating in MIPS for the current performance period or the following performance period, as applicable.

§414.1405 Payment.

(a) *General.* Each MIPS eligible clinician receives a MIPS payment adjustment factor, and if applicable an additional MIPS payment adjustment factor for exceptional performance, for a MIPS payment year determined by comparing their final score to the performance threshold and additional performance threshold for the year.

(b) *Performance threshold.* A performance threshold will be specified for each MIPS payment year.

(1) MIPS eligible clinicians with a final score at or above the performance threshold receive a zero or positive MIPS payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a final score at the performance threshold and an adjustment factor of the applicable percent is assigned for a final score of 100.

(2) MIPS eligible clinicians with a final score below the performance threshold receive a negative MIPS payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a final score at the performance threshold and an adjustment factor of the negative of the applicable percent is assigned for a final score of 0; further, MIPS eligible clinicians with final scores that are equal to or greater than zero, but not greater than one-fourth of the performance threshold, receive a negative MIPS payment adjustment factor that is equal to the negative of the applicable percent.

(3) 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.

(c) *Applicable percent.* For MIPS payment year 2019, 4 percent. For MIPS payment year 2020, 5 percent. For MIPS payment year 2021, 7 percent. For MIPS payment year 2022 and each subsequent MIPS payment year, 9 percent.

(d) *Additional performance threshold.* An additional performance threshold will be specified for each of the MIPS payment years 2019 through 2024.

(1) In addition to the MIPS payment adjustment factor, MIPS eligible clinicians with a final score at or above the additional performance threshold receive an additional MIPS payment adjustment factor for exceptional performance on a linear sliding scale such that an additional adjustment factor of 0.5 percent is assigned for a final score