Quality Payment PROGRAM

2019 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2021 Payment Adjustment FAQs

Purpose

This document will answer key questions (with screenshots) about the MIPS performance feedback experience for practice representatives, MIPS Alternative Payment Model (APM) entity representatives, individual clinicians, and virtual group representatives.

Third party representatives such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries are not able to access your performance feedback.

Table of Contents

Each section contains frequently asked questions and supporting screenshots

- Fast Facts About Performance Feedback
- COVID-19's Impact on Performance Feedback and Payment Adjustments
- Accessing Performance Feedback
- Navigating Performance Feedback
  - Practice Representatives
  - APM Entity Representatives
  - Individual Clinicians
  - Virtual Group Representatives
- Final Score and Payment Adjustment Overview
- Quality
- Improvement Activities
- Promoting Interoperability
- Cost
- Facility-Based Scoring
- Items and Services
- Performance Feedback for APM Entities and Clinicians Scored Under the APM Scoring Standard
- General Questions
- Help & Support
- Version History
- Appendices

Have questions about a particular topic?

Click the links to jump ahead or use the "CTRL-F" function to enter key words.

Before You Begin

If you don't already have an HCQIS Authorized Roles and Profile (HARP) account or access to your organization on qpp.cms.gov, you will need to create an account, request access, and wait to be approved.

- More information is available in the QPP Access User Guide

Please note that due to a mandatory federal-wide security update, you will need a CMS supported version of Firefox or Chrome to access qpp.cms.gov. You may encounter errors if you use a different web browser.

- **Please update your browser to at least Firefox v47 or Chrome v69 or newer**

Fast Facts about Performance Feedback

What is Performance Feedback?

Performance feedback is a summary of the data you've submitted to us and that we collected on your behalf. Feedback includes:

- Measure-level performance data and scores
- Activity-level scores
- Performance category-level scores and weights
- Final score
- Payment adjustment information

Who Receives Performance Feedback and Payment Adjustment Information?

- **MIPS eligible clinicians** (including those who opted-in to MIPS participation during the submission period) will receive performance feedback and payment adjustment information for **each associated practice at which they were eligible**
- **Practices that were eligible and submitted data as a group** (including those who opted-in to MIPS participation during the submission period) will receive performance feedback and payment adjustment information
- **Virtual groups** will receive performance feedback and payment adjustment information
- **Alternative Payment Model (APM) Entities and clinicians scored under the APM scoring standard** will receive performance feedback and payment adjustment information
- Clinicians and groups that **voluntarily reported** will not receive a payment adjustment but will have performance feedback, as long as they are found in our eligibility information (i.e. billed Medicare Part B claims under that TIN or TIN/NPI combination between 10/1/2018 and 9/30/2019).

Who Does Not Receive Performance Feedback?

- Qualifying APM Participants (QPs)
- Partial QPs who did not elect to participate in MIPS

***Please note**: All screenshots are for illustrative purposes only.*
Screenshots do not represent real clinicians, organizations, or payment adjustments.

How Do I Access Performance Feedback?

- Sign in to qpp.cms.gov
- Select Performance Feedback from the home page
- Select your organization (Practice, APM Entity, Virtual Group)
    - Practice representatives can access both individual and group feedback through the practice organization

What If There is an Error with Our Performance Feedback and Payment Adjustment?

If you believe there is an error in your performance feedback and payment adjustment, you can request a Targeted Review. More information on that process is available in the 2019 Targeted Review User Guide.

COVID-19's Impact on Performance Feedback and Payment Adjustment

We extended our **automatic extreme and uncontrollable circumstances policy** to all MIPS eligible clinicians in response to the 2019 Novel Coronavirus (COVID-19) pandemic. This policy only applies to clinicians participating in MIPS as individuals.

- Clinicians who did not submit any data, or who only submitted data in one performance category, will automatically receive a neutral payment adjustment in 2021.
- Any performance category for which an individual clinician did not submit data is weighted at 0% for the 2019 performance year.
- Because there is no data submission, the Cost performance category is always weighted at 0% for individual clinicians under the automatic extreme and uncontrollable circumstances policy.
- Appendix A outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.

We also reopened our **extreme and uncontrollable circumstances application** to clinicians, groups, and virtual groups.

- Approved applications will reweight performance categories to 0% and void any previously submitted data.
- Appendix B outlines performance category weights and payment adjustment implications based on the performance categories selected in approved applications.

How does the neutral payment adjustment assigned to all MIPS eligible clinicians who did not submit data affect the 2021 payment adjustment for those who did submit data?

The MIPS automatic extreme and uncontrollable policy does not affect the Quality Payment Program's budget neutrality requirement. MIPS payment adjustments are required by law to be budget neutral. Generally stated, this means that the projected negative payment adjustments must be balanced by the projected positive payment adjustments. We understand that a lower than expected positive payment adjustment may be disappointing, however it's critical that we support every clinician's ability to focus on caring for patients impacted by the COVID-19 pandemic.

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Accessing Performance Feedback

How can I access my/our MIPS performance feedback?

You can access your performance feedback through the Quality Payment Program website by signing in with the same credentials that allowed you to submit and view data during the submission period.

If you don't have an account or role for your organization, refer to the following resources for information on creating an account and requesting a role for your organization. (Note, we've updated the workflow for some of these actions to improve your experience since these videos were recorded.)

- QPP Access User Guide
- How to Create a QPP Account video
- Connect to an Organization: Practice video
- Connect to an Organization: APM Entity video
- Connect to an Organization: Virtual Group video
- Request the Clinician Role video

See Appendix C for more information about what you can and can't view in performance feedback based on your credentials.

I am a clinician. What is the best way for me to access my performance feedback and payment adjustment?

We've added a **Clinician role** that will let you view your performance feedback for all of your associated practices without requesting access to each practice or gaining access to information about other clinicians in your practice.

If you're a clinician in a MIPS APM, this role also lets you directly access performance feedback based on the APM scoring standard.

Please review the **Register for a HARP Account** and **Connect as a Clinician** documents in the QPP Access User Guide.

Can third-party intermediaries access performance feedback?

Performance feedback preview can only be accessed by authorized group or practice representatives. CMS does not grant direct access to performance feedback for vendors or other third-party intermediaries because it will contain sensitive information, including payment and beneficiary information.

Vendors who have an account and a role for their Registry (or QCDR) organization can still access their dashboard and view the measures and activities they submitted on behalf of their clients, and the related scoring information. However, they will **not** see:

- Data submitted directly by their client or by another third-party intermediary;
- Quality or cost measures CMS calculated from administrative claims;
- Patient-level information for the administrative claims' measures;
- Final score information; or
- Payment adjustment information.

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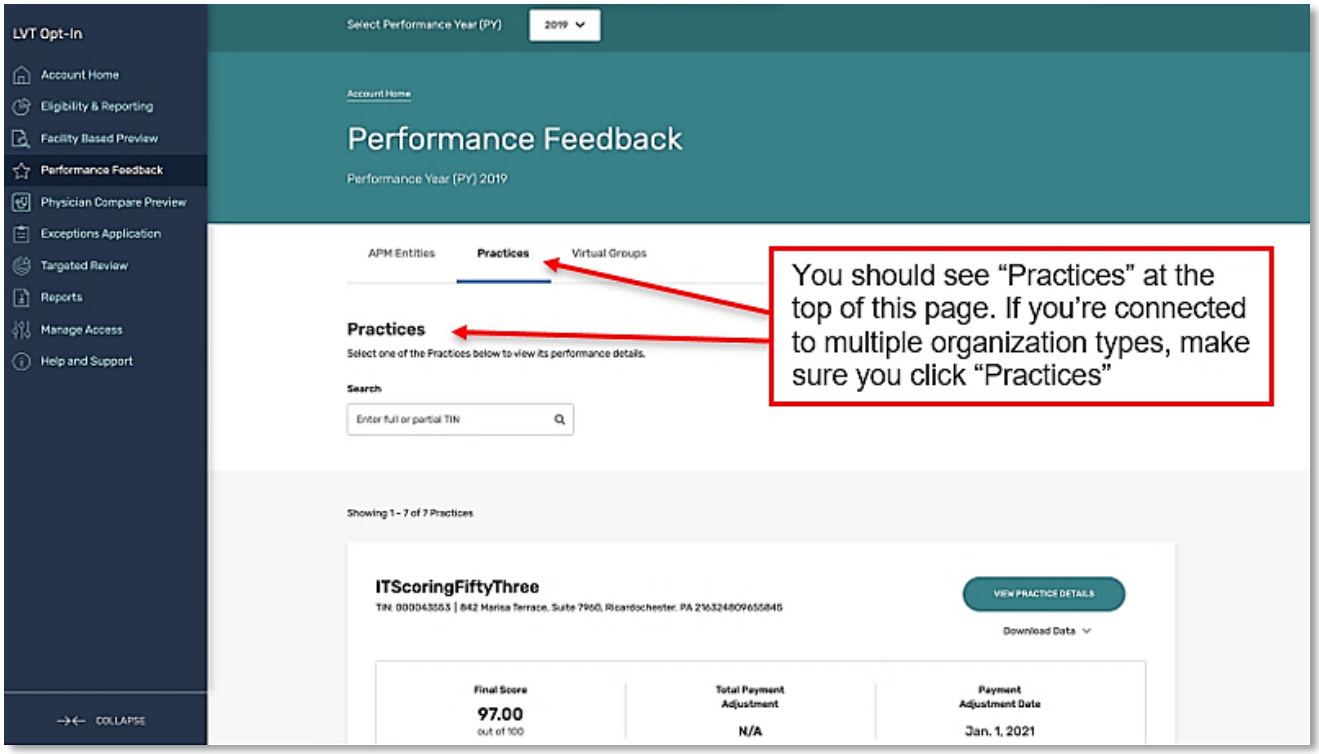
To view their clients' performance feedback, vendors would need a QPP Account and to submit a request for a role for each practice (TIN), virtual group, or APM Entity they represent. The Security Official for each organization would then need to approve the request, authorizing the vendor to access performance feedback. If the request is approved, they would be able to access that client's performance feedback.

Navigating Into Performance Feedback: Practice Representatives

This section assumes you have either the Staff User or Security Official role for a **Practice** organization. (This is distinct from access to a Virtual Group and/or APM Entity organization.)

From Performance Feedback, select View Practice Details to access group-level or clinician-level performance feedback.



You can also select Download Data to access:

- Your Submission Data (data submitted for your entire practice, which may or may not contribute to your final score);
- Your Connected Clinician List; and
- Payment Adjustment Information for the clinicians in your practice

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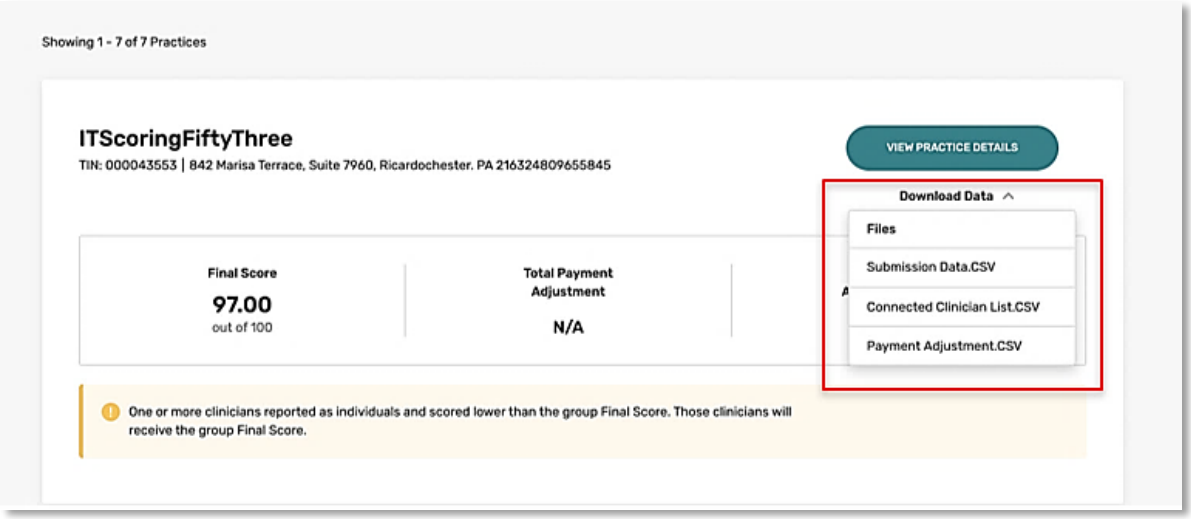
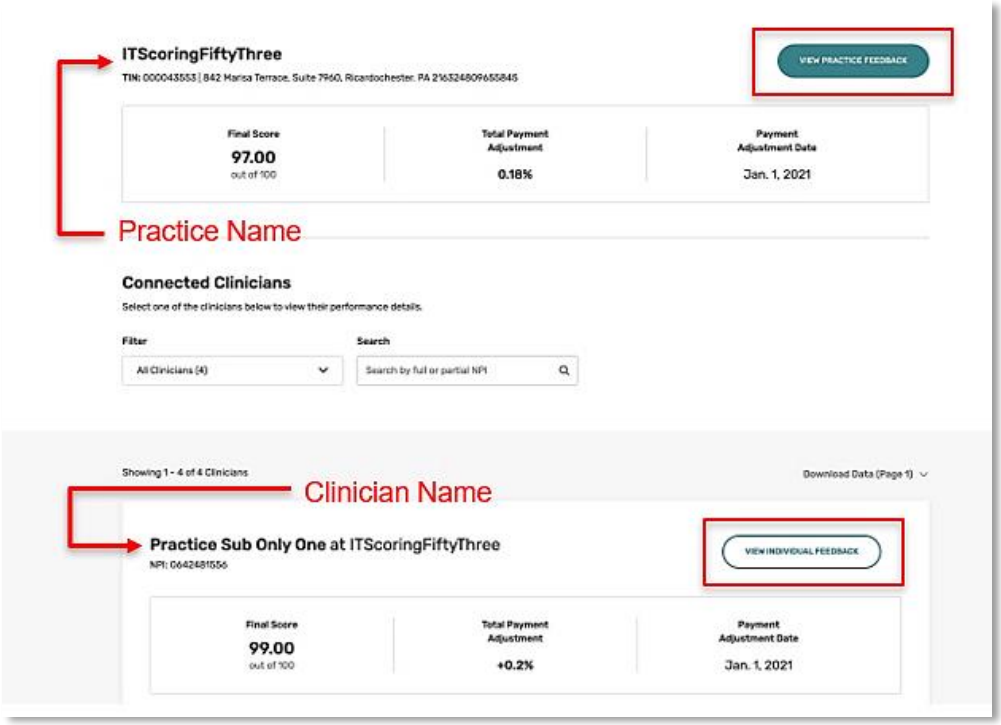
Select **View Practice Feedback** to the right of the practice's name to access performance feedback and payment adjustment information based on the group's aggregated data.



Select **View Individual Feedback** to the right of the clinician's name to access performance feedback and payment adjustment information based on an individual clinician's data.



Continue with these Frequently Asked Questions or Skip Ahead to walk through the rest of your feedback.

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Our practice did not participate/submit data as a group. What will we see in performance feedback?

If your practice did not submit data as a group for the 2019 performance period, you will see a message indicating that your clinicians only reported as individuals:

- "All clinicians in this practice reported as individuals. They will each receive a separate Final Score."

You can View Individual Feedback for each Connected Clinician.

If your practice didn't submit data but could be scored as a group on one or more cost measures, you may still see a final score and payment adjustment assigned to the group. This score and payment adjustment will only be applied to individually eligible clinicians who didn't have a higher final score from individual participation. When individual data was submitted by or on behalf of clinicians in your practice, you'll see a message indicating that these clinicians will receive their higher individual score.

We recommend that you review the Payment Adjustment CSV (select "Download" to the right of the practice name and score), a summary of the payment adjustments earned by clinicians in your practice, to validate the expected final score and payment adjustment for each MIPS eligible clinician at your practice who participated in MIPS as an individual. You can also filter your connected clinician list by "Receiving Group Score". This list will only display clinicians who were individually eligible and who did not have a higher score through individual data submission.

What is a 'Connected Clinician' and who is included in this list?

Connected clinicians are all clinicians (NPIs) associated with your practice (TIN) through Medicare Part B claims billed between 10/1/2018 and 12/31/2019 regardless of their individual MIPS eligibility. This list appears when you select '**Performance Feedback**' (from the home page or left-hand navigation), under the link to any group-level feedback.

We participate in a MIPS APM/ We have clinicians who participate in a MIPS APM. What kind of performance feedback will we see?

You will see performance feedback based on the data your practice submitted to QPP at the group or individual level.

Final MIPS APM performance feedback is available to the APM Entity and to the individual clinicians scored under the APM scoring standard (with the appropriate permissions). No APM scoring information will be available to Practice representatives (including ACO Participant TINs) with clinicians scored under the APM scoring standard.

We participate in a virtual group. Why don't I see our performance feedback?

Representatives of solo practitioners and practices participating in a virtual group must have a staff user role connected to the virtual group to access the virtual group's performance feedback. These permissions are different than the ones that let you access information specific to your practice. Please review the ***Connect to an Organization*** document in the QPP Access User Guide.

Any data submitted by individual clinicians, solo practitioners, or practices within the virtual group will be considered voluntary and not eligible for a payment adjustment.

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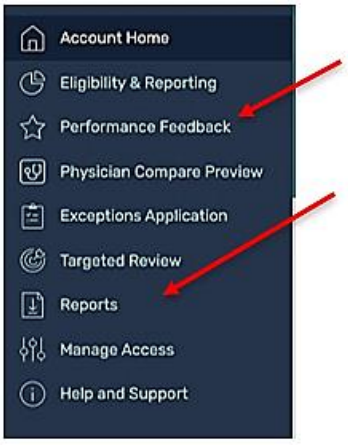
What's the difference between the Performance Feedback and Reports tabs?

Some practice representatives may notice a new tab in their left-hand navigation panel.



You will access your 2019 MIPS performance feedback through the **Performance Feedback** tab.

The **Reports** tab is where some practices will find:

- 2019 CAHPS for MIPS survey results (which groups can also access through performance feedback)
- 2020 Cost Field Measure Test Reports (these are currently planned to be available late Summer and aren't related to MIPS performance feedback; more information will be available on the MACRA Feedback Page, beginning August 17, 2020.

Navigating into Performance Feedback: APM Entity Representatives

This section assumes you have either the Staff User or Security Official role for an **APM Entity** organization. (This is distinct from access to a Practice and/or Virtual Group organization.)

The following models are able to review 2019 MIPS performance feedback, based on the APM scoring standard, if applicable and available:

- Shared Savings Program ACO
- Next Generation ACO
- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Independence at Home Demonstration
- Maryland Total Cost of Care (TCOC)
- Vermont All Payer ACO
- Oncology Care Model (OCM)

From Performance Feedback, select **View APM Entity Details** to access APM Entity-level performance feedback.

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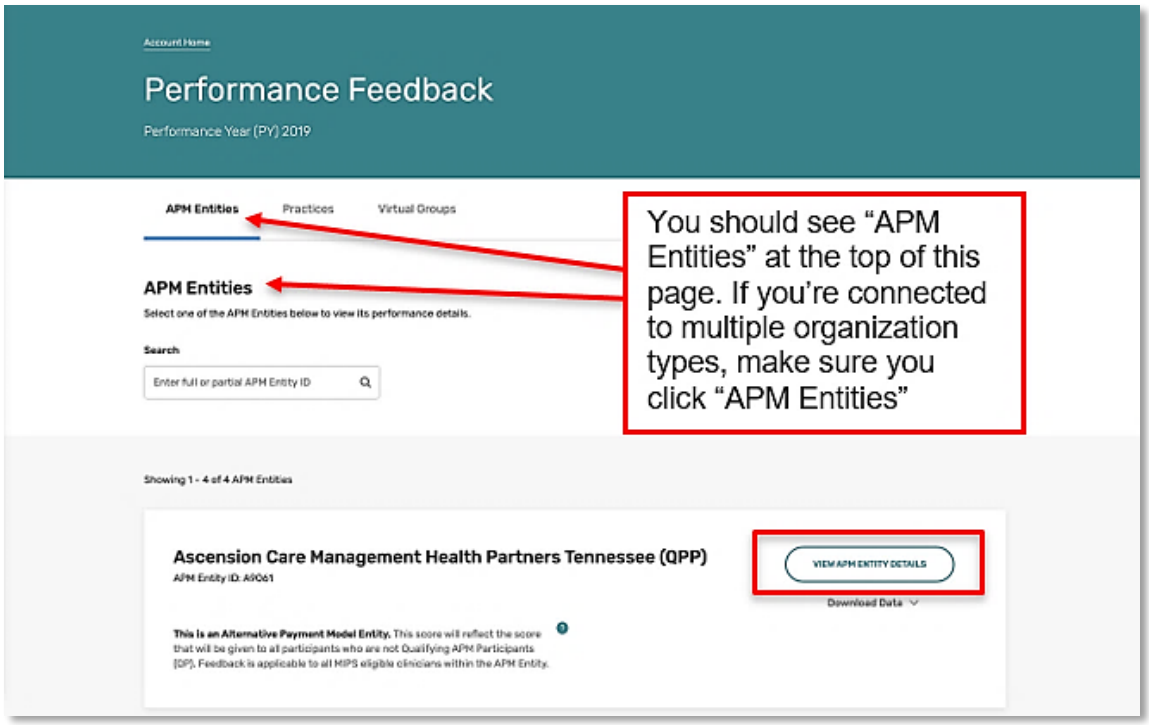

Continue with these Frequently Asked Questions or Skip Ahead to walk through the rest of your feedback. You can also click here for more information about which performance categories are included in your performance feedback, based on your model.

Can I access a list of the clinicians associated with our APM entity?

Yes. You can download this list by clicking the "View Participant Eligibility" link from the

Eligibility & Reporting tab. Once you land on the Participating Practices screen, you can click on the link that says, "Download participant list" for a list of all Participating Practices and Clinicians associated with the APM Entity. You can also click "Clinician Eligibility" for any of the practices to view the clinicians within that practice.

What should I expect to see in feedback?

Users with access to the APM Entity (i.e. a Staff User or Security Official role for the APM Entity organization) will be able to see payment adjustment information, plus the APM Entity's final score, and performance category scores (Quality, Improvement Activities, Promoting Interoperability as applicable). They can also access all of the individual or group Promoting Interoperability scores that contributed to the APM Entity's Promoting Interoperability score.

You will also be able to see scoring information for individual Quality measures if you represent a Medicare Shared Savings Program ACO or Next Generation ACO. Model specific information is available here.

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Can individual clinicians view our APM Entity feedback?

Yes. Final MIPS APM performance feedback and payment adjustment information is available to the APM Entity and to the individual clinicians scored under the APM scoring standard. The individual clinician will need to be approved for the clinician role or be approved as a staff user by the APM Entity.

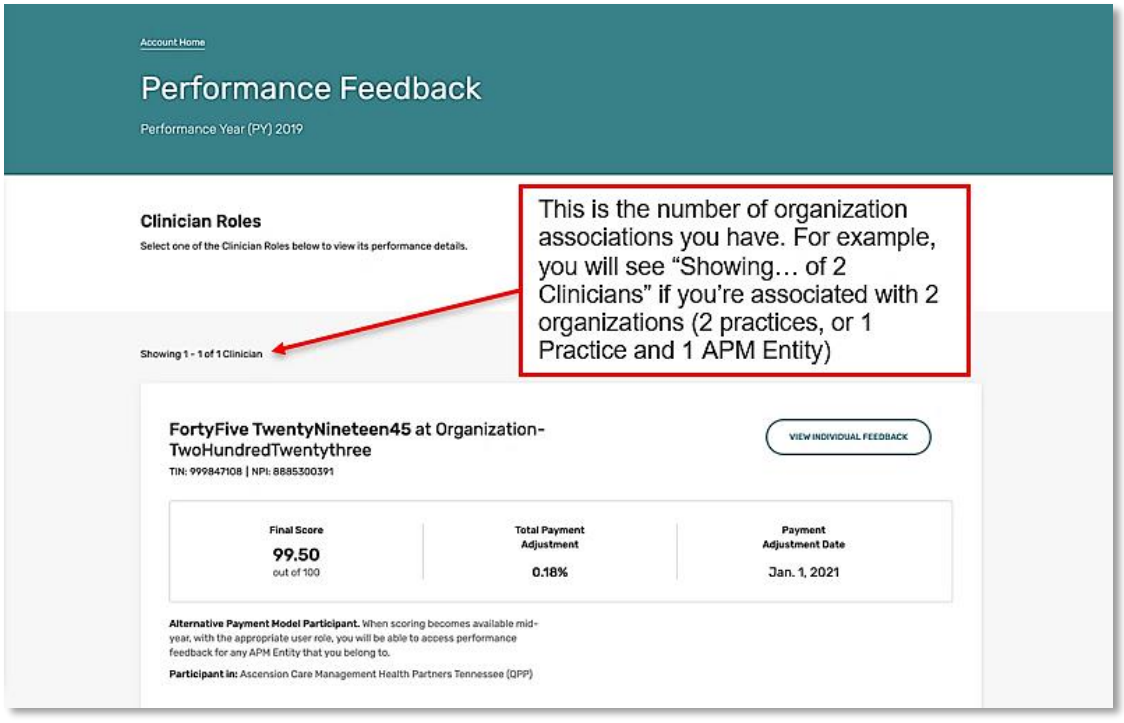
Representatives of participant TINs and practices with clinicians scored under the APM scoring standard will not be able to access the APM Entity's performance feedback unless they have been approved as a staff user by the APM Entity.

Navigating into Performance Feedback: Individual Clinicians

Note: This section assumes you have the Clinician role. (This is different from the Staff User role for a Practice, APM Entity or Virtual Groups.

From the performance feedback page, you will see a list of all your associated organizations (Practices, APM Entities, and Virtual Groups).

Select **View Individual Feedback** to access your performance feedback and payment adjustment information associated with this organization. Your feedback at an organization may be based on individual, group or MIPS APM participation.



Continue with these Frequently Asked Questions or Skip Ahead to walk through the rest of your feedback.

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How do I identify my associated organizations in Performance Feedback?

You should see the same associations on the Performance Feedback tab as you see for PY 2019 in the QPP Participation Status Tool. Click **View Individual Feedback** to see performance feedback, including your final score and payment adjustment, as well as any individual data you may have submitted. (See below.)

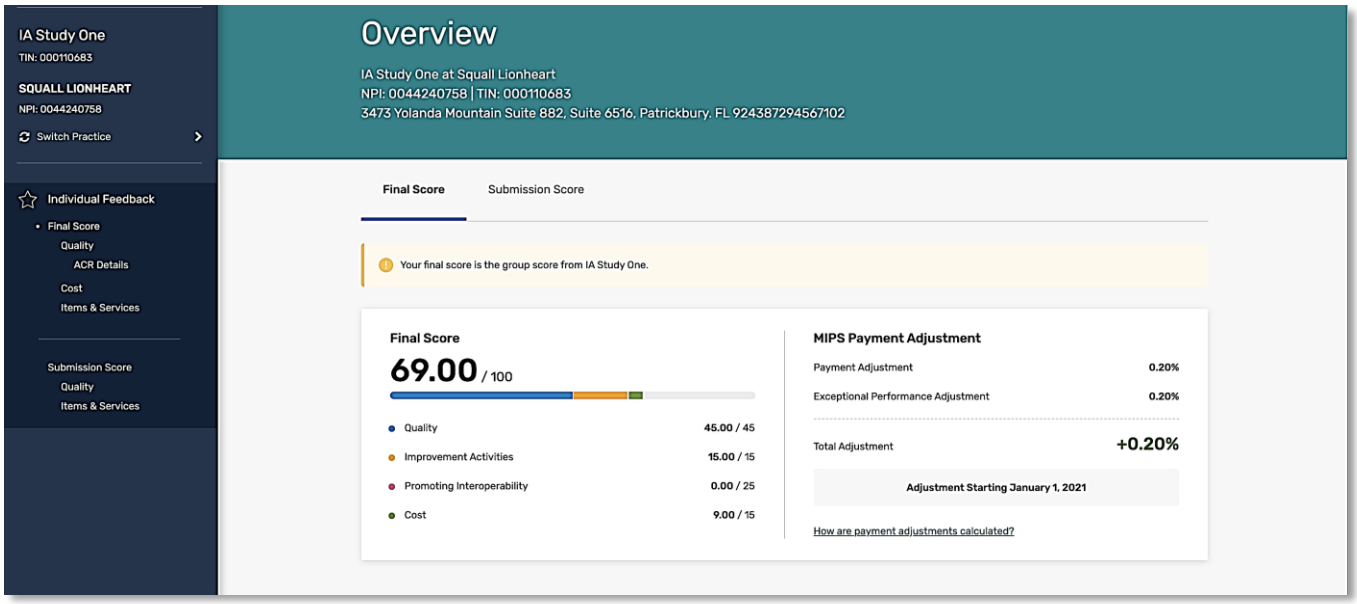
I have the Clinician Role and see both a Final Score and a Submission Score in my individual feedback. What is the difference?

These tabs appear for clinicians who submitted individual data in addition to (or as part of) the data used to determine their final score. (If there is only one submission associated with your TIN/NPI combination, you won't see these tabs and will only see performance feedback for the data used to determine your final score.)

The Final Score tab provides feedback on the data that will be used to determine your payment adjustment under that TIN/NPI combination. The Submission Score tab provides feedback on individual data you submitted (or was submitted on your behalf) under that TIN/NPI combination.

Let's look at an example. "Squall Lionheart" is in a practice that reported as a group and she also reported some data as an individual.

- The **Final Score** tab displays the group's final score and performance feedback because that is the higher of the 2 scores attributed to her under this TIN/NPI combination.
- The **Submission Score** tab will display performance feedback based on any individual (TIN/NPI level) data she submitted.



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I am a MIPS APM participant, and scored under the APM scoring standard. What should I expect to see?

Once you have the Clinician role, you will be able to see the payment adjustment plus the APM Entity's final score, MIPS performance category scores (Quality, Improvement Activities, Promoting Interoperability as applicable), and your individual Promoting Interoperability score.

You will also be able to see scoring information for individual Quality measures if you participate in a Medicare Shared Savings Program ACO, Next Generation ACO or Comprehensive Primary Care Initiative Plus (CPC+) practice because these APM entities submit their quality measures to QPP. Model specific information is available here.

If you participate in multiple MIPS APMs, you will be able to view MIPS performance feedback for each APM Entity for which you were included on the MIPS APM participation list (based on APM snapshot dates). Your MIPS payment adjustment will be based on the APM Entity with the highest payment adjustment. You can also contact the Quality Payment Program to find out how the MIPS payment adjustment will apply to them.

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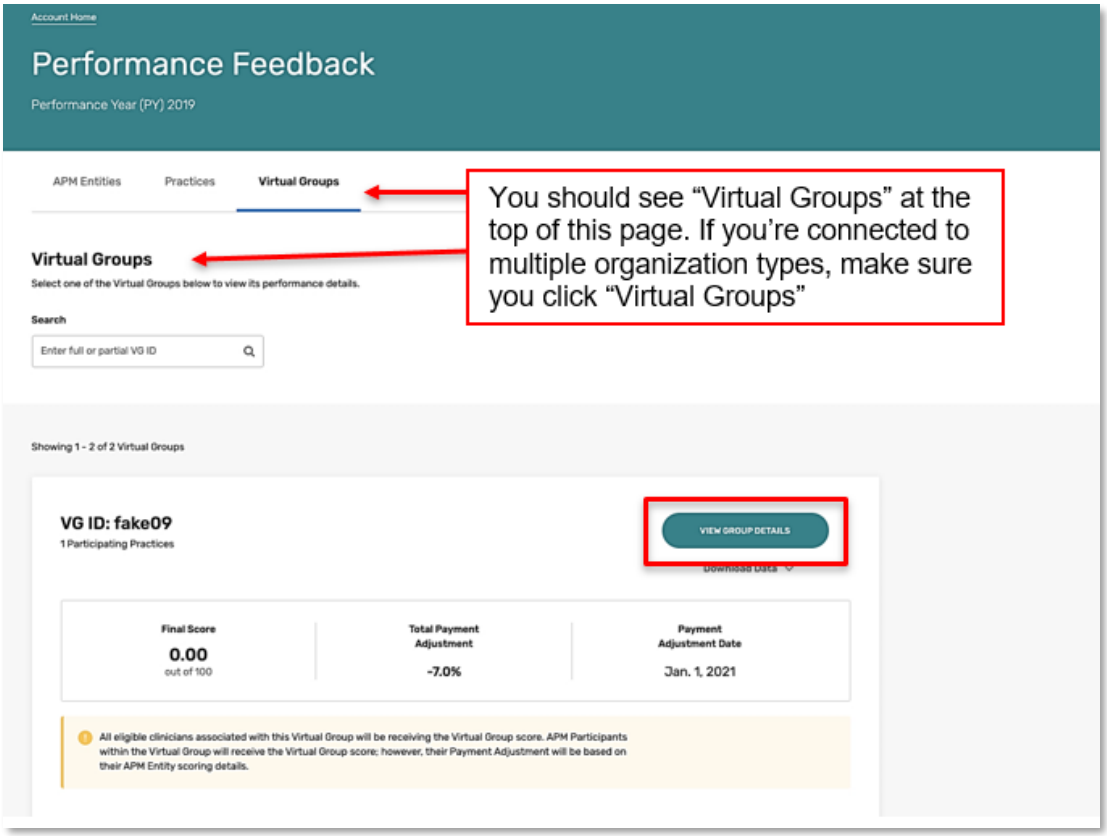
Navigating Performance Feedback: Virtual Group Representatives

This section assumes that you have either the Staff User or Security Official role for a **Virtual Group** organization. (This is distinct from access to a Practice and/or APM Entity organization.)

From Performance Feedback, select **View Group Details** to access virtual group-level performance feedback.



Continue with these Frequently Asked Questions or Skip Ahead to walk through the rest of your feedback.

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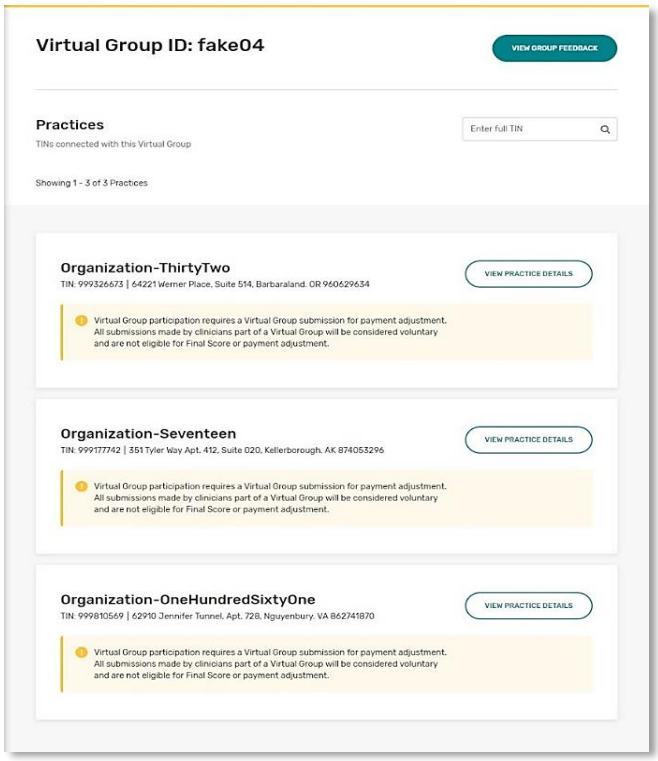
Can the practices and/or solo practitioners who participate in our virtual group access our performance feedback?

Yes, if they have an approved Staff User role for your virtual group. This means they connected to your virtual group organization and requested the staff user role; these permissions are different than the ones that let them access information specific to their practice. For more information, review the ***Connect to an Organization*** document in the QPP Access User Guide.

Can I access a list of the clinicians participating in our virtual group?

Yes. You can access a list of clinicians associated with each practice in the virtual group. Select **View Practice Details** next to each practice name.



We have clinicians in our virtual group who participate in a MIPS APM. What kind of performance feedback will we see?

You will see performance feedback based on the data you submitted to QPP at the virtual group level. Beginning with 2018 performance feedback, we will make final MIPS APM performance feedback available to the APM Entity and to the individual clinicians scored under the APM scoring standard. No APM scoring information will be available to a virtual group with clinicians scored under the APM scoring standard.

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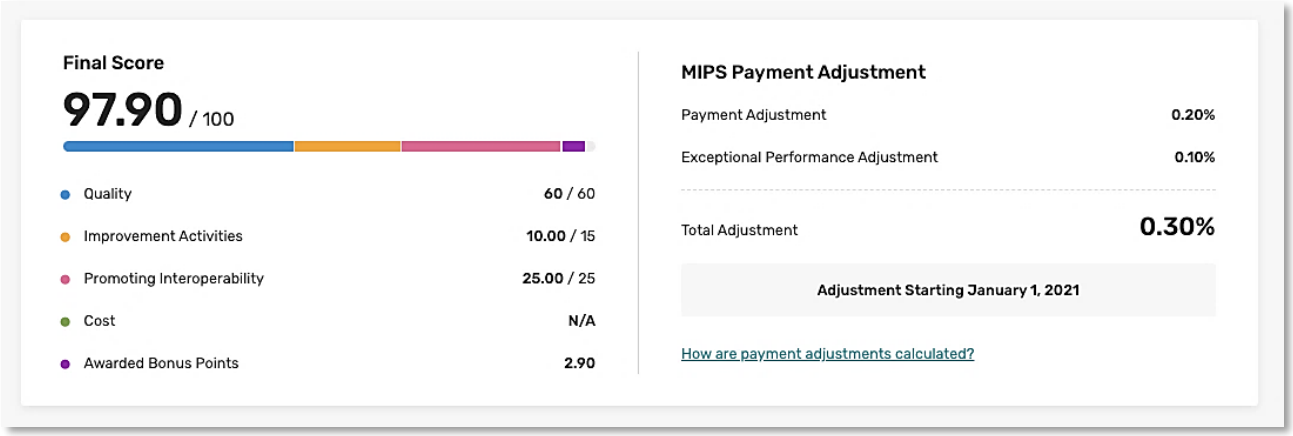
Overview: Final Score and Payment Adjustment

When you navigate into feedback, you will land on the Overview page. From here, you can access:

- Your final score
- Your score and the weight for each MIPS performance category
- Your payment adjustment(s) information

How is the final score determined?

Your final score is the sum of your performance category scores and any points awarded for the complex patient bonus (reflected as **Awarded Bonus Points**).



Note: Representatives of some Medicare Shared Savings Program ACOs may see two tabs above their final score referring to different 6-month periods (January 1 – June 30, 2019 and July 1 – December 31, 2019). Click here for more information.

Select View Details on the performance category cards to access category-level feedback.

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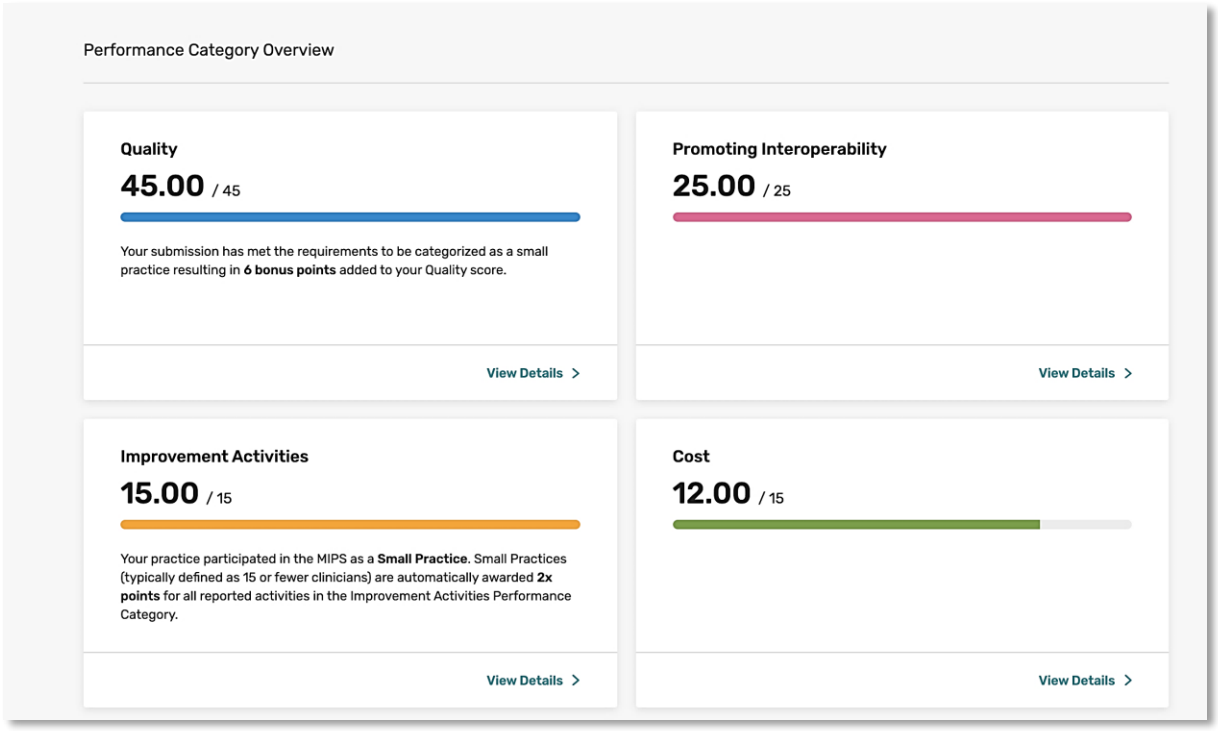

Who gets the 2021 MIPS payment adjustment(s) that I see in performance feedback?

The payment adjustment information is specific to the final score that is being viewed.

If you are viewing performance feedback for a **practice** (aggregated data for the entire group):

- This is the payment adjustment that will be applied to payments for covered professional services furnished in 2021 by the MIPS eligible clinicians in your Connected Clinicians list **unless**:
  - They are individually eligible and have a higher payment adjustment from an individual submission under your practice,
  - They participate in a MIPS APM and are scored with their APM Entity, OR
  - They are Qualifying APM Participant (QP) or Partial QP that didn't elect to participate in MIPS.

Your practice's Connected Clinicians list includes those clinicians who started billing Part B claims under your practice's TIN between 10/1/2019 and 12/31/2019.

If you are viewing performance feedback for an **APM Entity** with clinicians scored under the APM scoring standard:

- This is the payment adjustment that will be applied to payments for covered professional services furnished in 2021 by the MIPS eligible clinicians in the APM Entity, **unless** they have a higher payment adjustment from participation in a different MIPS APM.

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If you are viewing performance feedback for an **individual** (not scored under the APM scoring standard):

- This is the payment adjustment that will be applied to payments for covered professional services furnished in 2021 by that MIPS eligible clinician **unless** he or she has a higher payment adjustment based on a group submission from your practice.

If you are viewing performance feedback for a **virtual group** (aggregated data for the entire virtual group):

- This is the payment adjustment that will be applied to payments for covered professional services furnished in 2021 by the MIPS eligible clinicians in your Connected Clinicians list.
- You can access the Connected Clinicians list for each practice in your virtual group.

For group, virtual group and MIPS APM participation, **MIPS eligible clinicians** includes clinicians who did not exceed the low-volume threshold as individuals but are not otherwise excluded from MIPS based on their:

- Clinician type/ specialty
- Medicare enrollment date
- Reaching QP thresholds if they are in an Advanced APM

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How does my payment adjustment relate to my final score?

Payment adjustments are determined on a sliding scale based on your final score.

Final Score	Payment Adjustment
75.00 – 100.00 points (Additional performance threshold = 75.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
30.01 – 74.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
30.00 points (Performance threshold = 30.00 points)	Neutral MIPS payment adjustment (0%)
7.51 – 29.99	Negative MIPS payment adjustment (between 0% and -7%)
0 – 7.50 points	Negative MIPS payment adjustment of -7%

Why is our payment adjustment low when our final score is high?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires MIPS to be a budget neutral program, which generally stated means that the projected negative adjustments must be balanced by the projected positive adjustments. The magnitude of the payment adjustment amount is influenced by two factors: the performance threshold and the distribution of final scores in comparison to the performance threshold in a given year. (The low-volume threshold, which is used to determine eligibility for the program, does not factor into the magnitude of the payment adjustment.)

The modest positive payment adjustment you see is a result of high participation rates in combination with a high percentage of participating clinicians earning a final score well above the relatively low performance threshold of 30 points. With many clinicians successfully participating, the distribution of positive adjustments is spread across many more people. This year's distribution was further affected by the flexibilities we introduced to reduce burden on those clinicians on the front lines of the COVID-19 response. By extending the automatic extreme and uncontrollable circumstances policy to all MIPS eligible clinicians, clinicians who did not submit any data will receive a neutral payment adjustment instead of the maximum negative adjustment.

We understand that a lower than expected positive payment adjustment may be disappointing, however it's critical that we support every clinician's ability to focus on caring for patients impacted by the COVID-19 pandemic.

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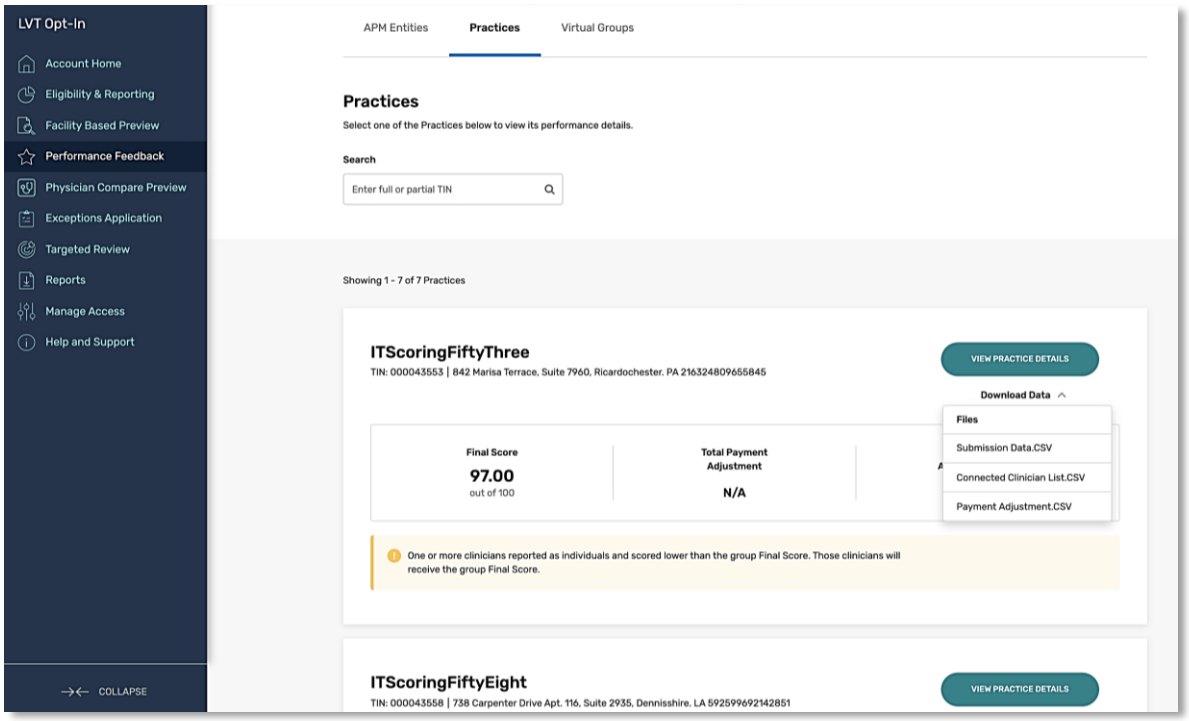
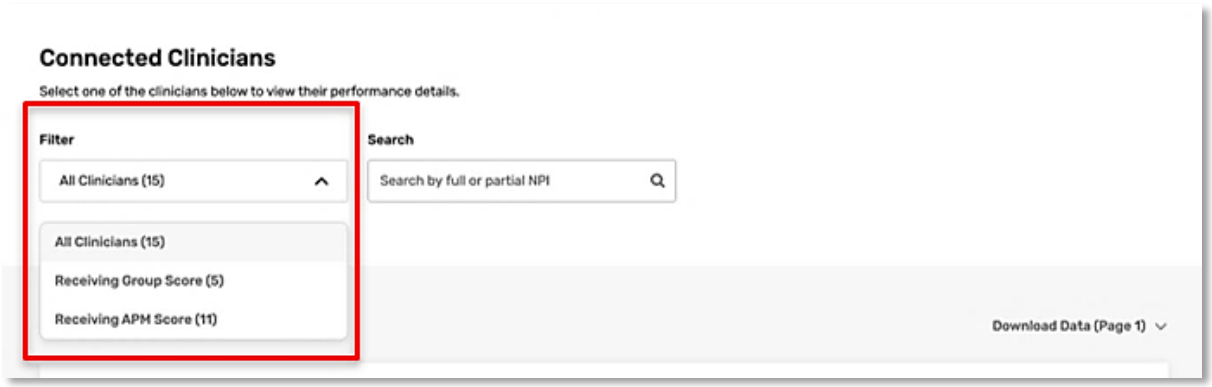
Is there a way for me to see a list of the final scores and payment adjustments for all the MIPS eligible clinicians in my practice?

Yes. From the **Performance Feedback** tab, select “Payment Adjustment CSV” from the **Download Data** menu under the **View Practice Details** button.



You can also filter your Connected Clinicians list once you have clicked **View Practice Details**. The list defaults to showing **All Clinicians**.



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Receiving Individual Score (not shown in list on the previous page)

- Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on their individual reporting

Receiving Group Score

- Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the group's reporting

Receiving APM Score

- Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the APM Entity reporting under the APM scoring standard

We didn't report as a group, why do I see a final score and payment adjustment?

If your practice didn't submit data but could be scored as a group on one or more cost measures, you may still see a final score and payment adjustment assigned to the group. This score and payment adjustment will only be applied to individually eligible clinicians who didn't have a higher final score from individual participation. When individual data was submitted by or on behalf of clinicians in your practice, you'll see a message indicating that these clinicians will receive their higher individual score.

We recommend that you review the Payment Adjustment CSV (select "Download" to the right of the practice name and score), a summary of the payment adjustments earned by clinicians in your practice, to validate the expected final score and payment adjustment for each MIPS eligible clinician at your practice who participated in MIPS as an individual. You can also filter your connected clinician list by "Receiving Group Score". This list will only display clinicians who were individually eligible and who did not have a higher score through individual data submission.

Why do I see "N/A" for one or more performance categories?

When you see N/A instead of a score for a performance category, this means that the category was reweighted to 0% of your final score.

- MIPS eligible clinicians who submitted some data as individuals will see N/A for every performance category for which they did not submit data (due to the automatic extreme and uncontrollable circumstances triggered by the COVID-19 pandemic).
- MIPS eligible clinicians, groups and virtual groups will see N/A for every performance category they selected in an approved COVID-19 extreme and uncontrollable circumstances application

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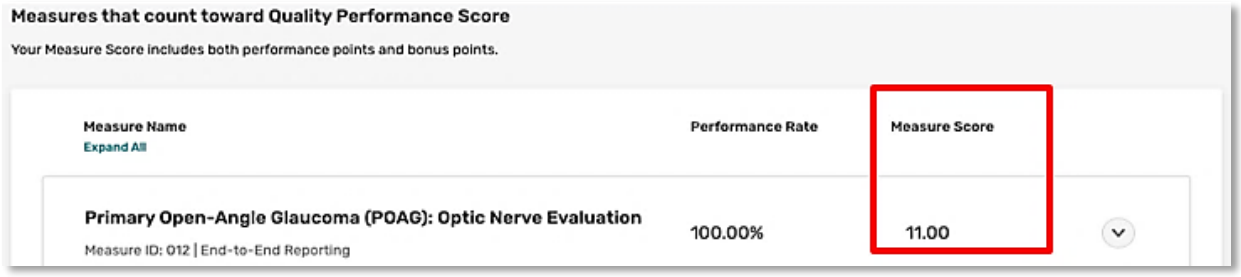
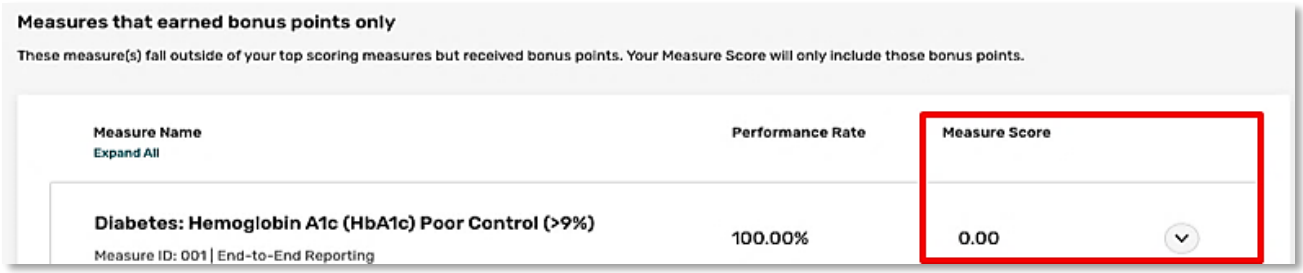
Quality

When you navigate into the Quality section, you may see quality measures divided in up to 3 groups:

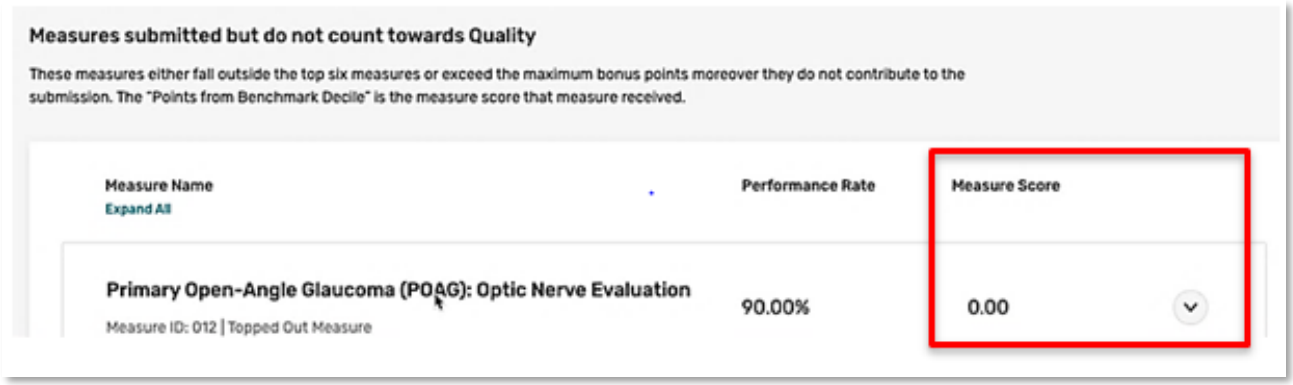
1. Measures whose performance points and bonus points count toward your Quality performance category score. The measure score will display the sum of your performance and bonus points.



2. Measures whose bonus points contribute to your Quality performance category score. You will see “0.00” in the measure score but if you click the arrow to the right, you can see the bonus points earned by these measures.



3. Measures that contribute no points to your Quality performance category score. You will also see a “0.00” in the measure score.



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We submitted more than 6 measures. How did you determine which ones counted towards our Quality performance category score?

If you submitted more than 6 measures, only 6 of those measures will contribute measure achievement points to your Quality performance category score. However, we will include any bonus points from the remaining measures, as long as you have not exceeded the 10 percent cap for the applicable bonus.

When determining which measures are included in the top 6:

- We will select the highest scoring outcome measure.
    - If you didn't have an outcome measure available, then we will select the highest scoring high priority measure.
- We will then select the next 5 highest scoring measures.
- If you didn't submit an outcome or high priority measure, we selected your 5 highest scoring measures and you will receive a score of 0/10 for the missing outcome or high priority measure unless the Eligible Measure Applicability (EMA) process found you didn't have one available.

When there are multiple measures with the same score, we will select measures for the top 6 based on the measure ID (in ascending order).

Example: You submit 7 measures, and your 2 lowest scoring measures (after the required outcome measure) were the Colorectal Cancer Screening and Screening Colonoscopy Adenoma Detection Rate measures, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top six because its measure ID (113) has a lower value than the Adenoma Detection Rate measure (343).

If you submit the same measure through multiple collection types—e.g. as a Medicare Part B claims measure and as an eCQM—we will select the higher scoring version of the measure based on achievement points. Under no circumstances will two versions of the same measure count towards your Quality performance category score.

What does it mean when I see a measure score of '--"?

If you reported through the CMS Web Interface, you will see '--' as the Measure Score for measures that were excluded from scoring because there is no benchmark, or because you did not meet case minimum.

How can I access details about the measures I submitted?

Click the arrow to the right of the measure score to expand and view the measure details such as measure type, numerator, denominator, and data completeness.

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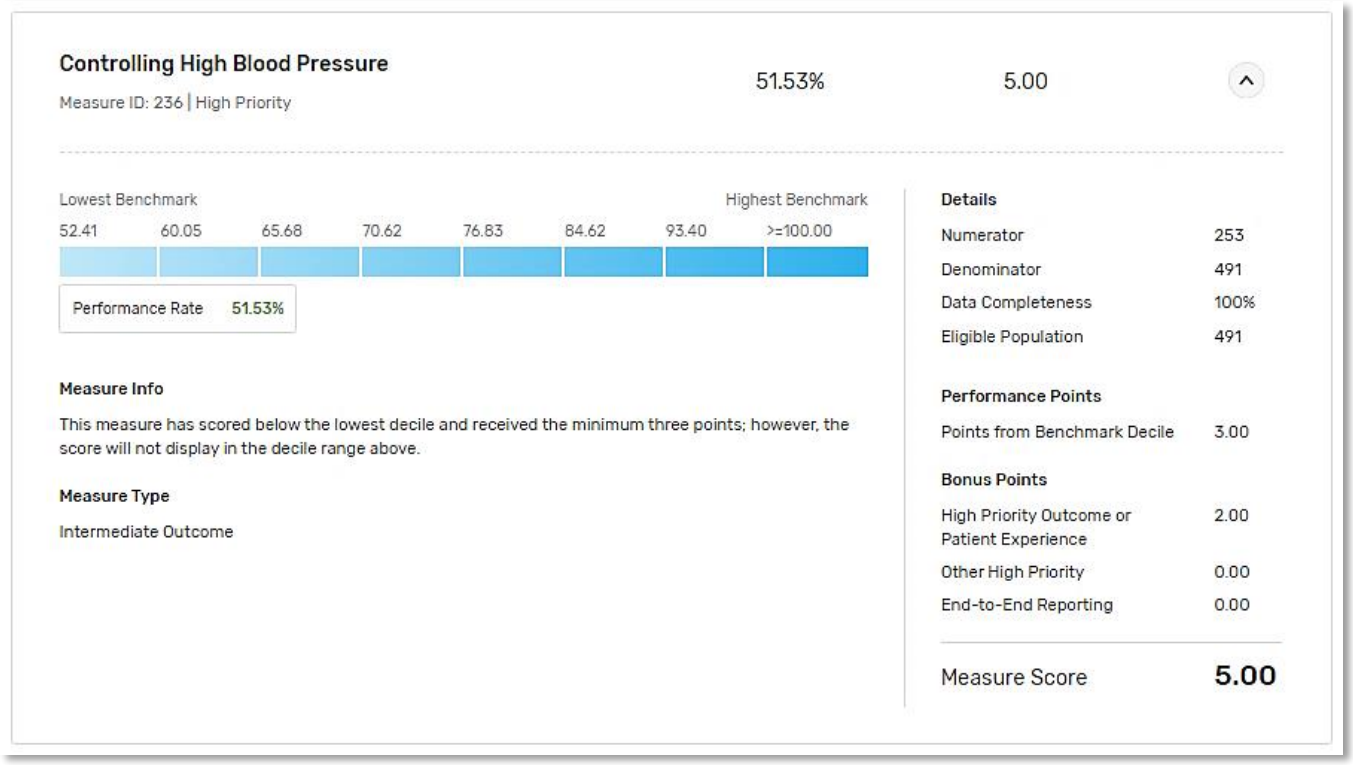

Why are measures with higher performance rates not counted towards my Quality performance category score?

We included your highest scoring quality measures. Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit two measures, each with an 85% performance rate, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

I reported six measures and they all had benchmarks. Why was I only scored on five of them?

There are a small number of quality measures whose scoring was impacted by:

- Changes to clinical guidelines during the performance period;
- ICD-10-CM code changes during the performance period; and
- Specification changes that were later determined to be substantive.

In some cases, the performance period was truncated to 9 months. More frequently, the measure was suppressed from scoring. This means the measure was not scored and your quality denominator – the maximum number of points available – was reduced by 10 points.

For a complete list of these impacted measures (and their collection types), refer to Appendix D.

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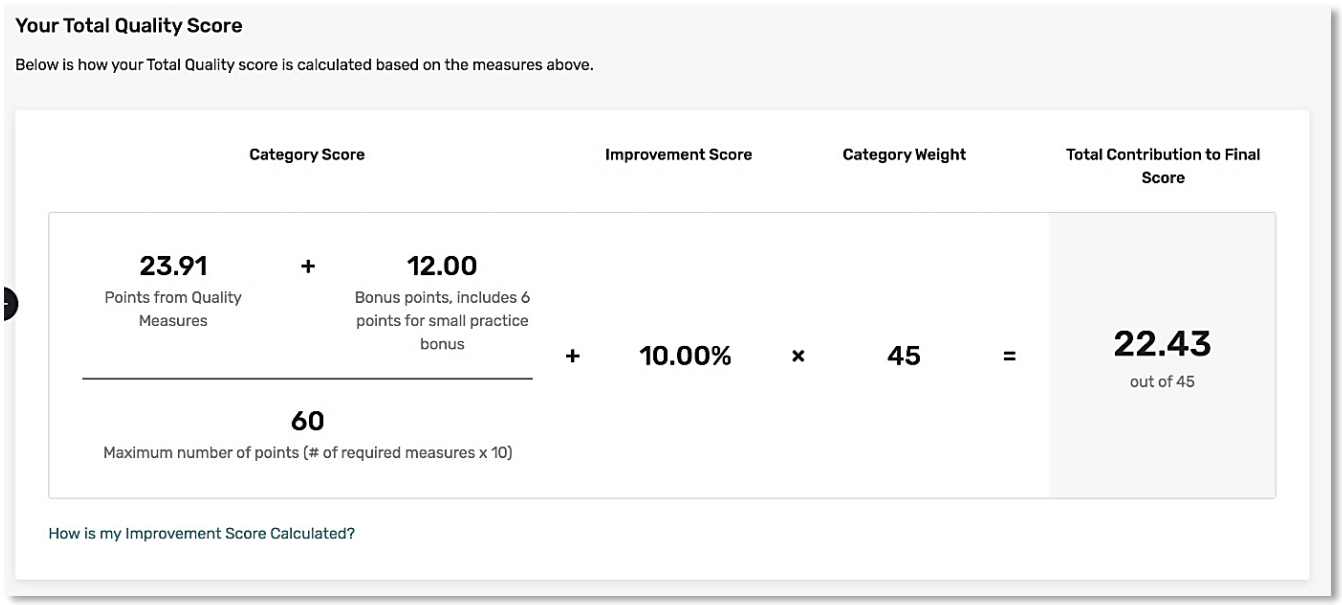
How do you calculate my Quality performance category score?

At the bottom of the Quality page, you can see how we arrived at the points contributing to your final score.

We divide the sum of your achievement and bonus points by the maximum number of points available in the Quality performance category, and add that number to your improvement percent score, if applicable. Finally, we multiply that number by the category weight.



I submitted all of the Medicare Part B claims measures (or MIPS CQMs, "registry" measures) available to me. How do I know if the Eligible Measure Applicability (EMA) process was applied to my submission?

Clinicians who don't have six available quality measures and who report Medicare Part B Claims measures or MIPS CQMs may qualify for the Eligible Measure Applicability, or EMA, process. This process checks for unreported, clinically related measures and can result in a denominator reduction in the Quality performance category.

If you submitted fewer than six Medicare Part B Claims measures or MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA. Denominator reductions are reflected in the Total Quality Score calculation section.

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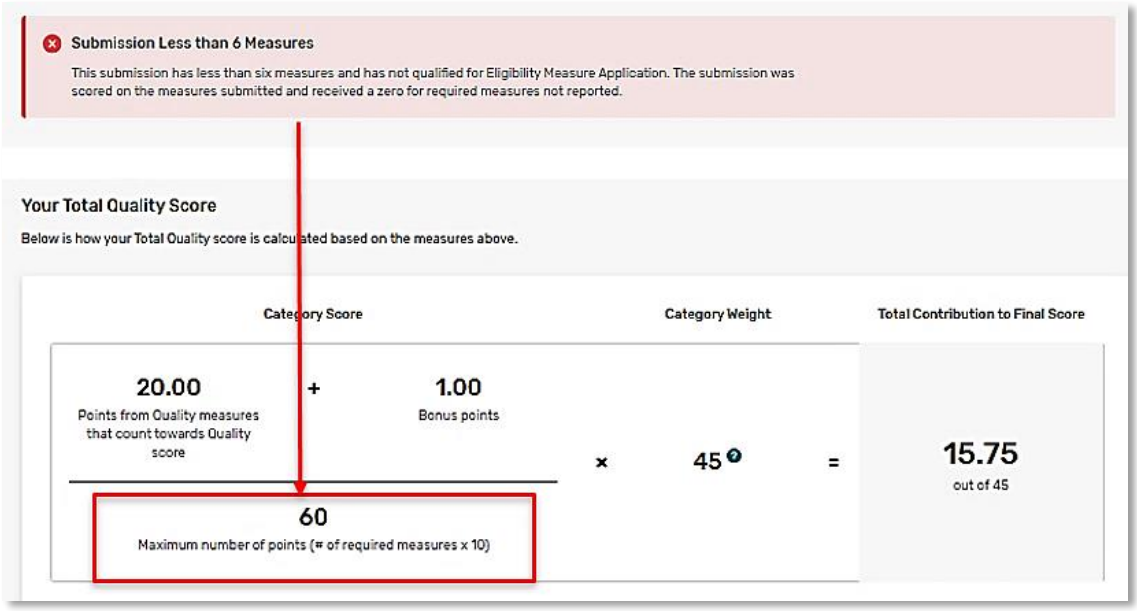
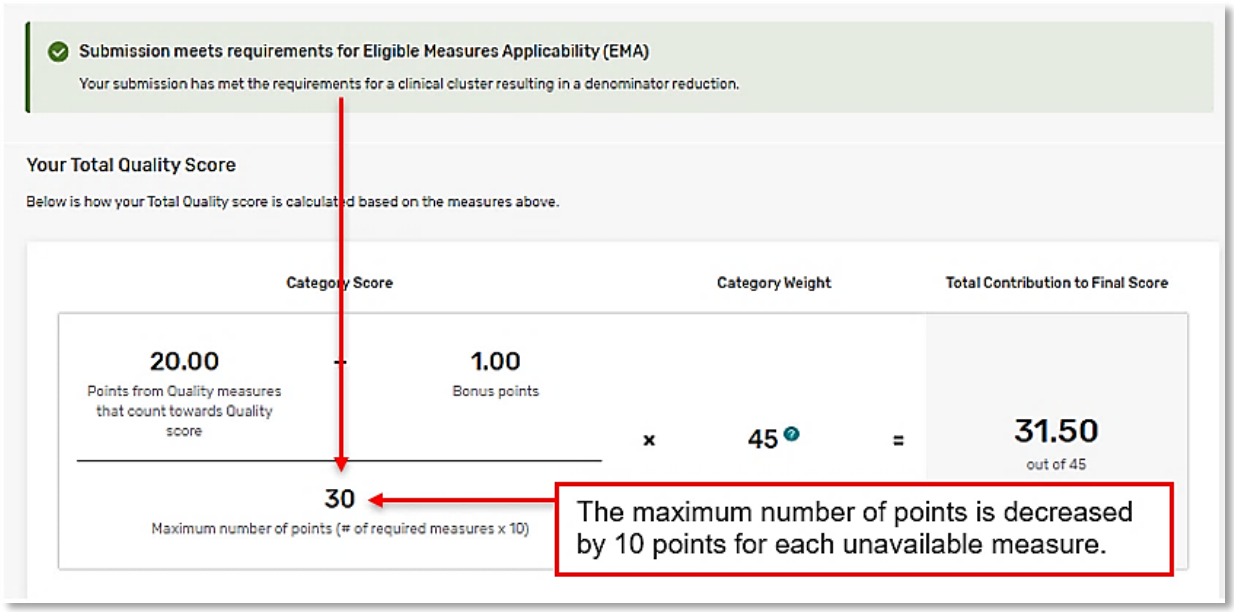
Submission (MIPS CQMs) does not qualify for denominator reduction



Submission (MIPS CQMs) qualifies for denominator reduction



If you submitted all available Medicare Part B claims measures or MIPS clinical quality measures (CQMs) and were still scored out of 60 Total Possible Points (or 70 if you participated as a group and were scored on the All-Cause Hospital Readmission measure), you may want to request a targeted review so we can take another look.

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Where can I find information on the All-Cause Hospital Readmission (ACR) measure for our group?

We will only display the All-Cause Hospital Readmission (ACR) measure for groups who could be scored on the measure. This means that:

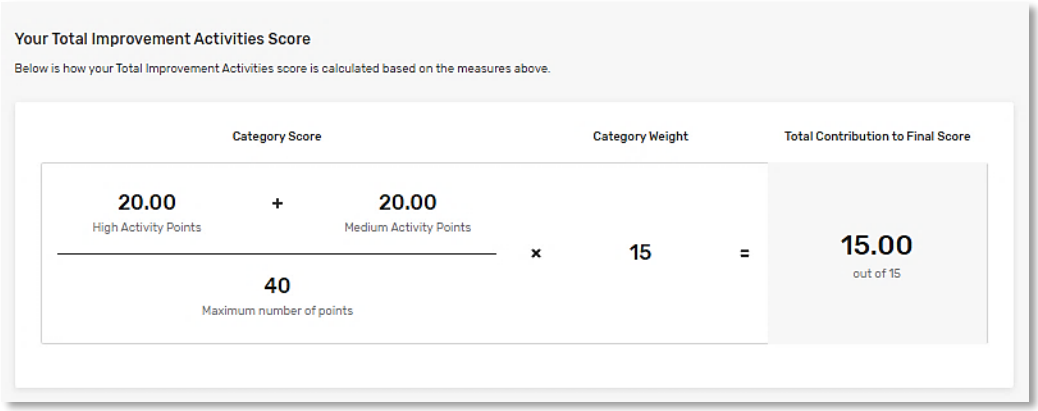
- The group included 16 or more clinicians; and
- The group met the case minimum (200 patients) for the measure.

If you don't see the ACR measure as part of your Quality score, then your group did not meet one or both of the criteria above.

The ACR measure is scored like other quality measures, where your group's performance earns points based on comparison to a benchmark. For more information about the measure itself, please review the measure specifications, available on the QPP Resource Library. You can also refer to Frequently Asked Questions in the 2019 MIPS Performance Feedback Patient-Level Data Reports FAQs.

Improvement Activities

The Improvement Activities page will display the name, weight and points received for each activity you attested to performing. At the bottom of the Improvement Activities page, you can see how we arrived at the points contributing to your final score. We divide the sum of the points earned for your medium and high weighted activities by 40 (the maximum number of points available), then we multiply that number by the category weight.



We are a certified patient-centered medical home. Why didn't we receive full credit in the Improvement Activities performance category?

If you're a MIPS eligible clinician practicing in a certified patient-centered medical home, including Medical Homes Model, or a comparable specialty practice, **you earn full credit for the Improvement Activities performance category as long you attested to this during the submission period**.

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Promoting Interoperability

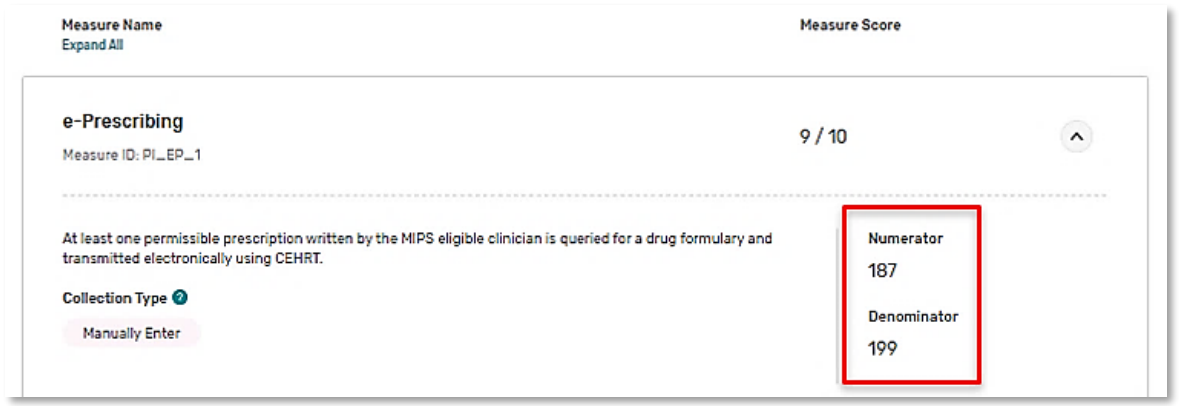
We overhauled the MIPS Promoting Interoperability performance category for the 2019 performance period to increase transparency about reporting requirements and scoring.

In addition to the required attestations and unscored Security Analysis measure, there was a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed.

Each required measure was worth a specified number of points, though the maximum points per measure could change based on reporting exclusions for other measures.

For measures submitted with a numerator and denominator, we calculated a score for each measure by dividing the numerator you submitted by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure, and then rounding that value to the nearest whole number.

Click the arrow on the right-hand side of the measure information to see numerator/denominator details or click **Expand All** below Measure Name to see the details of all the measures in that objective.



At the bottom of the Promoting Interoperability page, you can see how we arrived at the points contributing to your final score. We divided the points earned by 100 (the maximum number of points available), then we multiplied that number by the category weight.

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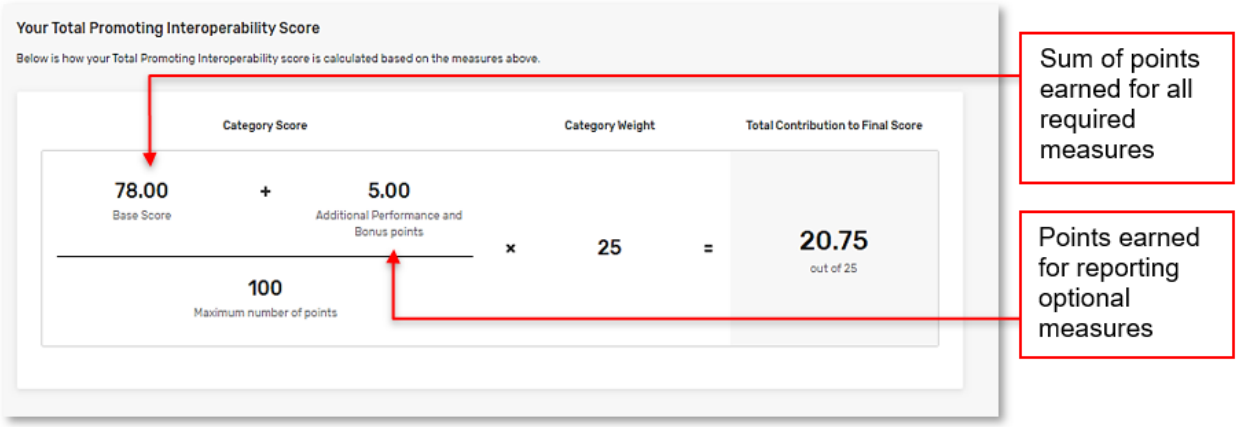


Why did I receive a performance category score of 0 out of 25 points when I qualified for reweighting?

If a MIPS eligible clinician or group submitted any data for the Promoting Interoperability performance category, CMS scored them according to the data submitted and the category was **NOT** reweighted to 0%. This includes clinicians and groups who started data entry (such as performance period) on the Manual Entry page during the submission period.

Note: If you did not submit data and received a performance category score of 0 but should have qualified for reweighting based on your clinician type, special status, and/or exception status, you may need to request a targeted review.

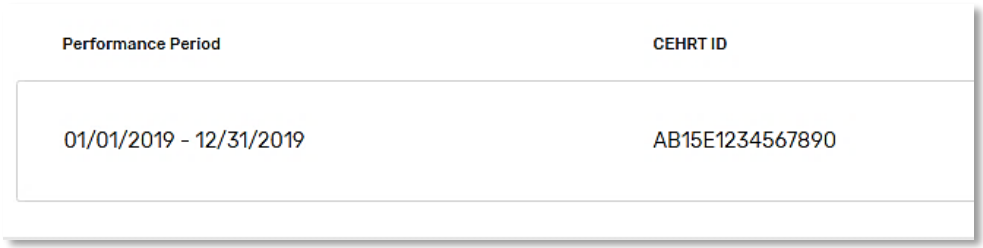
Why did I receive a performance category score of 0 out of 25 points when I submitted all of my data?

If you reported Promoting Interoperability data through multiple submission types (ex. Manual entry and file upload) and there was any conflicting data, you received a score of 0 out of 25 for the performance category.

What is the CEHRT ID?

Beginning with the 2019 performance period, 2015 CEHRT – or Certified EHR Technology – was required for reporting your MIPS Promoting Interoperability measures.

The CEHRT ID is the CMS Certification ID for your EHR product(s) proving that it is certified by ONC to the 2015 Edition. Submissions without a valid CEHRT ID resulted in a performance category score of 0.



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We participate in a MIPS APM and submitted our Promoting Interoperability measures as individuals. Why is our score lower than what we saw during 2019 submissions?

The score you saw during submission was based on the individual or group data you submitted and is not your final Promoting Interoperability performance category score. Under the APM scoring standard, each MIPS eligible clinician in the APM Entity receives the same score which is a weighted average of all the scores for the MIPS eligible clinicians in the APM Entity.

Cost

Why don't I see any cost measure information?

Only clinicians, groups and virtual groups who could be scored on at least one measure will see cost measure information in performance feedback.

- **Reminder**: We extended the automatic extreme and uncontrollable circumstances policy to all individual MIPS eligible clinicians. You will only see a score of 'N/A' for the Cost performance category in an individual clinician's feedback, even if additional feedback is available.

If you don't see any cost measure details and see a score of 'N/A' in the "Final score at a glance", then your group did not meet the case minimum for either cost measure and the weight for this performance category was reallocated to another (typically Quality).

Groups and virtual groups who were approved for reweighting in this performance category can still access measure-level and patient-level feedback if they met the case minimum for at least one cost measure.

What are the 2019 case minimums for each MIPS cost measure?

The case minimums are as follows: 10 episodes for the procedural measures, 20 episodes for the acute inpatient medical condition measures, 35 episodes for the MSPB measure and 20 patients for the TPCC measure, as summarized in the table below:

Cost Measure Name/Episode Type, if Applicable	Case Minimum
Total per Capita Costs (TPCC)	20
Medicare Spending per Beneficiary (MSPB)	35
Elective Outpatient Percutaneous Coronary Intervention (PCI)/ Procedural	10
Knee Arthroplasty/Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia/Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation/Procedural	10
Screening/Surveillance Colonoscopy /Procedural	10
Intracranial Hemorrhage or Cerebral Infarction/Acute Inpatient Medical Condition	20
Simple Pneumonia with Hospitalization/ Acute Inpatient Medical Condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) / Acute Inpatient Medical Condition	20

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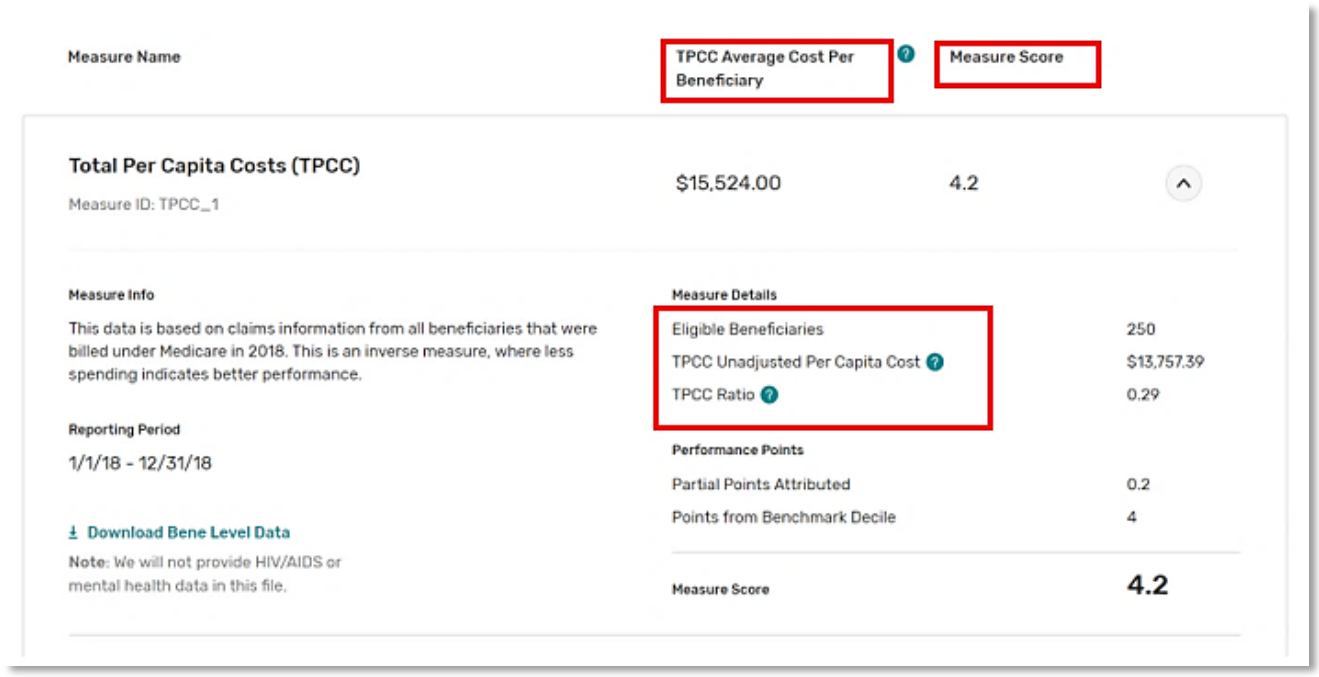
Can you explain the different elements displayed in the Medicare Spending per Beneficiary (MSPB) measure details?

Please refer to the descriptions below the screenshot.



MSPB Average Cost Per Episode:

- This figure represents your performance on the measure, from which we determine your "measure score."
- It is the average of the ratio of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to the TIN-NPI or TIN, multiplied by the national average payment-standardized observed MSPB episode cost.

The national average payment-standardized observed MSPB episode cost is $22,274.00.

Measure Score (Points from Benchmark Decile + Partial Points Attributed):

- This is the number of points you earned (out of 10) on the measure.
- This score was derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups and virtual groups who were evaluated on the measure.

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Eligible Episodes

- This represents the measure denominator.
- It is the number of eligible patient episodes that were attributed to your individual TIN-NPI (if reporting as an individual clinician) or TIN (if reporting as a group) based on the MSPB measure attribution methodology. For detailed attribution methodology information, please refer to Step 5 on page 7 of the 2019 MSPB Measure Information Form.

MSPB Unadjusted Per Episode Cost:

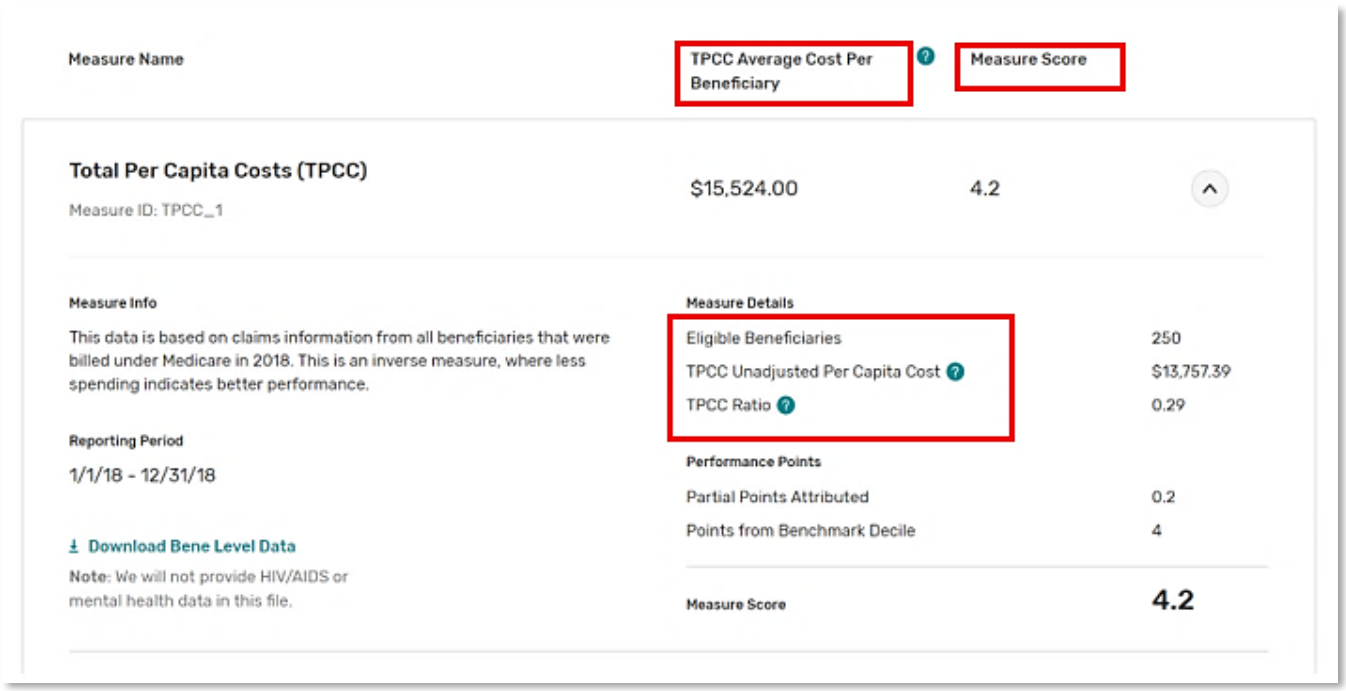
- This figure is the un-adjusted, average, price-standardized observed cost of patient episodes attributed to an individual clinician's TIN-NPI or to all eligible clinicians under a TIN that participated in MIPS as a group.
- The figure is neither risk-adjusted nor normalized.

MSPB Ratio:

- The MSPB Ratio is the average of the ratios of payment-standardized, risk-adjusted, observed-to-expected MSPB episode costs calculated for each MSPB episode attributed to an individual clinician's TIN-NPI or attributed to all eligible clinicians in a TIN that participated in MIPS as a group.

Can you explain the different elements displayed in the Total Per Capita Costs (TPCC) measure details?

Please refer to the descriptions below the screenshot.



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TPCC Average Cost Per Beneficiary:

- This figure represents your performance on the measure, from which we determine your "measure score."
- It is the risk-adjusted, specialty-adjusted, normalized, payment-standardized, average amount of Medicare Parts A and B costs incurred during the 12-month performance period by all patients attributed to an individual MIPS eligible clinician's TIN-NPI for individual reporting or to all individual eligible clinicians in a practice, identified by TIN, when participating in MIPS as a group.

Measure Score (Points from Benchmark Decile + Partial Points Attributed):

- This is the number of points you earned (out of 10) on the measure.
- This score was derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups and virtual groups who were evaluated on the measure.

Eligible Beneficiaries

- This represents the measure denominator.
- It is the number of patients whose costs were attributed to your individual TIN-NPI (if reporting as an individual clinician) or TIN (if reporting as a group) based on the TPCC measure attribution methodology. For detailed attribution methodology information, please refer to Step 1 on page 5 of the 2019 TPCC Measure Information Form.

TPCC Unadjusted Per Capita Cost:

- This figure is the average, unadjusted, payment-standardized, annualized, observed (actual) per capita cost incurred during the 12-month performance period by patients attributed to the individual clinician or group.
- This value does not account for provider specialty nor patient risk factors.

TPCC Ratio:

- The TPCC Ratio is the specialty-adjusted, risk-adjusted, per capita costs of patients attributed to an individual TIN-NPI or TIN divided by the simple, un-weighted mean of the specialty-adjusted, risk-adjusted, per capita costs calculated across all TINs or TIN-NPIs nationwide.
- This is your TIN or TIN-NPI's TPCC Average Cost Per Beneficiary divided by the national average TPCC Average Cost Per Beneficiary.

The national average TPCC average cost per patient is $14,282.70

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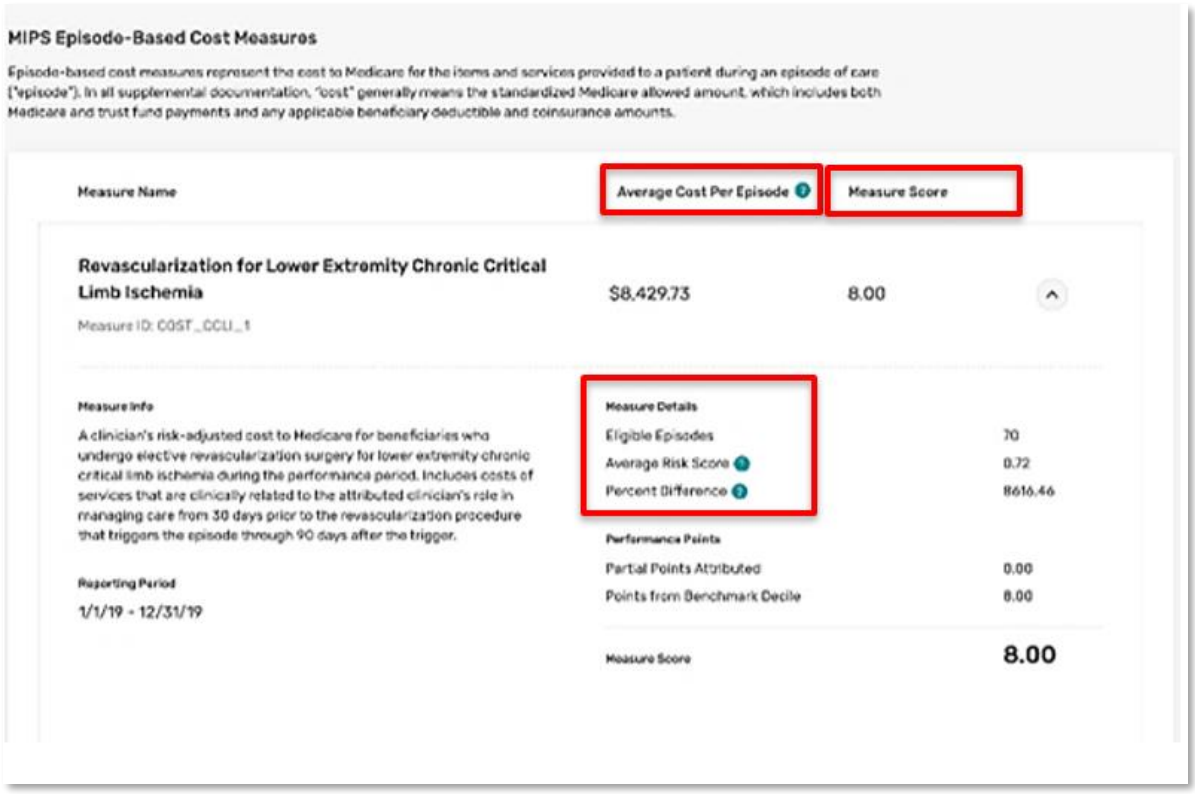
Can you explain the different elements displayed in the MIPS Episode-based Measures details?

Please refer to the descriptions below the screenshot.



Average Cost per Episode:

- This figure represents your performance on the measure, from which we determine your "measure score".
- This is the average ratio of payment-standardized observed to expected episode costs for all episodes attributed to the TIN-NPI or TIN, multiplied by the national average payment-standardized observed episode cost.

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Episode-based Cost Measure (Abbreviation)	National Average Observed Episode Cost for All TINs	National Average Observed Episode Cost for Individual TIN-NPIs
Elective Outpatient Percutaneous Coronary Intervention (eo-pci)	$11,129.76	$11,130.44
Intracranial Hemorrhage or Cerebral Infarction (ich-cva)	$23,904.35	$27,070.67
Knee Arthroplasty (knee-arthro)	$17,555.25	$17,487.45
Simple Pneumonia with Hospitalization (pna-hosp)	$10,506.28	$11,089.56
Routine Cataract Removal with Intraocular Lens (IOL) Implantation (rcr-iol)	$3,149.27	$3,149.29
Revascularization for Lower Extremity Chronic Critical Limb Ischemia (rle-cli)	$22,815.24	$23,053.45
Screening/Surveillance Colonoscopy (ss-clnscpy)	$957.52	$957.53
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) (stemi-pci)	$20,452.98	$21,764.15

Measure Score (Points from Benchmark Decile + Partial Points Attributed):

- This is the number of points you earned (out of 10) on the measure.
- This score was derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups and virtual groups who were evaluated on the measure.

Average Risk Score:

- This figure represents the average of the rescaled HCC risk scores assigned to each episode attributed to the provider or group. The rescaled score for an episode is computed by multiplying the HCC risk score by the risk score factor code for the patient in the month that the episode occurred.
- For additional information, refer to the 2019 MIPS Performance Feedback Patient-Level Data Reports FAQs. There's a Q&A regarding the "hcc" column value in the downloadable patient-level reports for MIPS episode-based cost measures.

Percent Difference:

- The percent difference between the individual clinician or group's average, risk-adjusted episode cost and the national average risk-adjusted episode cost.
- The percent difference between your TIN or TIN-NPI and the national average risk-adjusted episode costs for TINs or TIN-NPIs is provided so that you may compare your TIN or TIN-NPI's performance to the national average.

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Facility-Based Scoring

If you qualified for facility-based scoring, you will see a message on the Quality and Cost pages of feedback showing Your QPP Equivalent Quality (or Cost) Score Based on the HVBP Percentile.

Facility-based scoring allows certain clinicians and groups to receive scores in the Quality and Cost performance categories for the 2019 MIPS performance period based on their attributed facility's FY 2020 performance in the Hospital Value Based Purchasing Program.

We map this performance to performance by MIPS eligible clinicians and groups on MIPS quality and cost measures to arrive at a score for the performance category.

Step 1. We looked at your facility's FY 2020 Hospital VBP Program score.

Step 2. We determined how your facility's FY 2020 Hospital VBP Program score compared to all other facilities with a FY 2020 Hospital VBP Program score and arrive at a percentile.

Step 3. We looked at the range and distribution of unweighted PY 2019 MIPS Quality and Cost performance category percentile scores for MIPS participants, and identified which 2019 MIPS Quality (percentile) score and Cost (percentile) score mapped to the percentile associated with your FY 2020 Hospital VBP Program score. Note that we will not assign a Quality percentile score below 30%.

Step 4. We multiplied the mapped 2020 MIPS Quality percentile score by the 2020 Quality performance category weight to determine the Quality performance category points contributing to your final score. (Note, this would be 70% for those who qualify for reweighting in the Promoting Interoperability performance category.)

Step 5. We multiplied the mapped 2019 MIPS Cost percentile score by the 2019 Cost performance category weight (15%) to determine the Cost performance category points contributing to your final score.

Let's apply these steps to the example on the next page:

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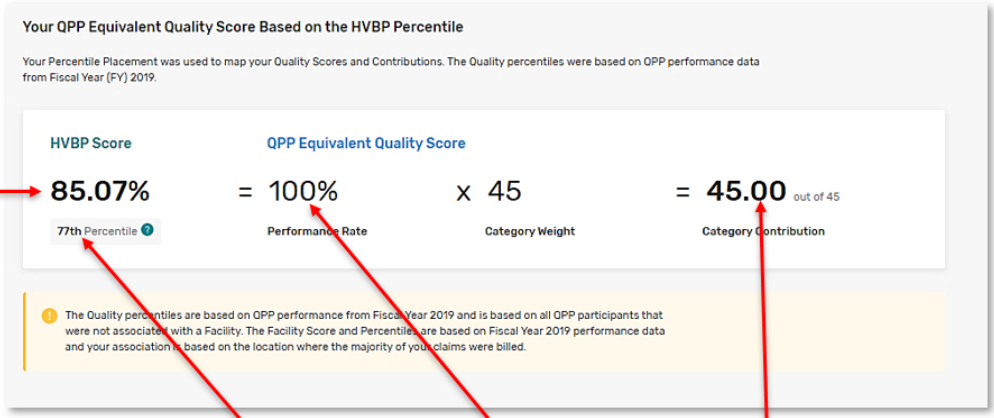
Quality



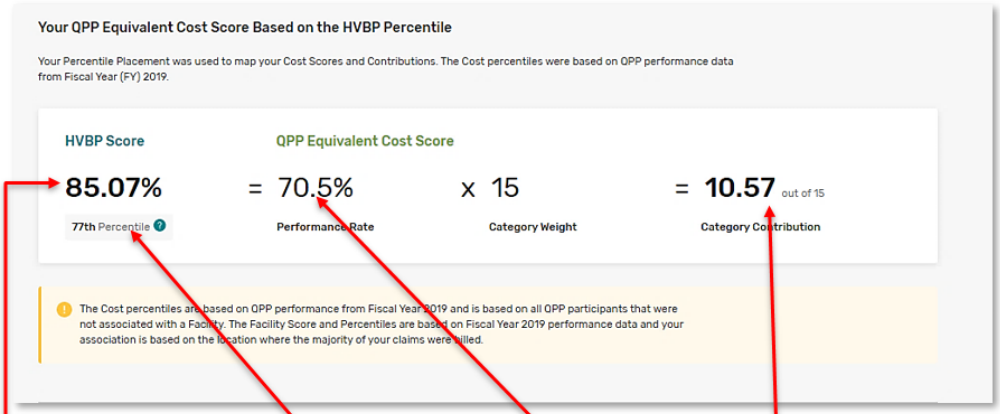
Step 1. Your facility had a total performance score of 85.07%

Step 2. This score put you in the 77th percentile of all facilities participating in the Hospital VBP program

Step 3. Clinicians in the 77th percentile for the MIPS Quality category earned the maximum score available for the category (100%)

Step 4. The rate from Step 3 is multiplied by 45% to arrive at 45 out of 45 points (the maximum score available for the Quality performance category)

Cost



Step 1. Your facility had a total performance score of 85.07%

Step 2. This score put you in the 77th percentile of all facilities participating in the Hospital VBP program.

Step 3. Clinicians in the 77th percentile for the MIPS Cost category had an unweighted percentile score of 70.5%

Step 5. The rate from Step 3 is multiplied by 15% to arrive at 10.57 out of 15 points for the Cost performance category

***Please note**: All screenshots are for illustrative purposes only.*
Screenshots do not represent real clinicians, organizations, or payment adjustments.

Why are these scores different from the scores I saw in our Facility Preview during the performance period?

The Facility-Based Preview, which was available during calendar year 2019, allowed you to preview what your Quality and Cost performance category scores *could* look like for the 2019 MIPS performance period if you are facility-based and attributed to a facility with a Fiscal Year (FY) 2020 Hospital Value-Based Purchasing (VBP) score. However, these were not your actual scores for the 2019 performance period.

- The Facility-Based Preview reflected **FY 2019 Hospital VBP scores** mapped to QPP data from the **2017 MIPS performance period**.
- Your 2019 Quality and Cost performance category scores from facility-based measurement map the facility's **FY 2020 Hospital VBP score** to MIPS scores in the Quality and Cost performance categories, using QPP data collected and submitted for the **2019 MIPS performance period**.

For more information on Facility-Based Preview, please refer to these FAQs on the Resource Library.

I'm a facility-based clinician. Why didn't I receive Quality and/or Cost scores from facility-based measurement as an individual?

Because we extended the automatic extreme and uncontrollable circumstances policy to all individual MIPS eligible clinicians for the 2019 performance year, we only applied facility-based measurement to the Quality performance category for individual clinicians who submitted data as individuals in at least two performance categories.

Furthermore, under the automatic extreme and uncontrollable circumstances policy, the Cost performance category is weighted at 0% of an individual clinician's final score. Because this policy was extended to all individual MIPS eligible clinicians for the 2019 performance year, facility-based individual clinicians will not get a Cost score from facility-based measurement.

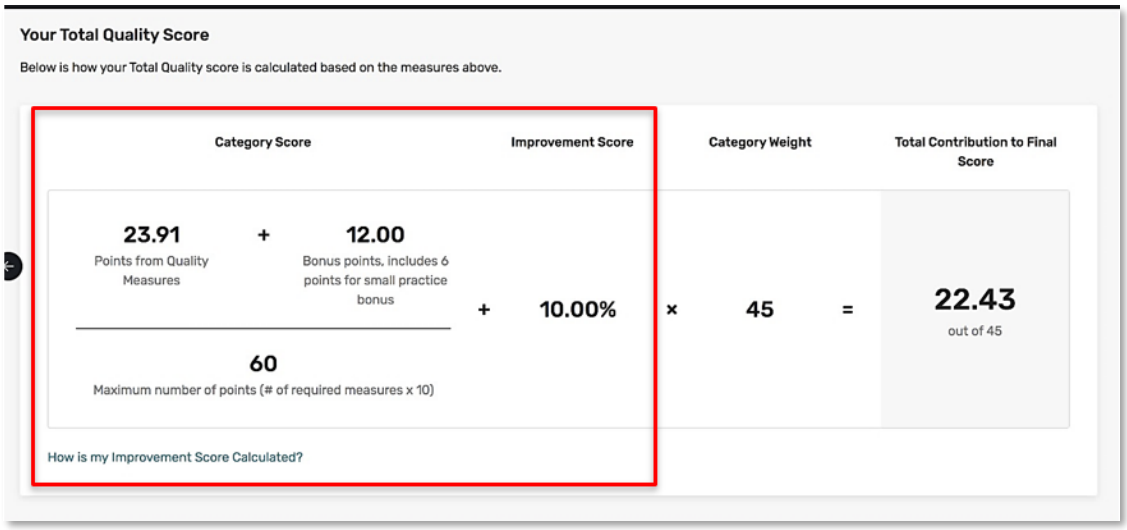
Our practice is facility-based as a group. Why did we only receive a Quality score from facility-based measurement?

A facility-based group that doesn't meet case minimum on at least one MIPS cost measure will not receive a score in the Cost performance category from facility-based measurement. They will receive a Quality score from facility-based measurement, and the weight from the unavailable Cost performance category will be reallocated to the Quality performance category.

What is the “Performance Rate” in the QPP Equivalent Score?

The Performance Rate value is the unweighted percentile score (for the Quality or Cost performance categories) that maps to your Hospital VBP score percentile.

For context, the unweighted percentile score for an individual clinician, group or virtual group would be the product of the highlighted portion of their Total Quality Score calculation below.



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Items and Services

What is the purpose of the Items and Services section of MIPS performance feedback?

The Items and Services section of your performance feedback includes information about your patients' health care utilization and emergency department use. The purpose of this breakdown is to provide clinicians and groups with additional information on the types of Medicare covered items and used by their patients throughout a calendar year. Please note that the Items and Services data is for informational purposes only and will not affect your MIPS performance scores.

How are you defining the types of Items and Services used by patients?

We define the types of items and services utilized by patients using Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS codes represent a standard coding system for procedures, supplies, products and services billed by health care providers. The data in the Items and Services section of performance feedback is aggregated by ranges of HCPCS codes for ease of review.

What is a HCPCS code and how are they classified by level?

The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into two levels:

- **Level I HCPCS Codes:** Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing services of physicians, non-physician practitioners and other suppliers.
- **Level II HCPCS Codes:** These codes are alpha-numeric codes consisting of a single alphabetical letter followed by four numeric digits. Level II HCPC codes are used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes and descriptors are maintained and distributed by CMS.[1]

What is a Current Procedural Terminology (CPT®) code?

Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, and to increase accuracy and efficiency. All CPT codes are five digits and can be either numeric or alphanumeric, depending on the category. HCPCS Level 1 codes are on the American Medical Association's CPT codes.

[1] https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf

How are HCPCS codes divided into sections in the Items and Services section of performance feedback?

In the Items and Services feedback, the HCPCS codes are categorized based on the following ranges of codes for ease of review:[2]

HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS	
00000-09999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital, maternity care, and delivery system
60000-69999	Endocrine, nervous, eye and ocular adnexa, auditory system
70000-79999	Radiology services
80000-89999	Pathology and laboratory services
90000-99999	Evaluation and management services
Level 2 HCPCS	
HCPCS A	Transportation services including ambulance, medical & surgical supplies
HCPCS B	Enteral and parenteral therapy
HCPCS C	Temporary codes for use with outpatient prospective payment system
HCPCS E	Durable medical equipment (DME)
HCPCS G	Procedures or professional services
HCPCS H	Alcohol and drug abuse treatment services or rehabilitative services
HCPCS J	Drugs administered other than oral method, chemotherapy drugs
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS V	Vision, hearing and speech-language pathology services

[2] https://hcpcs.codes/section/

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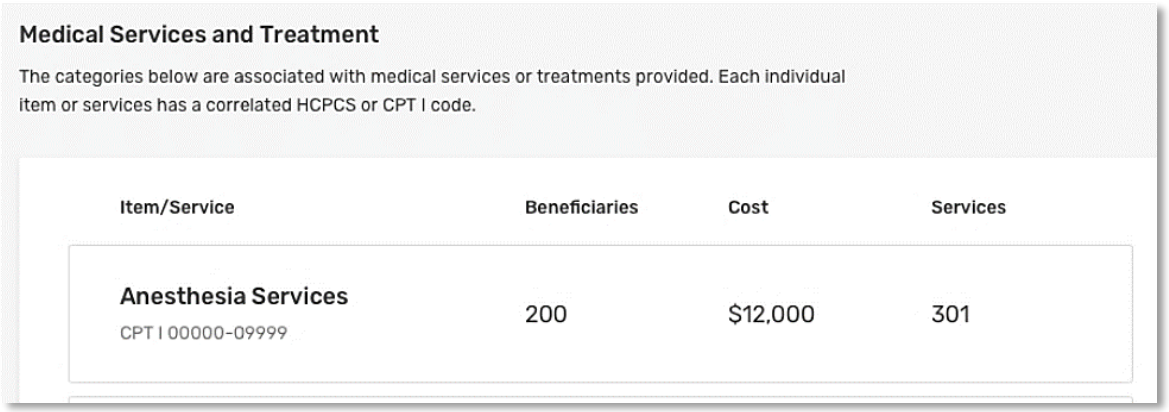
What data is being used in the Items and Services section of performance feedback?

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Type 71 and 72) billed with dates of services between January 1, 2019 and December 31, 2019 and received by CMS within 60 days of 12/31/2019 (a “60 day runout”).



How is the number of “beneficiaries,” in the Items and Service section of performance feedback, derived?

The number of patients reflected is the number of all patients for the related HCPCS/CPT codes on Part B professional claim lines with positive allowed charges.

For individual clinicians, this number includes all unique Part-B enrolled patients who received at least one service of any type from the individual clinician (identified by TIN-NPI) during CY2019 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

For groups, this number includes all Part-B enrolled patients who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2019 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

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How is the "cost," in the Items and Service section of performance feedback, derived? Is the cost adjusted and/or price standardized in any way? If so, how?

The cost reflected in Items and Services is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines. These numbers are raw allowed charge amounts and are not payment standardized, risk adjusted, nor specialty adjusted.

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines for patients who received at least one service of any type from the individual clinician (identified by TIN-NPI) during calendar year (CY) 2018 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

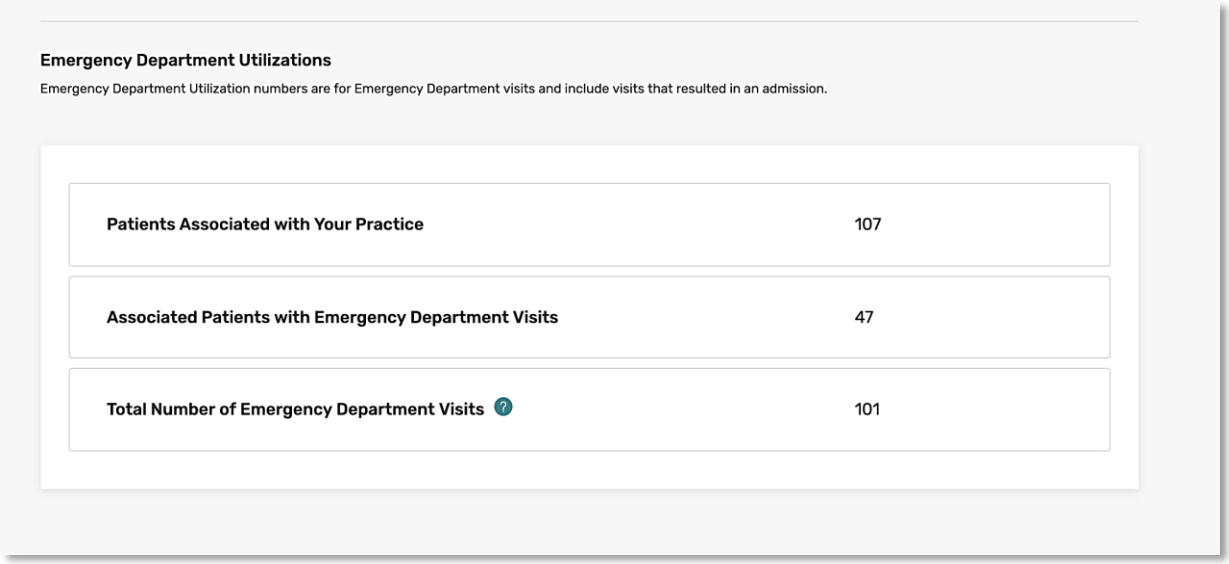
For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2019 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

How is the number of "services," in the Items and Services section of performance feedback, derived?

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from the individual clinician (identified by TIN-NPI) during calendar year (CY) 2019 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

For groups, this number is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2019 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2019.

Emergency Department Utilization



Which patients are counted in the "patients associated with your practice" entry under the "Emergency Department Utilization" heading?

In this context, "patients associated with your practice" is defined as patients attributed to an individual clinician's TIN-NPI or to a group's TIN (depending on the chosen level of reporting) via the same two-step attribution methodology as used to compute the Total Per Capita Costs for All Attributed Beneficiaries measure (TPCC) measure, which is based on primary care services received in CY 2019.

For more information regarding the TPCC attribution logic, please refer to page 14 of the 2019 Cost Performance Category Fact Sheet and the 2019 TPCC Cost Measure Information Form.

Which patients are counted in the "associated patients with emergency department visits" entry under the "Emergency Department Utilization" heading?

This metric reflects the number of attributed patients who also had an emergency department (ED) visit in CY 2019. An ED visit is defined as any 2019 claim with a claim-line containing any of the following ED revenue center codes: 0450-0459 and/or 0981.

How is the "total number of emergency department visits" entry under the "Emergency Department Utilization" heading defined?

The figure reflects the actual number of ED visits across all attributed patients in CY 2019.

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Performance Feedback for APM Entities and Clinicians Scored Under the APM Scoring Standard

We participate in a MIPS APM. What kind of feedback will be available to us?

Beginning with the 2018 performance period, MIPS performance feedback for clinicians scored under the APM scoring standard will be available to the APM Entity and to the individual clinicians directly. The clinicians and entities participating in the following models will be able to access their performance feedback based on the APM scoring standard directly on qpp.cms.gov:

- Medicare Shared Savings Program Accountable Care Organizations (ACO)
- Next Generation ACO Model
- Oncology Care Model (OCM)
- Comprehensive ESRD Care (CEC) Model
- Comprehensive Primary Care Plus (CPC+)
- Bundled Payments for Care Improvement (BPCI) Advanced
- Independence at Home Demonstration
- Maryland Total Cost of Care (TCOC)
- Vermont All Payer ACO

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Shared Savings Program ACO participants

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity *(Staff User or Security Official role for the APM Entity)*	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality (measure data including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM entity roll up") • Scores attributed to each clinician in the Entity based on their ACO Participant TIN's submission	Can view: • A message that they've earned full credit for this performance category	N/A
Practice (ACO Participant TIN) *(Staff User or Security Official role for the Practice)*	• Can view a message that they have clinicians participating in an Alternate Payment Model • **Cannot** view any scoring information related to the APM scoring standard • Can view performance category scores and a final score based solely on the data submitted or calculated at the group level Can view a payment adjustment based on the group's final score if there are clinicians in the group who will be scored based on the group's data				
Individual Clinicians *(Clinician Role)* **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data submitted to QPP on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM entity roll up") • Their individual score based on data submitted by their ACO Participant TIN	Can view: • A message that they've earned full credit for this performance category	*If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record*

***Please note**: All screenshots are for illustrative purposes only.*
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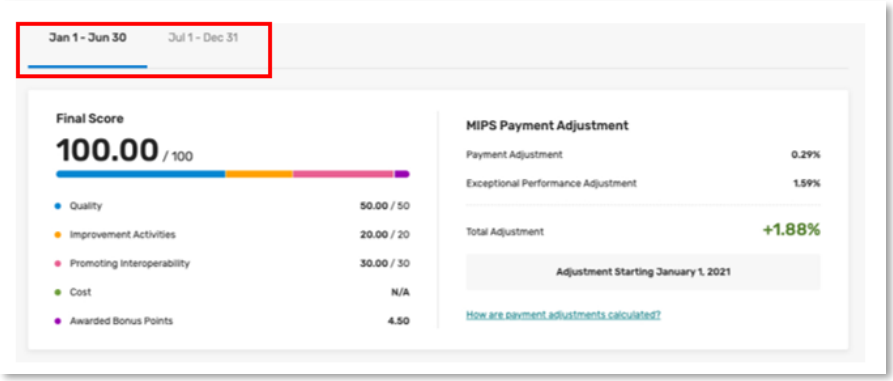
Why Does Our ACO Have Two Final Scores in 2019 MIPS Performance Feedback?

In the Medicare Shared Savings Program "Pathways to Success" December 2018 Final Rule (83 FR 67816), CMS issued a combination of policy changes to redesign and set a new direction for the Shared Savings Program. The restructure focused on advancing 5 goals: Accountability, Competition, Engagement, Integrity, and Quality.

As a result of this restructuring, for calendar year 2019, a subset of ACOs had a 6-month performance year that began on January 1, 2019 under the previous policies, and a 6-month performance year that began on July 1, 2019 under the new Pathways to Success policies. If your ACO participated in both performance periods, it could affect the MIPS eligible clinicians who appeared on your certified ACO Participant List, and therefore the clinicians whose data was included when calculating the Promoting Interoperability performance category score and complex patient bonus for your ACO under the APM Scoring Standard.

As a result, your ACO could be assigned two different 2019 MIPS Final Scores: one that will apply to MIPS eligible clinicians who participated in your ACO from January 1, 2019 – June 30, 2019 (and had reassigned billing rights to an ACO participant TIN as of the March 31 and/or June 30 *snapshot date(s)*), and one that applies to MIPS eligible clinicians who participated in your ACO from July 1, 2019 – December 31, 2019 (and had reassigned billing rights to the ACO as of *August 31 and/or December 31 snapshot date(s)*). The scores for the Quality and Improvement Activities will be the same, but there can be a difference in the Promoting Interoperability performance category score and complex patient bonus.

- MIPS eligible clinicians who are only associated with the January 1 – June 30, 2019 performance period will receive the final score and associated payment adjustment from that performance period unless they have a higher score through a different APM Entity.
- MIPS eligible clinicians who are only associated with the July 1 – December 31, 2019 performance period will receive the final score and associated payment adjustment from that performance period unless they have a higher score through a different APM Entity.
- MIPS eligible clinicians who are associated with both performance periods will receive the higher of the two final scores and payment adjustments unless they have a higher score through a different APM Entity.



***Please note**: All screenshots are for illustrative purposes only.*
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Organization Type	Role	Performance Feedback View (Two Scores for Shared Savings Program ACOs)
APM Entity	Staff User or Security Official	• Representatives of affected ACOs will see two final scores on the Overview page of performance feedback. • The downloadable "PI Rollup" file will identify the performance period associated with each TIN/NPI in the ACO ○ There will be two records for a clinician who participated in the ACO for the whole year, one for each 6-month performance period.
Practice (ACO Participant TIN)	Staff User or Security Official	• N/A – Participant TINs do not have access to performance feedback for the ACO.
Individual Clinicians	Clinician Role	• Individual clinicians in an affected ACO do not see multiple performance periods or scores; they will only see the final score and payment adjustment attributed to them through the ACO.

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Next Generation ACO Participants

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity *(Staff User or Security Official role for the APM Entity)*	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data (including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Scores attributed to each clinician in the Entity	Can view: • A message that they've earned full credit for this performance category	N/A
Individual Clinicians *(Clinician Role)* **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data (including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Their individual score based on data submitted at the individual or group level	Can view: • A message that they've earned full credit for this performance category	*If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record*

***Please note**: All screenshots are for illustrative purposes only.*
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Oncology Care Model (OCM)

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score but no details (data is submitted outside of QPP system)	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Scores attributed to each clinician in the Entity	Can view: - A message that they've earned full credit for this performance category	N/A
Individual Clinicians **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score but no details (data is submitted outside of QPP system)	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Their individual score based on data submitted at the individual or group level	Can view: • A message that they've earned full credit for this performance category	*If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record*

***Please note**: All screenshots are for illustrative purposes only.*
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Comprehensive ESRD Care (CEC) | Comprehensive Primary Care Plus (CPC+) | Bundled Payments for Care Improvement (BPCI) Advanced | Independence at Home Demonstration | Maryland Total Cost of Care (TCOC) | Vermont All Payer ACO

	Overview	Quality (0%)	Promoting Interoperability (50%)	Improvement Activities (50%)	Cost, Items & Services
APM Entity *(Staff User or Security Official role for the APM Entity)*	Can view: • Final Score • Payment Adjustment	N/A – quality data submitted for this model not available for performance feedback	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Scores attributed to each clinician in the Entity	Can view: • A message that they've earned full credit for this performance category	N/A
Individual Clinicians *(Clinician Role)* **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	N/A – quality data submitted for this model not available for performance feedback	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Their individual score based on data submitted at the individual or group level	Can view: • A message that they've earned full credit for this performance category	*If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record*

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General

Why does my final performance feedback differ from my preliminary performance feedback?

When the 2019 submission period closed, CMS continued to make preliminary performance feedback available, providing information about scores in progress. Final MIPS Performance Feedback includes the following:

- Patient-level data for the All-Cause Hospital Readmission measure, calculated using administrative claims data
- Patient-level data for Cost measures, calculated using administrative claims data
- Performance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey measure
- Improvement Activity credit based on successful participation in the CMS Study on Factors Associated with Reporting Quality Measures
- Scoring updates based on the creation of performance period benchmarks for quality measures without a historical benchmark
- 2021 payment adjustment information for MIPS eligible clinicians
- Access to request a targeted review

Can I download Feedback Reports?

Yes, you can print performance feedback using the **Print** button accessible on each page within Performance Feedback. (This feature uses your browser's native print functionality.)

What if there is an error with my Payment Adjustment/Performance Feedback/Final Score?

If you believe an error has been made in your 2021 MIPS payment adjustment calculation, you have until 8 p.m. ET on October 5, 2020, to request a targeted review .

However, we encourage you to contact the Quality Payment Program before submitting a targeted review if possible. You may be experiencing an issue we've already identified as impacting clinicians and groups and are working to address outside of the Targeted Review process. We can best serve you if you use the **Print** feature within feedback ("**save as PDF")** so we can attach this information to your case.

What's a targeted review?

A targeted review is a process where MIPS eligible clinicians, groups and MIPS APM participants (individual clinicians, participating groups and the APM Entity) can request that CMS review the calculation of their 2021 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. For more information on targeted review, please review the 2019 Targeted Review User Guide.

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We continue to listen to you and make improvements to the system based on your feedback.

There may be slight variation between the information and screenshots in this document and what you see on your screen.

Contact the Quality Payment Program if you have questions about a discrepancy.

Where Can I Learn More?

- Quality Payment Program
- 2019 MIPS Performance Feedback Resources
- 2021 Payment Adjustment Fact Sheet
- 2019 Targeted Review User Guide
- 2019 MIPS Scoring Guide

You can subscribe to the QPP listserv and you can also contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m. - 8:00 p.m. Eastern Time or by email at: QPP@cms.hhs.gov. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Comment
8/5/2020	Original version

Appendix A: Automatic Extreme and Uncontrollable Circumstances Policy

Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2019 performance category reweighting policies that CMS will apply to individual clinicians under the MIPS automatic extreme and uncontrollable circumstances policy, including those that submit MIPS data as individuals. (This does not reflect reweighting for clinicians scored under the APM scoring standard.)

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for One Performance Category					
Quality Only	100%	0%	0%	0%	Neutral
Promoting Interoperability Only	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability	75%	25%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities **and** Promoting Interoperability	0%	50%	50%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality **and** Improvement Activities **and** Promoting Interoperability	60%	25%	15%	0%	Positive, Negative, or Neutral

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Appendix B: Extreme and Uncontrollable Circumstances Application

The table below illustrates the 2019 performance category reweighting policies that CMS will apply to clinicians, groups, and virtual groups with an approved COVID-19 automatic extreme and uncontrollable circumstances application, including those that submitted data in those performance categories. (This does not reflect reweighting for clinicians scored under the APM scoring standard.)

Application Approved	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
All 4 performance categories	0%	0%	0%	0%	Neutral
Applications Approved for 3 Performance Categories					
Promoting Interoperability, Cost, and Improvement Activities	100%	0%	0%	0%	Neutral
Quality, Cost, and Improvement Activities	0%	100%	0%	0%	Neutral
Quality, Promoting Interoperability and Cost	0%	0%	100%	0%	Neutral
Applications Approved for 2 Performance Categories					
Quality **and** Promoting Interoperability	75%	25%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities **and** Promoting Interoperability	0%	50%	50%	0%	Positive, Negative, or Neutral
Applications Approved for One Performance Category					
Quality	0%	45%	40%	15%	Positive, Negative, or Neutral
Promoting Interoperability	70%	0%	15%	15%	Positive, Negative, or Neutral
Improvement Activities	60%	25%	0%	15%	Positive, Negative, or Neutral
Cost	60%	25%	15%	0%	Positive, Negative, or Neutral

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Appendix C: Performance Feedback Based on Access

This table provides a snapshot of what you can and can't view within performance feedback based on your access and organization type

With This Access	You CAN	You CANNOT
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ View group-level ("practice") performance feedback ✓ View and download clinician-level performance feedback (excluding APM participants) ✓ View and download payment adjustment information for all clinicians in the practice (excluding APM participants)	X View APM Entity level performance feedback ***Example.*** If you're a Participant TIN in a Shared Savings Program ACO, you will not be able to view performance feedback or payment adjustment information for the ACO (clinicians scored under the APM scoring standard). You will only be able to view feedback on the data submitted at the individual or group level X View performance feedback for your virtual group
Staff User or Security Official for an **APM Entity**	✓ View and download MIPS performance feedback for the entire Entity under the APM scoring standard ✓ View and download payment adjustment information for all clinicians in the Entity	X View the Promoting Interoperability data submitted by individual clinicians and groups in your APM entity
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ View preliminary scoring for your clients based on the data you submitted for them (same information that was available during the submission period)	X View final performance feedback or payment adjustment information for your clients, which may include: ○ Data submitted by your clients directly ○ Data submitted by another third party on behalf of your clients ○ Data collected and calculated by CMS on behalf of your clients ▪ Cost measures ▪ All-Cause Hospital Readmission measure
Clinician Role	✓ View your performance feedback and payment adjustment information for all associated APM Entities, practices, and virtual groups	X View performance feedback or payment adjustment information for other clinicians
Staff User or Security Official for a **Virtual Group**	✓ View virtual group-level performance feedback	X View performance feedback about data submitted by individuals or practices in your virtual group

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Appendix D: Quality Measures with Scoring Changes

Measures impacted by scoring changes due to clinical guideline changes during the 2019 performance period, ICD-10 coding changes during the performance period, or specifications determined during or after the performance period to have substantive changes.

Quality Measure ID	Collection Type	Issue	Reason for the Measure Change	Impact to Scoring and Feedback Expectations
001	Medicare Part B Claims	Truncation	American Medical Association (AMA) update to CPT code set	Medicare Part B claims data will be scored on a shortened performance period (1/1 – 9/30/19) from 12 months to 9 months.
069	MIPS CQM	Suppressed	National Comprehensive Cancer Network (NCCN) clinical guideline changes	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Feedback will show "- -" if measure was reported but excluded from scoring.
110/ PREV-7	Medicare Part B Claims, eCQM, MIPS CQM, CMS Web Interface	Suppressed	Centers of Disease Control (CDC)/Advisory Committee on Immunization Practice (ACIP) clinical guidelines changes	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Feedback will show "- -" if measure was reported but excluded from scoring.
134/ PREV-12	eCQM, CMS Web Interface	Suppressed	Substantive Change/ Removal of SNOMED codes	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure Feedback will show "- -" if measure was reported but excluded from scoring.
226/ PREV-10	CMS Web Interface	Suppressed	Measure specification was updated mid-year	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Feedback will show "- -" if measure was reported but excluded from scoring.
326	Medicare Part B Claims, MIPS CQM	Truncation	ICD-10 changes	Measure has a 9-month performance period (Jan. 1 to Sept. 30, 2019)
370/MH-1	CMS Web Interface	Suppressed	Measure does not have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met. Feedback will show "- -" if measure was reported but excluded from scoring.
392	MIPS CQM	Truncation	ICD-10 changes	Measure has a 9-month performance period (Jan. 1 to Sept. 30, 2019)
438/ PREV-13	CMS Web Interface	Suppressed	Measure does not have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Feedback will show "- -" if measure was reported but excluded from scoring.
450	MIPS CQM	Suppressed	Food and Drug Administration (FDA) clinical guideline change	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Feedback will show "- -" if measure was reported but excluded from scoring.

***Please note**: All screenshots are for illustrative purposes only.*
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