Quality Payment Program

2019 MEDICARE PHYSICIAN FEE SCHEDULE AND MIPS YEAR 3 PROPOSED RULES

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2019 MEDICARE PHYSICIAN FEE SCHEDULE (PFS) PROPOSED RULE

Documentation Requirements and Payment for Evaluation and Management (E/M) Visits & Advancing Virtual Care
Patients Over Paperwork

- The Patients Over Paperwork initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients’ ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.
Medical Record Documentation Supports Patient Care

• Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services.

• Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient’s health history.

• Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time.

• Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.
Documenting E/M Requires Choosing the Appropriate Code

• Currently, documentation requirements differ for each level and are informed by the 1995 and 1997 E/M documentation guidelines.

• Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type (new v. established),
  - Setting of service (e.g. outpatient setting v. or inpatient setting), and
  - Level of E/M service performed.

*CPT codes, descriptions and other data only are copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
Level of E/M Visits

- The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.

- The three key components when selecting the appropriate level of E/M services provided are **history**, **examination**, and **medical decision making**. For visits that consist predominantly of counseling and/or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.
How to Streamline E/M Payment and Reduce Clinician Burden

• Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.

• Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.

• Proposing to allow practitioners to review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

• Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.
## Proposed Payment for Office/Outpatient Based E/M Visits

<table>
<thead>
<tr>
<th>Level</th>
<th>Current Payment* (established patient)</th>
<th>Proposed Payment**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$22</td>
<td>$24</td>
</tr>
<tr>
<td>2</td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$74</td>
<td>$93</td>
</tr>
<tr>
<td>4</td>
<td>$109</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$148</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
<th>Current Payment* (new patient)</th>
<th>Proposed Payment**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$45</td>
<td>$44</td>
</tr>
<tr>
<td>2</td>
<td>$76</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$110</td>
<td>$135</td>
</tr>
<tr>
<td>4</td>
<td>$167</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$211</td>
<td></td>
</tr>
</tbody>
</table>

*Current Payment for CY 2018  
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate
Proposed Payment for Office/Outpatient Based E/M Visits

• Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).

• Proposing a **minimum documentation** standard where, for Medicare PFS payment purposes, practitioners would only need to document the information to support a level 2 E/M visit.
Proposed Additional Payment Codes

- Proposing $5 add-on payment to recognize additional resources to address inherent complexity in E/M visits associated with primary care services.
- Proposing $14 add-on payment to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.
- Proposing a multiple procedure payment adjustment that would reduce the payment when an E/M visit is furnished in combination with a procedure on the same day.
- Proposing an $67 add-on payment for a 30 minute prolonged E/M visit.
Advancing Virtual Care

• In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that support technological developments in healthcare.

• We are interested in recognizing changes in healthcare practice that incorporates innovation and technology in managing patient care.

• We are aiming to increase access for Medicare beneficiaries to physicians’ services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.
Advancing Virtual Care

• To support access to care using communication technology, we are proposing to:
  - Pay clinicians for virtual check-ins –brief, non-face-to-face assessments via communication technology;
  - Pay for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
  - Pay clinicians for evaluation of patient-submitted photos or recorded video; and
  - Expand Medicare-covered telehealth services to include prolonged preventive services.
For Further Information

See the Physician Fee Schedule website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview
• Comprised of four performance categories.

• **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*

• The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.
Merit-based Incentive Payment System (MIPS)
Timeline for 2019 Performance Year

- **Performance period** opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year
- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early
- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year
- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021
Provides additional authority to continue the gradual transition in MIPS, including:

- Changing the application of MIPS payment adjustments, so adjustments will not apply to all items and services under Medicare Part B, but will now apply only to covered professional services under the Physician Fee Schedule (PFS) beginning in 2019, which is the first payment year for MIPS.

- Changing the way MIPS eligibility is determined with respect to low-volume threshold. Beginning in 2018 (current performance period), low-volume threshold determinations are based on allowed charges for covered professional services under the PFS, not all Medicare Part B allowed charges.

- Providing flexibility in the weighting of the Cost performance category for three additional years.

- Allowing flexibility in establishing the performance threshold for three additional years to ensure gradual and incremental transition to the estimated performance threshold based on the mean or median of final scores from prior year that will apply in 6th year of program.
PROPOSED RULE FOR YEAR 3 - MIPS

Eligibility
MIPS Year 3 (2019) Proposed

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists

Year 3 (2019) Proposed

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers
MIPS Year 3 (2019) Proposed

Low-Volume Threshold Criteria

What do I need to know?

   - The Year 3 (2019) low-volume threshold determinations will only be made on covered professional services under the Physician Fee Schedule (PFS).
   - Different from the 2017 Transition Year where the low-volume threshold determinations were made on all Medicare Part B allowed charges.

2. Proposing to add a third element – Number of Services – to the low-volume threshold determination criteria.
   - The proposed criteria includes:
     • Dollar amount
     • Number of beneficiaries
     • Number of services (Newly proposed)

3. Proposing to add an opt-in option for clinicians who are excluded from MIPS.
   - This proposal gives clinicians who would have been excluded in previous years the choice to participate in MIPS.
Proposing that to be included in MIPS in Year 3 (2019), clinicians must:

1. Be a MIPS eligible clinician type

2. **Exceed all three elements** of the low-volume threshold criteria:
   - Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)
   - Furnish covered professional services to more than 200 Medicare beneficiaries
   - Provide more than 200 covered professional services under the PFS (Newly Proposed)
Proposing an opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

- MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

### MIPS Opt-in Scenarios

<table>
<thead>
<tr>
<th>Dollars</th>
<th>Beneficiaries</th>
<th>Professional Services (New-proposed)</th>
<th>Eligible for Opt-in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>No – excluded</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>No – required to participate</td>
</tr>
</tbody>
</table>
MIPS Year 3 (2019) Proposed

MIPS Determination Period

**Year 2 (2018) Final**

**Low Volume Threshold Determination Period:**
- First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out)
- Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)

**Special Status**
- Use various determination periods to identify MIPS eligible clinicians with a special status and apply the designation.
- Special status includes:
  - Non-Patient Facing
  - Small Practice
  - Rural Practice
  - Health Professional Shortage Area (HPSA)
  - Hospital-based
  - Ambulatory Surgical Center-based (ASC-based)

**Year 3 (2019) Proposed**

**Change to the MIPS Determination Period:**
- First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out)
- Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out)
- **Goal:** consolidate the multiple timeframes and align the determination period with the fiscal year.
- **Goal:** streamlined period will also identify MIPS eligible clinicians with the following special status:
  - Non-Patient Facing
  - Small Practice
  - Hospital-based
  - ASC-based

*Note: Rural and HPSA status continue to apply in 2019*

**Quick Tip:** MIPS eligible clinicians with a special status are included in MIPS and qualify for special rules. Having a special status does not exempt a clinician from MIPS.
MIPS Year 3 (2019) Proposed

Reporting Options – General

**Same** reporting options as Year 2. Clinicians can report:

1. **As an Individual**—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. **As a Group**
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

3. **As a Virtual Group** – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year
PROPOSED RULE FOR YEAR 3 - MIPS

Performance Categories
### MIPS Year 3 (2019) Proposed

#### Performance Periods

**Year 2 (2018) Final**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12-months</td>
</tr>
<tr>
<td>Cost</td>
<td>12-months</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>90-days</td>
</tr>
</tbody>
</table>

**Year 3 (2019) – No Change**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12-months</td>
</tr>
<tr>
<td>Cost</td>
<td>12-months</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>90-days</td>
</tr>
</tbody>
</table>
Basics:

- **Proposed Change**: 45% of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Bonus Points</strong></td>
<td><strong>Same requirements</strong> as Year 2, with the following change:</td>
</tr>
<tr>
<td>- 2 points for outcome or patient experience</td>
<td></td>
</tr>
<tr>
<td>- 1 point for other high-priority measures</td>
<td></td>
</tr>
<tr>
<td>- 1 point for each measure submitted using electronic end-to-end reporting</td>
<td></td>
</tr>
<tr>
<td>- Cap bonus points at 10% of category denominator</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Completeness</th>
<th><strong>Same requirements</strong> as Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 60% for submission mechanisms except for Web Interface and CAHPS</td>
<td></td>
</tr>
<tr>
<td>- Measures that do not meet the data completeness criteria earn 1 point</td>
<td></td>
</tr>
<tr>
<td>- Small practices continue to receive 3 points</td>
<td></td>
</tr>
</tbody>
</table>

Quick Tip: A small practice is defined as 15 or fewer eligible clinicians.
MIPS Year 3 (2019) Proposed
Cost Performance Category

**Basics:**

- **Proposed Change:** 15% of Final Score in 2019
- **Measures:**
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost
  - **Adding** 8 episode-based measures
  - No reporting requirement; data pulled from administrative claims
  - No improvement scoring in Year 3

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Measure Case Minimums</strong></td>
<td>Same requirements as Year 2, with the following additions:</td>
</tr>
<tr>
<td>• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB</td>
<td>• Case minimum of 10 for procedural episodes</td>
</tr>
<tr>
<td></td>
<td>• Case minimum of 20 for acute inpatient medical condition episodes</td>
</tr>
<tr>
<td><strong>Measure Attribution</strong></td>
<td>Same requirements as Year 2, with the following additions:</td>
</tr>
<tr>
<td>• Plurality of primary care services rendered by the clinician to determine attribution for the Total per Capita Cost measure</td>
<td>• For procedural episodes: CMS will attribute episodes to the clinician that performs the procedure</td>
</tr>
<tr>
<td></td>
<td>• For acute inpatient medical condition episodes: CMS will attribute episodes to clinicians who bill at least 30 percent of the inpatient evaluation and management claim during hospitalization</td>
</tr>
<tr>
<td></td>
<td>• Plurality of Part B services billed during the index admission to determination attribution for the MSPB measure</td>
</tr>
<tr>
<td></td>
<td>• Added two CPT codes to the list of primary care services used to determine attribution under the Total per Capita Cost measure</td>
</tr>
</tbody>
</table>
MIPS Year 3 (2019) Proposed

Improvement Activities Performance Category

**Basics:**

- *Proposed: 15% of Final Score in 2019*
- Select Improvement Activities and attest “yes” to completing
- Activity weights remain the same:
  - Medium = 10 points
  - High = 20 points
- Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than 2 activities to receive the highest score

**Activity Inventory**

- Adding 6 new Improvement Activities
- Modifying 5 existing Improvement Activities
- Removing 1 existing Improvement Activity

**CEHRT Bonus**

- Proposing to remove the bonus to align with the new Promoting Interoperability scoring requirements, which no longer consists of a bonus score component.*

*Contingent upon the new Promoting Interoperability scoring methodology being finalized*
MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Reporting Requirements

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Comprised of a base, performance, and bonus score</td>
<td>• Eliminate the base, performance, and bonus scores</td>
</tr>
<tr>
<td>• Must fulfill the base score requirements to earn a</td>
<td>• Propose a new performance-based scoring at the individual</td>
</tr>
<tr>
<td>Performance Interoperability score</td>
<td>measure level</td>
</tr>
<tr>
<td></td>
<td>• Must report the required measures under each Objective,</td>
</tr>
<tr>
<td></td>
<td>or claim the exclusions</td>
</tr>
</tbody>
</table>

Basics:

- **Proposed:** 25% of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology (CEHRT)** in 2019
- **Proposed:** New performance-based scoring
- **Proposed:** 100 total category points
## MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

### Objectives and Measures

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>• Two measure set options for reporting based on the MIPS eligible clinician’s edition of CEHRT (either 2014 or 2015)</td>
<td>• One set of Objectives and Measures based on 2015 Edition CEHRT</td>
</tr>
<tr>
<td></td>
<td>• Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange</td>
</tr>
<tr>
<td></td>
<td>• Add two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement</td>
</tr>
</tbody>
</table>

### Basics:

- **Proposed**: 25% of Final Score in 2019
- **Must use**: 2015 Edition Certified EHR Technology (CEHRT) in 2019
- **Proposed**: New performance-based scoring
- **Proposed**: 100 total category points
MIPS Year 3 (2019) Proposed
Promoting Interoperability Performance Category

**Scoring**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>- Fulfill the base score (worth 50%) by submitting at least a 1 in the numerator of certain measures AND submit “yes” for the Security Risk Analysis measure</td>
<td>- Performance-based scoring at the individual measure level</td>
</tr>
<tr>
<td>- Performance score (worth 90%) is determined by a performance rate for each submitted measure</td>
<td>- Each measure would be scored on performance for that measure based on the submission of a numerator or denominator, or a “yes or no”</td>
</tr>
<tr>
<td>- Bonus score (worth 10%) is available</td>
<td>- Must submit a numerator of at least one or a “yes” to fulfill the required measures</td>
</tr>
<tr>
<td>- Maximum score is 165%, but is capped at 100%</td>
<td>- The scores for each of the individual measures would be added together to calculate a final score</td>
</tr>
<tr>
<td></td>
<td>- If exclusions are claimed, the points would be allocated to other measures</td>
</tr>
</tbody>
</table>

**Basics:**

- **Proposed:** 25% of Final Score in 2019
- **Must use** 2015 Edition Certified EHR Technology (CEHRT) in 2019
- **Proposed:** New performance-based scoring
- **Proposed:** 100 total category points
**Basics:**

- **Proposed:** 25% of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology (CEHRT)** in 2019
- **Proposed:** New performance-based scoring
- **Proposed:** 100 total category points

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### Reweighting

<table>
<thead>
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<tbody>
<tr>
<td>Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs</td>
<td><strong>Same requirements</strong> as Year 2, with the following additions:</td>
</tr>
<tr>
<td>Application based reweighting also available for certain circumstances</td>
<td>• Extend the automatic reweighting to Physical Therapists, Occupational Therapists, Clinical Social Workers, and Clinical Psychologists</td>
</tr>
<tr>
<td>• Example: clinicians who are in small practices</td>
<td></td>
</tr>
</tbody>
</table>
## MIPS Year 3 (2019) Proposed
Performance Threshold and Payment Adjustments

### Year 2 (2018) Final

<table>
<thead>
<tr>
<th>Final Score 2018</th>
<th>Payment Adjustment 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>15.01-69.99 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>15 points</td>
<td>• Neutral payment adjustment</td>
</tr>
<tr>
<td>3.76-14.99 points</td>
<td>• Negative payment adjustment greater than -5% and less than 0%</td>
</tr>
<tr>
<td>0-3.75 points</td>
<td>• Negative payment adjustment of -5%</td>
</tr>
</tbody>
</table>

### Year 3 (2019) Proposed

<table>
<thead>
<tr>
<th>Final Score 2019</th>
<th>Payment Adjustment 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>30.01-79.99 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>30 points</td>
<td>• Neutral payment adjustment</td>
</tr>
<tr>
<td>7.51-29.99 points</td>
<td>• Negative payment adjustment greater than -7% and less than 0%</td>
</tr>
<tr>
<td>0-7.5 points</td>
<td>• Negative payment adjustment of -7%</td>
</tr>
</tbody>
</table>
CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance
Comments due September 10
When and Where to Submit Comments

• See proposed rule for information on submitting comments by close of 60-day comment period on September 10 (When commenting refer to file code CMS 2018-1693-P)

• Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted

• You must officially submit your comments in one of following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier