Merit-Based Incentive Payment System (MIPS)
Resource Guide

June 13, 2018

Contents

Section 1. MIPS and Who It Applies To

The Medicare and CHIP Reauthorization Act (MACRA) of 2015 created sweeping reforms to reimbursement to providers under Medicare Part B and establishes the Medicare Quality Payment Program. The Quality Payment Program outlines two pathways for providers participating in Medicare Part B: Advanced Alternative Payment Models (Advanced APMs) and the Merit-Based Incentive Payment Program (MIPS). The vast majority of providers will be reimbursed under MIPS. This MIPS Resource Guide includes details related to the performance reporting categories, and information on specific reporting options available to providers.

All of the information provided in this 2018 MIPS Resource Guide is based on detail in the final rule issued by the Centers for Medicare and Medicaid Services in November 2017, for an effective date of January 1, 2018.

About MIPS

MIPS collapses three existing quality reporting programs into one, while adding a fourth category:

- The Physician Quality Reporting System (PQRS) becomes **Quality** under MIPS, and requires eligible clinicians to report certain quality measures on an annual basis.
- The Value-based Payment Modifier Program (VM) becomes **Resource Use** under MIPS, and compares costs to treat similar care episodes and clinical condition groups across practices.
- The Medicare Electronic Health Record (EHR) incentive program becomes **Advancing Care Information** under MIPS, and retains an emphasis on interoperability and information exchange.
- The newest reporting area (also available in Year 1) is **Clinical Practice Improvement Activities**, which rewards practices that engage in quality improvement activities, including for their Medicaid and other non-Medicare patient populations.

MIPS-Eligible Clinicians

Clinicians that will be counted for the 2018 reporting year include physicians (including psychiatrists), nurse practitioners, physician assistants, clinical nurse specialists and nurse anesthetists.

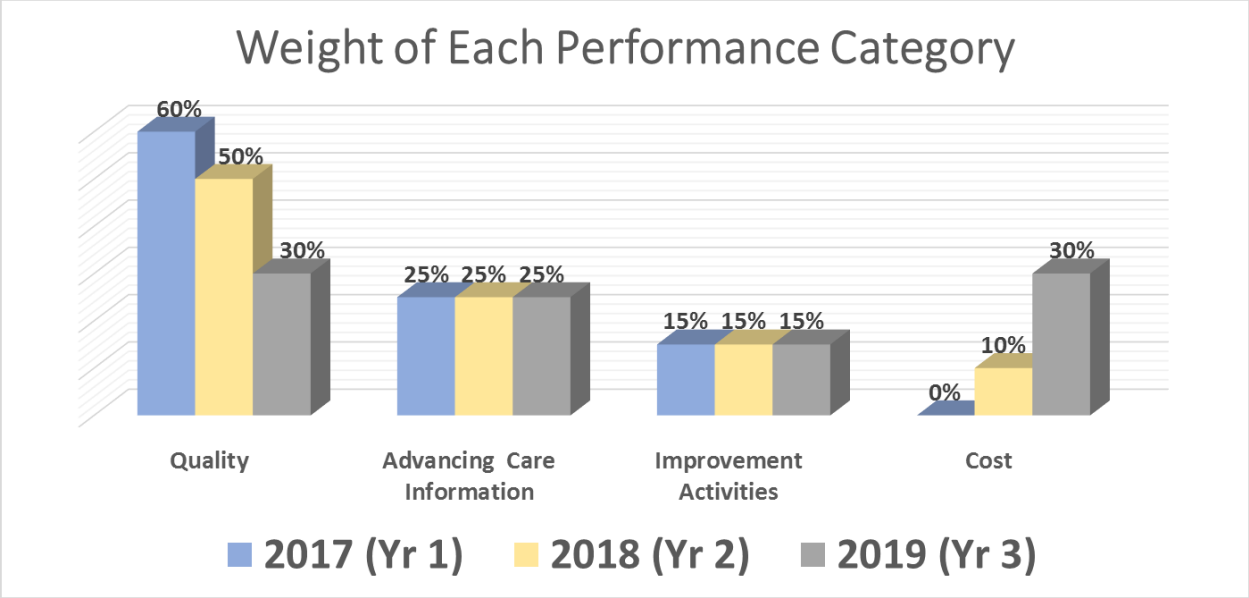
In 2018, MIPS does **NOT** apply to:

- Clinical psychologists & licensed clinical social workers (LCSWs)
- First-year Medicare providers
- Qualifying Advanced APM clinicians
- Hospitals and facilities (e.g., skilled nursing facilities)
- Clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries (this is an increase in the low-volume threshold from performance 2017/Year 1)
- Clinicians and groups who are not paid under the Physician Fee Schedule (e.g., FQHCs and partial hospitalization programs); MIPS does not apply to Managed Care payments

Although they are not considered eligible in 2018, the proposed rule states that clinical psychologists and LCSWs may be added to the MIPS eligible clinician list in 2019.

Section 2. Performance Categories

The weight of the Quality performance category has changed in calculation of the MIPS composite score.



Quality Performance Category (50%)

For the 2018 reporting year, the Quality Performance Category is worth 50% of the Composite Performance Score. An adaptation of the Physician Quality Reporting System (PQRS) program, the MIPS Quality category requires clinicians to choose six measures to report that best reflect their practice. One measure must be a "cross cutting" measure, and at least one must be an outcome or other high-priority measure.

Clinicians may report measures from the Mental/Behavioral Health Specialty Set to fulfill this requirement (information about 2018 measures can be found here: 2018 Resources), but MIPS provides a very limited number of behavioral health-related quality measures. If a clinician/group can only report on fewer than six measures, CMS may reduce the weight of the Quality category and reassign the missing weight proportionally to other performance categories.

Cost Performance Category (10%)

For the 2018 reporting year, the Cost Performance Category is worth 10% of the Composite Performance Score. CMS will calculate cost measure performance; no action is required from clinicians for Year 2 (2018). CMS is including the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate your Cost performance category score for the 2018 MIPS performance period. These two measures carried over from the Value Modifier program and are currently being used to provide feedback for the MIPS transition year.

Advancing Care Information Performance Category (25%)

For the 2018 reporting year, there is no change to the base score requirements for the 2020 payment year in the Advancing Care Information Performance Category. This performance category is worth 25% of the Composite Performance Score. Under the Merit-Based Incentive Payment System (MIPS), the Advancing Care Information (ACI) performance category replaces the Medicare EHR Incentive Program, often called "Meaningful Use." For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry. A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. Additional activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least one of the specified Improvement Activities. An additional 10% bonus score will be applied for using the 2015 Edition exclusively.

Base Score (50 points)

CMS proposes six objectives, which were adopted in the 2015 EHR Incentive Programs Final Rule for Stage 3:

- Protect Patient Health Information
- Electronic Prescribing
- Patient Electronic Access to Health Information
- Care of Coordination Through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

To receive the full base score of 50 points, MIPS eligible clinicians must simply provide the numerator/denominator or yes/no for each objective and measure (See Table 1).

Note: Because of the importance of protecting patient privacy and security, MIPS eligible clinicians must be able to report "yes" to the Protect Patient Health Information objective to receive any score in the ACI performance category. Also, failure to meet the submission criteria and measure specifications for any measure in any of the objectives would result in an ACI performance category score of zero.

Table 1. Advancing Care Information Score Objectives and Measures
Protect Patient Health Information: Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology 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 certified EHR technology in accordance with requirements in 45 CFR164.312(a)(2)(iv) and 45 CFR 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.
Electronic Prescribing: MIPS eligible clinicians must generate and transmit permissible prescriptions electronically.
ePrescribing Measure: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology. • **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order 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 certified EHR technology
Patient Electronic Access: The MIPS eligible clinician provides patients (or patient authorized representative) with timely electronic access to their health information and patient-specific education.
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 certified EHR technology. • **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 certified HER technology.
Patient-Specific Education Measure: The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and

Table 1. Advancing Care Information Score Objectives and Measures
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 certified EHR technology during the performance period
Coordination of Care Through Patient Engagement: Use certified EHR technology to engage with patients or their authorized representatives about the patient's care.
View, Download or 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. An 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 certified EHR technology; or (3) a combination of (1) and (2). • **Denominator:** Number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.
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 certified EHR technology 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 certified EHR technology 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

Table 1. Advancing Care Information Score Objectives and Measures
• **Numerator:** The number of patients in the denominator for whom data from nonclinical settings, which may include patient-generated health data, is captured through the certified EHR technology into the patient record during the performance period.
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of certified EHR technology.
Patient Care Record Exchange 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 certified EHR technology; and (2) electronically exchanges the summary of care record. • **Denominator:** Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the 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 certified EHR technology and exchanged electronically
Request/Accept Patient Care Record 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 certified EHR technology.
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 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.

Table 1. Advancing Care Information Score Objectives and Measures
• **Numerator:** The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list.
Public Health and Clinical Data: 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 certified EHR technology, except where prohibited, and in accordance with applicable law and practice. (Note: MIPS eligible clinicians can only earn up to one bonus point)
(Required) 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).
(Optional; worth one bonus point) 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.
(Optional; worth one bonus point) 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.
(Optional; worth one bonus point) 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.
(Optional; worth one bonus point) Clinical Data Registry Reporting Measure: The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

Performance Score (80 points)
MIPS eligible clinicians can select the performance score measures that best fit their practice from three objectives —Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Each measure would be assigned a total of 10 possible points. For each measure, a MIPS eligible clinician may earn up to 10 percent of their performance score based on their performance rate for the given measure.

Total Score (100%)
To determine the MIPS eligible clinician's overall ACI performance category score, CMS will use the sum of the base score, performance score, and the potential Public Health and Clinical Data Registry Reporting bonus point. If the sum of the MIPS eligible profession's base score (50 percent) and performance score (out of a possible 80 percent) with the Public Health and Clinical Data Registry Reporting bonus point are greater than 100 percent, CMS will apply an ACI performance category score of 100 percent.

Clinical Practice Improvement Activity Performance Category (15%)

For the 2018 reporting year, the Clinical Practice Improvement Activity (CPIA) Performance Category is worth 15% of the Composite Performance Score. CPIA enables clinicians to choose from a list of more than 112 quality improvement activities and determine which ones best suit their practice. CPIAs fall into nine categories (see below). MIPS eligible clinicians may choose activities within the Integrated Behavioral and Mental Health category or other CPIAs that apply to behavioral health care, including participation in CMS's four-year Transforming Clinical Practice Initiative. "Medium" weighted CPIAs are worth 10 points, and "high" weighted CPIAs are worth 20 points.

Table 2. Integrated Behavioral and Mental Health CPIAs

Activity	Weight[1]
Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication	Medium
Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco Dependence	Medium
Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.	Medium
Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions	Medium
Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings	High

[1] Medium weight = 10 points; High weight = 20 points

Table 2. Integrated Behavioral and Mental Health CPIAs	
Activity	**Weight[1]**
Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium
Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions	Medium
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 certified 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.	High

Table 3. Select CPIAs that are Relevant to Behavioral Health Care		
Category	**Activity**	**Weight**
Expanded Practice Access	Provide 24/7 access to MIPS eligible clinicians, eligible groups, or care teams for advice about urgent and emergent care (e.g., 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)	High
Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or tele-audiology pilots that assess ability to still deliver quality care to patients	Medium
Expanded Practice Access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs	Medium
Population Management	Use of a Qualified Clinical Data Registry to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High
Population Management	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population	Medium

Table 3. Select CPIAs that are Relevant to Behavioral Health Care		
Category	**Activity**	**Weight**
Population Management	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team.	Medium
Population Management	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.	Medium
Population Management	Provide longitudinal care management to patients at high risk for adverse health outcome or harm	Medium
Population Management	Provide episodic care management, including management across transitions and referrals	Medium
Care Coordination	Participation in the CMS Transforming Clinical Practice Initiative	High
Care Coordination	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network	Medium
Care Coordination	Implementation of regular care coordination training.	Medium
Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan	High
Beneficiary Engagement	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities	Medium
Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making	Medium
Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms	Medium
Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Medium
Beneficiary Engagement	Provide peer-led support for self-management.	Medium
Beneficiary Engagement	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community	Medium
Beneficiary Engagement	Provide coaching between visits with follow-up on care plan and goals.	Medium
Beneficiary Engagement	Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence	Medium
Achieving Health Equity	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan	High

Table 3. Select CPIAs that are Relevant to Behavioral Health Care		
Category	**Activity**	**Weight**
Patient Safety and Practice Assessment	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	Medium
Patient Safety and Practice Assessment	Completion of training and obtaining an approved waiver for provision of medication –assisted treatment of opioid use disorders using buprenorphine.	Medium
Patient Safety and Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement	Medium
Patient Safety and Practice Assessment	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities	Medium

Section 3. Reporting Mechanisms for MIPS Categories

Depending on how you choose to report—as an individual, group, or virtual group—MIPS data can be reported through several different mechanisms, which vary slightly by performance category (Table 4).

Table 4. Group and Individual MIPS Reporting Mechanisms by Performance Category		
	Individual Reporting	**Group and Virtual Group* Reporting**
Quality	• Claims • QCDR • Qualified registry • EHR • Administrative claims (no submission required)	• Qualified Clinical Data Registry (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) • Administrative claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified registry • EHR	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more)
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified registry • EHR • Administrative claims (if feasible, no submission required)	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • Administrative claims (if technically feasible, no submission required)
Resource Use	No independent reporting required for individuals or group practices	

* *Virtual Groups have same definition as groups.*

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number. You'll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

If you send your MIPS data with a group, the group will get **one payment adjustment** based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site. Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry.

Beginning in 2018, CMS added a new participation option: **Virtual Groups**. A Virtual Group is a combination of two or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) to participate in MIPS for a performance period of a year. A solo practitioner or group can only participate in one virtual group during a performance period. To be eligible to join or form a virtual group, you would need to be a:

- Solo practitioner who exceeds the low-volume threshold individually, and is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- Group that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Virtual groups participate in MIPS across all four performance categories, and are subject to the same measure and performance category requirements as other groups reporting under MIPS. Virtual groups can submit data the same ways groups can. Each virtual group would aggregate its data across its TINs for each performance category and be assessed and scored at the virtual group level.

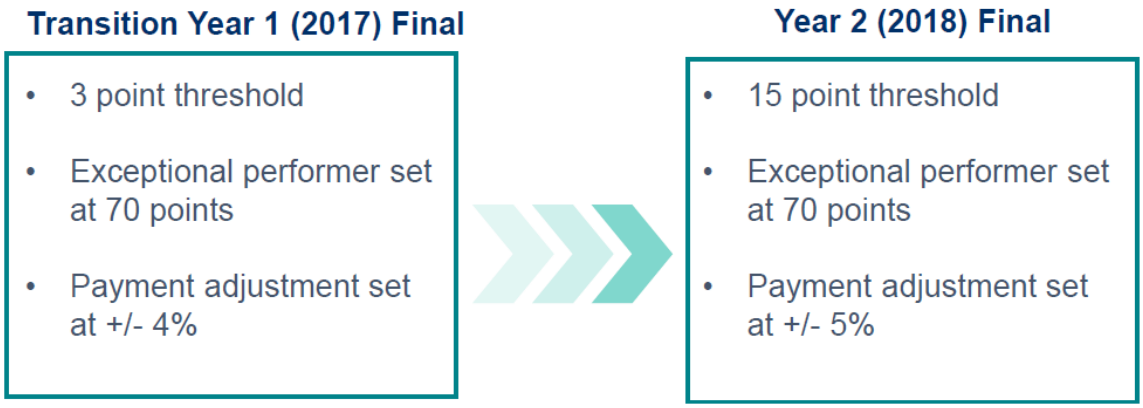
The formation of virtual groups provides for a comprehensive measurement of performance, shared responsibility, and an opportunity to effectively and efficiently coordinate resources to achieve requirements under each performance category. A small practice may elect to join a virtual group in order to potentially increase their performance under MIPS or elect to participate in MIPS as a group and take advantage of other flexibilities and benefits afforded to small practices.

Each virtual group must have a written formal agreement between each of the virtual group members before election; name an official representative; email the group's election by December 31st; include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative's contact information. Election must occur *prior* to the beginning of the performance period and cannot be chanced once the

performance period starts. The election period for 2018 was October 11 through December 31, 2017. CMS's Virtual Groups Toolkit contains more information.

Section 4. Payment Adjustments

Each of the four categories listed above are weighted and collectively form a Composite Performance Score (CPS) on a scale from 0-100. The CPS will be used to compare practices and inform payment adjustments. CMS will compare the final score to a performance threshold and determine whether a clinician or group will receive a positive, neutral, or negative payment adjustment. In 2017, the performance threshold was only 3/100 points, which enabled the majority of participating clinicians to receive a neutral or positive payment adjustment in 2019. In Year 2 (2018), CMS raised the performance threshold to 15/100 points. The payment adjustment for 2018 is set at +/- 5%.



How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	• Neutral payment adjustment
3.76-14.99	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

Section 5. Additional Resources

National Council for Behavioral Health

MACRA webpage: www.TheNationalCouncil.org/MACRA

Year 2 (2018) MACRA Fact Sheet

Capitol Connector Blog

Centers for Medicare and Medicaid Services (CMS)

CMS Year 2 (2018) Final Rule Executive Summary

Questions?
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