Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Scoring Guide for the 2020 Performance Year

Updated: 5/20/2021

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

Already know what MIPS is?
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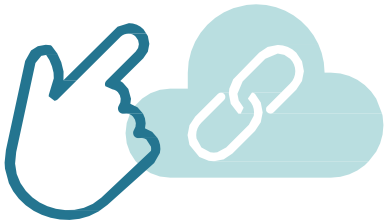
Purpose: *We developed this guide to provide a general summary about MIPS scoring. This guide does not address MIPS APM policies or the APM Scoring Standard. We are developing a separate guide to review the APM Scoring Standard, which will be available in the QPP Resource Library.*

How to Use This Guide

How to Use This Guide



Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

In this guide, we use the term "clinician" for MIPS eligible clinicians.

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Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

Overview

COVID-19 and 2020 Participation

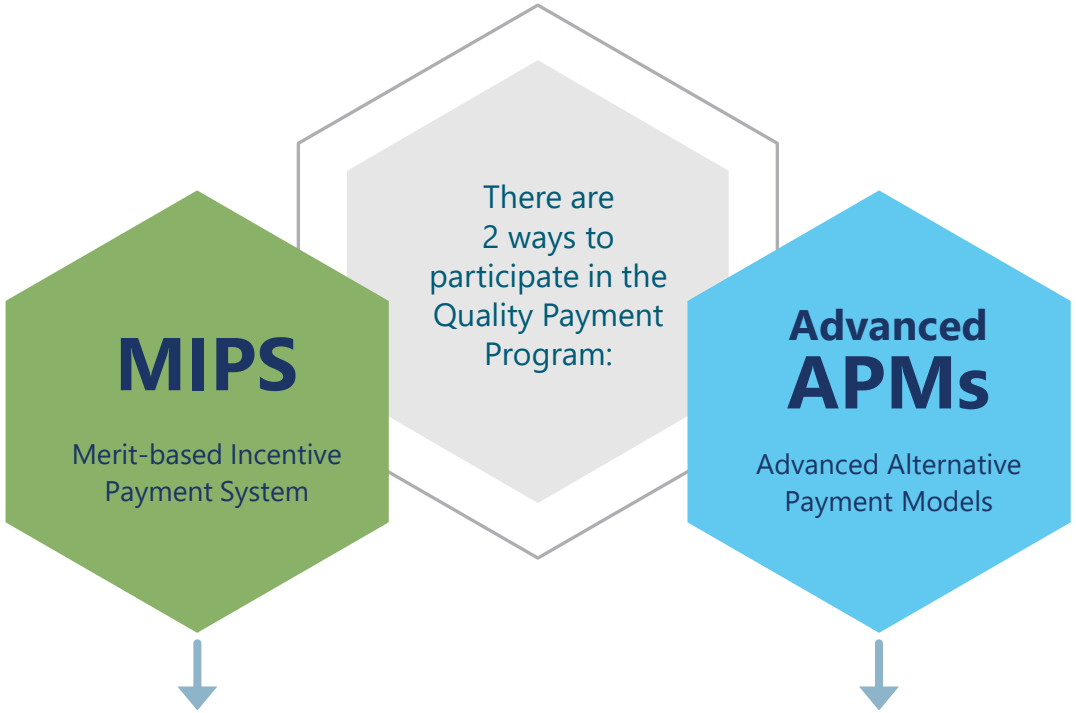
CMS continues to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We are applying the MIPS automatic extreme and uncontrollable circumstances (EUC) policy to all individual MIPS eligible clinicians for the 2020 performance period. We also reopened the MIPS EUC application for groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2021 at 8 p.m. ET.

Please note that applications received by March 31, 2021 won't override previously submitted data for individuals, groups and virtual groups. However, data submission for an APM Entity won't override performance category reweighting from an approved application.

For more information about the impact of COVID-19 on Quality Payment Program participation, see the Quality Payment Program COVID-19 Response webpage or the Quality Payment Program COVID-19 Response Fact Sheet.

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which rewards value in 1 of 2 ways:



If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve QP status, you will be excluded from MIPS and may be eligible for a 5% incentive payment

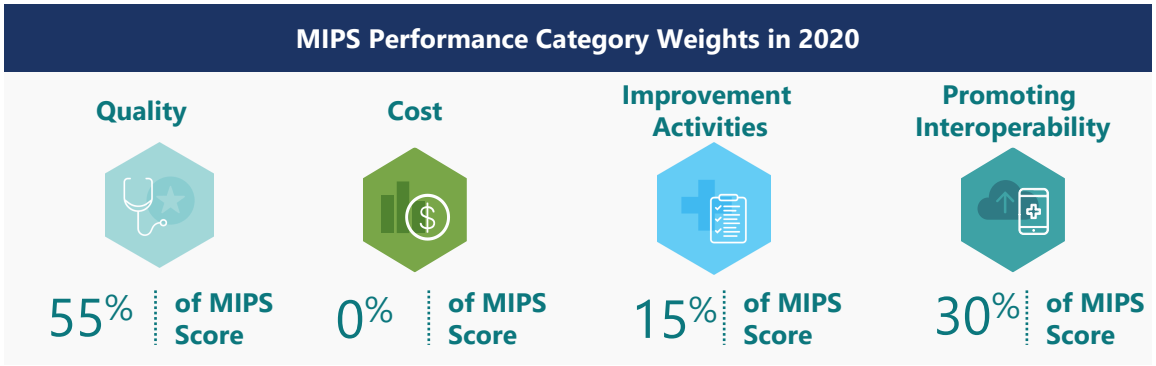
Overview

What is the Merit-based Incentive Payment System (MIPS)?

MIPS is one way to participate in QPP. The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes. Under MIPS, we evaluate your performance across 4 performance categories that lead to improved quality and value in our healthcare system.

If you're eligible for MIPS in 2020:

- You generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories. (We collect and calculate data for the Cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS Final Score of 0 to 100 points. **We have updated this resource to reflect the 0% weight of the cost performance category for all MIPS eligible clinicians in the 2020 performance year.**
- Your MIPS Final Score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2020 performance year and applied to payments for covered professional services beginning on January 1, 2022.



In certain circumstances, one or more of the performance categories may be reweighted to 0%. More information on reweighting, including for Extreme and Uncontrollable Circumstances, is provided in each category section and in Appendix B.

To learn more about how to participate in MIPS:

- *Visit the How MIPS Eligibility is Determined and Individual or Group Participation webpages on the Quality Payment Program website.*
- *View the 2020 MIPS Eligibility and Participation Quick Start Guide.*
- *Check your current MIPS participation status using the QPP Participation Status Tool.*

To learn more about MIPS APM participation and the APM Scoring Standard:

- *Review the 2020 APM Quality Scoring Resources.*
- *Review the 2020 APM Scoring Standard User Guide (available in the QPP Resource Library by the end of 2020).*

Getting Started: Reviewing MIPS Terms

Collection Type*

Collection Type is a set of quality measures with comparable specifications and data completeness criteria, identified as:

- Electronic clinical quality measures (eCQMs);
- MIPS clinical quality measures (CQMs);
- Qualified Clinical Data Registry (QCDR) measures;
- Medicare Part B claims measures;
- CMS Web Interface measures;
- Consumer Assessment of Healthcare, Providers and Systems (CAHPS) for MIPS Survey measure; and
- Administrative claims measures.

*The term "Collection Type" is unique to the Quality performance category and does not apply to the other 3 performance categories.

Measures and activities submitted via multiple submission types can count towards a single performance category score but there is some variation between performance categories. Please see Data Aggregation and Multiple Submissions within each performance category section for more information.

Submitter Type

Submitter Type refers to the MIPS eligible clinician, group, virtual group, or third-party intermediary (acting on behalf of a MIPS eligible clinician, group, or virtual group) that submits data on measures and activities.

Submission Type**

Submission Type is the mechanism by which the submitter type submits data to CMS:

- Direct (transmitting data through a computer-to-computer interaction, such as an Application Program Interface, or API);
- Sign in and upload (attaching a file);
- Sign in and attest (manually entering data);
- Medicare Part B claims; and
- CMS Web Interface.

**There is no submission type for cost data because we collect and calculate your cost measures from administrative claims data submitted for payment.

MIPS Quality Performance Category

MIPS Quality Performance Category

What are the Quality Performance Category Data Submission Requirements?

You can select from **more than 200** available quality measures finalized for the 2020 performance period. You will need to collect and submit data for each quality measure for the entire calendar year of 2020.

With the exception of CMS Web Interface measures, CMS will aggregate quality measures collected through multiple collection types. If you submit the same measure through multiple collection types, we will select the collection type for that measure with the greatest number of measure achievement points for scoring.

55% of final score
Unless you qualify for reweighting in the Promoting Interoperability or improvement activities performance categories

UPDATED 5/20/2021

To meet the Quality performance category requirements, a MIPS eligible clinician, group, or virtual group can:

Submit 6 quality measures for the 12-month performance period:

- 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
- If you're reporting from a defined specialty measure set that has fewer than 6 measures, you need to submit all measures within that specialty set.
- The CAHPS for MIPS Survey measure counts as 1 of the 6 measures for registered groups and virtual groups. The CAHPS for MIPS Survey measure is a patient experience measure and can be counted as a high priority measure if there are no applicable outcome measures.
- If you're reporting fewer than 6 measures, you will be evaluated to determine if there were any clinically related measures that should have been reported.

OR

Submit all quality measures included in the CMS Web Interface, a collection type available to registered groups or virtual groups with 25 or more eligible clinicians. The CAHPS for MIPS Survey measure can be submitted as an additional high priority measure.

What are the Quality Performance Category Data Submission Requirements? *(continued)*

The All-Cause Hospital Readmission Measure

UPDATE 2/25/2021: For the 2020 performance period, groups and virtual groups with 16 or more eligible clinicians were to be scored on the All-Cause Hospital Readmission measure if they met the case minimum of 200 patients for the measure. However, CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or be attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

You can also review the information in Appendix E.

Are the Quality Performance Category Data Submission Requirements Different for the CMS Web Interface?

Yes. Registered groups and virtual groups using the CMS Web Interface will submit data for all the required quality measures in the CMS Web Interface for a full year, even if they are also submitting the CAHPS for MIPS measure.

MIPS Quality Performance Category

What is Facility-based Scoring?

Facility-based clinicians, groups, and virtual groups may have the option to use facility-based measurement scores for their Quality and Cost performance category scores.

Facility-based scoring will be used for your Quality and Cost performance category scores when:

You are identified as facility-based at the level you intend to participate.	AND	You are attributed to a facility with a FY 2021 Hospital Value-Based Purchasing (VBP) Program score at the level you intend to participate.	AND	If you choose to submit Quality measures for MIPS, the Hospital VBP Program score results in a higher score than the MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

For example, if your practice is participating as a group (submitting aggregated data for the TIN), you would need to look for the facility-based designation and facility attribution at the **Practice Level** on qpp.cms.gov.

Did You Know? Due to Hospital VBP Program timelines, we can't confirm whether your assigned facility has a FY 2021 score (used for MIPS facility-based scoring in 2020) until the end of, or after, the 2020 MIPS performance period.

For more information on Facility-based Measurement, please review the 2020 Facility-Based Quick Start Guide.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Are you submitting your quality measures through the CMS Web Interface? Skip ahead.

How are Measures Assessed in the Quality Performance Category for the 2020 Performance Period?

Your performance on each quality measure is assessed against a benchmark to see how many points you earn for the measure.

Benchmarks are differentiated by collection type. There may be different benchmarks for the same measure if it can be reported through multiple collection types.

Whenever possible, we create historical benchmarks and post them on the QPP Resource Library at the start of the performance period. Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years prior to the applicable performance period. The historical benchmarks for the 2020 MIPS performance period were established from quality data submitted for the 2018 MIPS performance period.

For more information about 2020 quality benchmarks, please review the information included in the 2020 Quality Benchmark zip file on the QPP Resource Library.

Did You Know? If you submit eCQMs, you need to use CEHRT to collect the eCQM data. The CEHRT used to collect the data will need to be certified to the 2015 Edition by the last day of the Quality performance period (December 31, 2020).

UPDATE 2/25/2021: CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet or Appendix E

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

What if a Quality Benchmark Doesn't Have a Historical Benchmark?

For a measure without a historical benchmark, we will try to calculate a benchmark following the submission period based on 2020 performance data on those measures.

Performance period benchmarks can be calculated when 20 or more individuals, groups, or virtual groups submit the measure via the same collection type where the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured);
- Meets or exceeds the 70% data completeness criteria; and
- Has a performance rate greater than 0% (or less than 100% for inverse measures).

Individuals, groups, and virtual groups must be included in MIPS (i.e., are not voluntarily reporting) for their data to be used in the creation of a benchmark.

How are Measures Scored?

If a measure can be reliably scored against a benchmark, it means:

A benchmark is available.	AND	The volume of cases you've submitted is sufficient (>20 cases for most measures; >200 cases for the hospital readmission measure).	AND	You've met data completeness requirements (submitted data for at least 70% of the denominator eligible patients/instances).

MIPS Quality Performance Category

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

How are Measures Scored? *(continued)*

Did You Know? In 2020, we established an alternate benchmarking methodology for scoring quality measures MIPS 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), and MIPS 236 (Controlling High Blood Pressure) when we determined that their historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient.

- We will use **flat benchmarks** to score all collection types for MIPS 236.
- We will use **flat benchmarks** to score the Medicare Part B claims and MIPS CQM collection types for MIPS 001.
- We will continue to use the **historical, performance-based benchmark** to score the eCQM collection type of MIPS 001.

The 2020 Quality Benchmarks file includes these flat benchmarks.

Measure Achievement Points

Measure achievement points are based on your performance on a measure in comparison to a benchmark, exclusive of bonus points.

3 – 10 Points*	**3** Points	**3** Points	**0** (0 out of 10 points)
You will continue to receive between 3 and 10 achievement points for Quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.	You will continue to earn 3 points for quality measures that meet data completeness requirements but do not have a benchmark or meet the case minimum.	**Small practices only:** You will continue to receive 3 point for measures that don't meet data completeness requirements. .	*NEW!* If you are not (in) a small practice, you will receive 0 points for measures that do not meet data completeness requirements.

**Exception: There are specified, topped out measures that are capped at 7 points. (These measures are identified on the 2020 MIPS Quality Historical Benchmarks Excel file – see column Q – in the 2020 Quality Benchmarks zip file.)*

MIPS Quality Performance Category

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

How are Measures Scored? *(continued)*

Measure Bonus Points

You can earn bonus points in the Quality performance category in addition to measure achievement points when reporting eCQMs, MIPS CQMs, QCDR measures and Medicare Part B Claims measures.

Bonus Type	High Priority Bonus		End-to-End Reporting Bonus
	Additional Outcome or Patient Experience Measures (beyond the 1 required)	Other High Priority Measures	End-to-End Electronically Reported Measures
Bonus Points per measure	2	1	1
Performance Rate > 0% Required? (or less than 100% for inverse)	Yes		No
Must meet case minimum (20) and data completeness requirements (70%)?	Yes		No
Measures submitted through multiple collection types receive the bonus point(s) once?	Yes		N/A
Points for each Bonus type capped at 10% of the Quality performance category denominator?	Yes		Yes
Points automatically applied to eCQMs?	No		Yes*

*Bonus points can be applied to MIPS CQMs without an eCQM equivalent and QCDR measures if the submission indicates that the measure(s) meets end-to-end electronic reporting criteria. Please refer to Appendix C for more information.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

What if I Submit More Than 6 Measures?

If you submit 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 provided you haven't exceeded the 10% cap for the applicable bonus.

When determining which submitted measures are included in the top 6:

- We will select the highest scoring outcome measure.
  - If no outcome measure is available, then we will select the highest scoring high priority measure.
- We will then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we will select 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 finds you didn't have 1 available.

Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85% performance rate, 1 may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

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 outcome measure) were the Colorectal Cancer Screening and Photodocumentation of Cecal Intubation measures, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top 6 because its measure ID (113) has a lower value than the Photodocumentation of Cecal Intubation measure (425).

Groups and virtual groups that meet case minimum for the All-Cause Hospital Readmission measure will be scored on 7 measures.

***NOTE:** We continue to examine our current policies and the potential impact COVID-19 may have on participation in the Quality Payment Program for the 2020 performance period and beyond and may be addressing further changes through guidance and rulemaking.*

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

Data Aggregation and Multiple Submissions

If you submit the same quality measure multiple times through the same collection type, we will use the most recently reported data you submitted for that specific measure. We will not aggregate measure level performance data when the same measure is reported multiple times.

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 collection type of the measure based on achievement points. Under no circumstances will you earn achievement points from 2 collection types of the same measure.

How Many Measure Points Can I Earn in the Quality Performance Category?

Clinicians, groups, and virtual groups can earn a maximum of 60 measure achievement points in the Quality performance category (10 x the number of measures you're required to report).

Maximum Points by Participation Level:

Individuals
60 points

Groups/
Virtual Groups
60 points
The readmission measure won't apply for PY 2020

UPDATE 2/25/2021: CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet or Appendix E

Individuals, groups, and virtual groups that don't submit at least 1 available measure will receive 0 points in this category unless you qualify for reweighting.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

Can the Denominator (Maximum Number of Points) be Lower Than 60 Points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lowered.

IF…	THEN…
You submit a complete specialty measure set with fewer than 6 measures by Medicare Part B claims or as MIPS CQMs.	We will lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B claims measures or fewer than 6 MIPS CQMs AND the Eligible Measure Applicability (EMA) process determines no additional measures were available. ***How?*** *We compare the measures you submitted with a predefined list of clinically related measures.*	We will lower the denominator by 10 points for each measure that isn't available. ***NOTE:*** *If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the Quality performance category, and you will earn a score of 0 out of 10 for each unreported measure.*
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results. We will identify these measures by the beginning of the submission period via QPP listserv.	We will lower the denominator by 10 points for each impacted measure. ***Why?*** *So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification.*
Your group registers for the CAHPS for MIPS Survey but does not meet the minimum beneficiary sampling requirements AND submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS survey measure.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs *(continued)*

What are the Steps to Score Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs?

1. **Check to see if the 70% data completeness requirement was met.**
   - If Yes – continue to step 2
   - If No – assign 3 points to measures submitted by a small practice, or 0 points to all others
2. **Check to see if 20 case minimum requirement was met.**
   - If Yes – continue to step 3
   - If No – assign 3 points
3. **Check to see if there is a benchmark associated with the collection type.** (We'll attempt to create a performance period benchmark following the submission period if there is no historical benchmark.)
   - If Yes – continue to step 4
   - If No – assign 3 points
4. **Assign achievement points based on the benchmark. Achievement points are calculated by mapping the performance rate to the benchmark for the collection type.**
   - Determine the decile that the performance rate falls in and assign points
   - Reminder: Measures 001 and 236 will generally be scored against a flat benchmark instead of a performance-based historical benchmark.
   - Note: Specified topped out measures identified on the 2020 MIPS Quality Historical Benchmarks Excel file are capped at 7 points.
5. **Calculate and add any bonus points.**
   - The measure(s) doesn't/don't have to be in the "top 6" to earn bonus points
   - The high priority/outcome bonus measure(s) must meet the case minimum and data completeness requirements and have a performance rate greater than 0% (or less than 100% for inverse measures)
   - The end-to-end bonus measure(s) does/do not have to meet the case minimum and data completeness requirements
   - Each category of bonus points (high priority and end-to-end) is capped at 10% of the denominator of the Quality performance category score

Repeat steps 1-5 for each measure.

Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.

Skip ahead to review how we calculate the Quality performance category score.

Submitting CMS Web Interface Measures

REMINDER: This guide focuses on scoring for MIPS and does not address the APM Scoring Standard or scoring policies for APM Entities specific to their participation in an APM such as the Medicare Shared Savings Program or Next Generation ACO Model.

How are Web Interface Measures Assessed in the Quality Performance Category for the 2020 Performance Period?

When you submit measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. Groups and virtual groups submitting their quality measures through the CMS Web Interface will be assessed against benchmarks from the Medicare Shared Savings Program. For more information, review the Medicare Shared Savings Program Quality Measure Benchmarks for the 2020/2021 Performance Years.

NOTE: CMS Web Interface measures cannot be combined with other collection types other than the CAHPS for MIPS Survey measure.

What if a CMS Web Interface Measure Doesn't Have a Benchmark?

Unlike other collection types, we will not attempt to calculate a performance period benchmark if there isn't an existing benchmark for MIPS scoring (which generally occurs when the measure is classified as pay-for-reporting in the Shared Savings Program). CMS Web Interface measures without an existing benchmark do not count toward your Quality performance category score, as long as you meet data completeness requirements.

The following measures do not have benchmarks for 2020 MIPS scoring:

- MH-1: Depression Remission at Twelve Months
- PREV-12: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

This leaves a total of 7 measures that can be scored against a benchmark.

UPDATE 2/25/2021: CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet or Appendix E

MIPS Quality Performance Category

Submitting CMS Web Interface Measures *(continued)*

How are CMS Web Interface Measures Scored?

Measure Achievement Points

Measure achievement points are based on your performance on a measure in comparison to a benchmark, exclusive of bonus points.

3 – 10 points	0 (0 out of 10 points)	0 (0 out of 10 points)	N/A (0 out of 0 points)	N/A (0 out of 0 points)
You will continue to receive between 3 and 10 achievement points for Quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.	You will continue to receive 0 points (0 out of 10) for measures that are not reported.	You will continue to receive 0 points (0 out of 10) for measures that do not meet data completeness requirements.	You will not be scored on measures for which your sample is fewer than 20 Medicare patients, provided you report on all the patients in the sample.	You will not be scored on measures without an existing benchmark (or designated as "pay-for-reporting" under the Shared Savings Program) provided that data completeness requirements are met.

You must meet data completeness requirements for all CMS Web Interface measures to receive a quality score from CMS Web Interface reporting.

Measure Bonus Points

You can earn 1 bonus point per CMS Web Interface measure submitted according to Web Interface **end-to-end electronic reporting** criteria. For the 2020 performance period, this means submitting data collected in your CEHRT directly to CMS via the Web Interface Application Programming Interface (API) or Excel upload.

Did You Know?

- These bonus points are capped at 10% of the Quality performance category denominator (or the total available measure achievement points).
- Groups and virtual groups can still earn 2 bonus points for reporting the CAHPS for MIPS survey measure in addition to the CMS Web Interface measures.

MIPS Quality Performance Category

Submitting CMS Web Interface Measures *(continued)*

How Many Measure Points can I Earn in the Quality Performance Category?

Groups and virtual groups submitting through the CMS Web Interface that don't administer the CAHPS for MIPS survey can earn a maximum of 70 measure achievement points in the Quality performance category.

Groups and virtual groups submitting through the CMS Web Interface that administer the CAHPS for MIPS survey can earn a maximum of 80 measure achievement points in the Quality performance category.

Maximum Points for Groups/Virtual Groups:

70 points
CMS Web Interface Measures

80 points
CMS Web Interface Measures
+ CAHPS for MIPS Survey

UPDATE 2/25/2021: CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet or Appendix E

Can the Denominator (Maximum Number of Achievement Points) be Lower Than 70 Points?

Yes, your denominator will be lowered if:

- You have fewer than 20 Medicare patients in a measure's sample (don't meet case minimum); AND
- You submit complete data for all of the Medicare patients in the sample (meet data completeness requirements).

If you meet data completeness requirements, then we'll lower the denominator (maximum number of points) by 10 points for each measure that doesn't meet case minimum.

Submitting CMS Web Interface Measures *(continued)*

What are the Steps to Score CMS Web Interface Measures?

1. **Check to see if data completeness requirements are met (measure is reported for the first 248 consecutively assigned Medicare patients in the sample or 100% of the sample if less than 248 Medicare patients).**
   - If Yes – continue to step 2
   - If No – assign 0 points to measure
2. **Check to see if the 20 case minimum requirement was met.**
   - If Yes – continue to step 3
   - If No – exclude from scoring (measure earns 0 out of 0 points)
3. **Check to see if there is a Shared Savings Program benchmark associated with the measure.**
   - If Yes – continue to step 4
   - If No – exclude from scoring (measure earns 0 out of 0 points)
4. **Assign achievement points based on the benchmark.** Achievement points are calculated by mapping the performance rate to Shared Savings Program benchmark.
   - Determine the decile that the performance rate falls in and assign points
5. **Calculate and add any bonus points.**
   - The measure must meet the case minimum and data completeness requirements and have a performance rate > 0%
   - The end-to-end reporting category of bonus points is capped at 10% of the denominator of the Quality performance category score

Repeat steps 1 – 5 for each measure.

MIPS Quality Performance Category

Calculating the Quality Performance Category Percent Score

Scoring for Individuals, Groups, and Virtual Groups

For clinicians, groups, and virtual groups that are not a small practice:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points}}{\text{Total Available Measure Achievement Points*}} \times 100\% \right) + \text{Improvement Percent Score}$$

*Total Available Measure Achievement Points = the number of required measures x 10

For clinicians, groups, and virtual groups that are part of a small practice:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points} + \text{Small Practice Bonus (6 points)}}{\text{Total Available Measure Achievement Points*}} \times 100\% \right) + \text{Improvement Percent Score}$$

Calculating the Quality Performance Category Percent Score *(continued)*

Scoring for Individuals, Groups, and Virtual Groups *(continued)*

High priority and end-to-end electronic reporting bonus points are each capped at 10% of the denominator, which is the total possible points you could earn in the Quality performance category.

For example, if your Quality performance category denominator is 60 points, then you can earn up to 12 measure bonus points total, 6 points from each bonus category.

What is Improvement Scoring?

MIPS eligible clinicians can earn up to 10 additional percentage points in the Quality performance category based on the rate of their improvement in the Quality performance category from the previous year. The improvement percent score—calculated at the category level and represents improvement in achievement from one year to the next— may not total more than 10 percentage points. If CMS can't compare data between 2 performance periods, or there is no improvement, the improvement score will be 0%. The improvement percent score cannot be negative.

The small practice bonus will now be added to the Quality performance category, rather than in the MIPS Final Score calculation. 6 bonus points are added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure (these bonus points are available to small practices through individual, group, and virtual group participation).

Your Quality performance category percent score is then multiplied by the 45% Quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS Final Score.

The maximum score is 100% of the category weight.

Calculating the Quality Performance Category Percent Score *(continued)*

What is Improvement Scoring? *(continued)*

Eligibility for these additional percentage points is determined by meeting the following criteria:

1. **Full participation in the Quality category for the current performance period:**

Submits 6 measures (with at least 1 outcome/high priority measure) OR Submits a complete specialty measure set (which may have fewer than 6 measures) OR Submits all the measures in the CMS Web Interface

All submitted measures must meet data completeness requirements.

2. **Data sufficiency standard is met, meaning there is data available and can be compared:**

There is a Quality performance category achievement percent score (the score earned by measures based on performance excluding bonus points) for the previous performance period (Year 3, 2019) and the current performance period AND Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods

Did You Know?
Improvement scoring is not available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period. For example, if your PY 2019 Quality score is derived from facility-based measurement, you are not eligible for improvement scoring in PY 2019 or PY 2020.

Calculating the Quality Performance Category Percent Score *(continued)*

Scoring Example

A small practice, participating as a group, reports 2 Medicare Part B claims measures and 3 eCQMs. They also registered to administer the CAHPS for MIPS Survey but were unable to administer the survey because they didn't meet the beneficiary sampling requirements.

Measure Type	Collection Type	Achievement Points	Bonus Points	Total Points
Outcome Measure #1	Medicare Part B Claims	7.8	N/A (Required)	7.8
Process Measure	Medicare Part B Claims	7.1	N/A	7.1
Process Measure	eCQM	6.9	1 (End-to-End)	7.9
Outcome Measure #2	eCQM	8.2	1 (End-to-End) 2 (High Priority Outcome)	11.2
Process Measure	eCQM	6.1	1 (End-to-End)	7.1
Totals		36.1	5	41.1

Because they are a small practice, they qualify for 6 bonus points.

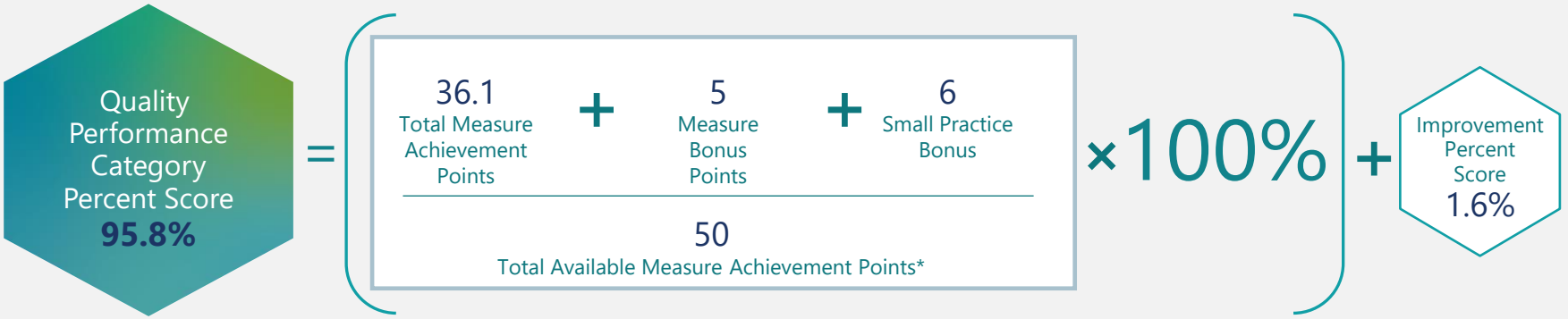
They also qualify for improvement scoring because their achievement percent score showed improvement from last year.

- Their 2020 achievement percent score = 36.1/50 = 72.2%
- Their 2019 achievement percent score = 62.2%
- The increase in their achievement percent score = 72.2% - 62.2% = 10%
- Their improvement percent score = (10% ÷ 62.2%) x 10 = 1.6%

MIPS Quality Performance Category

Calculating the Quality Performance Category Percent Score *(continued)*

Scoring Example *(continued)*



Why is Their Denominator 50?

The group registered for, but did not meet, the sampling requirements for the CAHPS for MIPS Survey measure and submitted less than 6 quality measures, so we reduced the denominator by 1 required measure.

Can the Quality Performance Category be Reweighted?

There are a couple of instances when the Quality performance category can be reweighted.

1. We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the Quality Payment Program COVID-19 Response Fact Sheet, 2020 MIPS Exceptions Application Fact Sheet or the Exceptions Application webpage for more information.
2. In the rare instance when there are no quality measures applicable and available to you, you won't be scored on this category and it will be reweighted to 0% of your final score. We anticipate that reweighting of the Quality performance category would be rare because there are quality measures applicable and available for most clinicians. Please contact the Quality Payment Program if this applies to you so that we can evaluate whether you have applicable and available quality measures to submit. You can contact the Quality Payment Program by phone (1-866-288-8292) or email (qpp@cms.hhs.gov). Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Please refer to Appendix B for more information on performance category reweighting, including the extreme and uncontrollable circumstances policy.

MIPS Cost Performance Category

MIPS Cost Performance Category

UPDATED 5/20/2021: Cost Will Be Weighted at 0% for all MIPS Eligible Clinicians for the 2020 Performance Period

0% of final score for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity

CMS is reweighting the cost performance category from 15% to 0% for the 2020 performance period for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. The 15% cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(D).

As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they will receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year. This reweighting of the cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policy under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), § 414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3). Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC will still have their cost performance category weighted to 0%.

MIPS Improvement Activities Performance Category

MIPS Improvement Activities Performance Category

What are the Data Submission Requirements for the Improvement Activities Performance Category?

15% of final score for most MIPS eligible clinicians and groups, unless they are in a MIPS APM

You can earn up to 40 points in the Improvement Activities performance category by submitting between 1 and 4 improvement activities.

To report (or "submit") an improvement activity, you simply attest to having completed it. No data needs to accompany the attestation as part of the submission.

You do not have to submit any supporting documentation when you attest to completing an improvement activity, but you must keep documentation of the efforts you (or the group or virtual group) undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the 2020 MIPS Data Validation Criteria.

Data Aggregation and Multiple Submissions

We will combine improvement activities submitted through attestation, file upload, and/or direct submission into a single performance category score (not to exceed 100%). If you submit the same activity through multiple submission types, the improvement activity will be counted once.

How are Activities Assessed and Scored?

Improvement activities have been assigned to 1 of 2 categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities.

Generally speaking, clinicians, groups, and virtual groups that do not have certain special status designation(s) will receive the following points for their submitted activities:

- Medium-weighted activities = 10 points
- High-weighted activities = 20 points

To earn the maximum score of 40 points for the Improvement Activities performance category, you can pick any of these:

4 medium-weighted activities = **40 points**

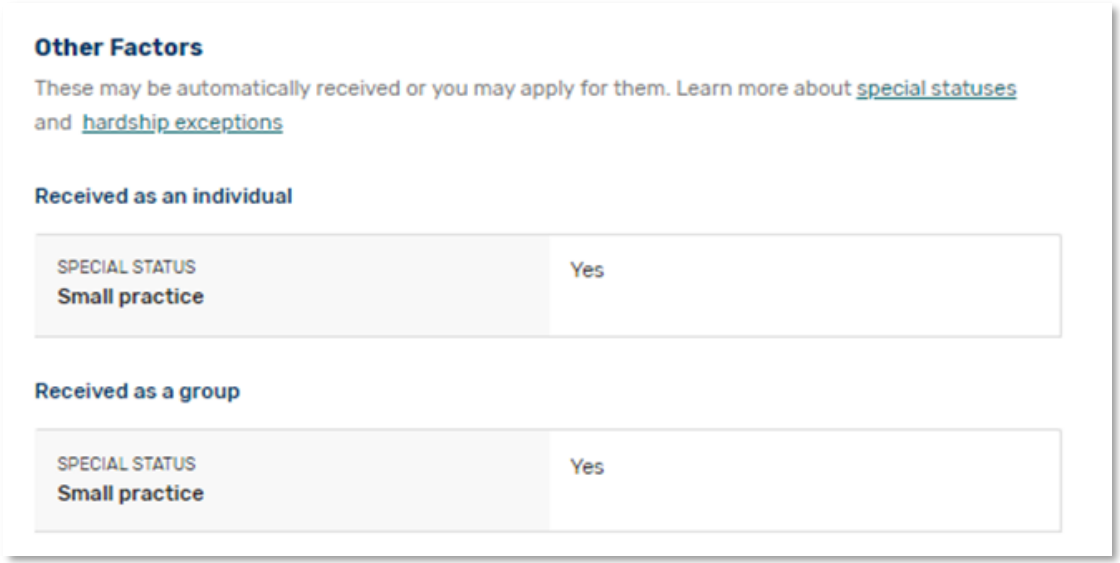
2 medium-weighted activities + 1 high-weighted activity = **40 points**

2 high-weighted activities = **40 points**

MIPS Improvement Activities Performance Category

How are Activities Assessed and Scored? *(continued)*

More points are given for improvement activities for clinicians, groups, and virtual groups identified with a 1) small practice designation (15 or fewer NPIs), 2) non-patient facing designation, 3) health professional shortage area (HPSA) or 4) rural designation on the QPP Participation Status Tool.



These clinicians, groups, and virtual groups will receive the following points for their submitted activities:

Medium-weighted activities = **20 points**

High-weighted activities = **40 points**

To earn the maximum 40 points for the improvement activity performance category, they can complete either:

40 points = 2 medium-weighted activities + 2 medium-weighted activities OR 1 high-weighted activity

To learn more, see the 2020 MIPS Improvement Activities User Guide or review the 2020 Improvement Activities Inventory.

MIPS Improvement Activities Performance Category

How Many Points Can I Earn in the Improvement Activities Performance Category?

Clinicians, groups, and virtual groups can earn a maximum of 40 points in the Improvement Activities performance category. The Improvement Activities score, like all performance categories, is capped at 100%.

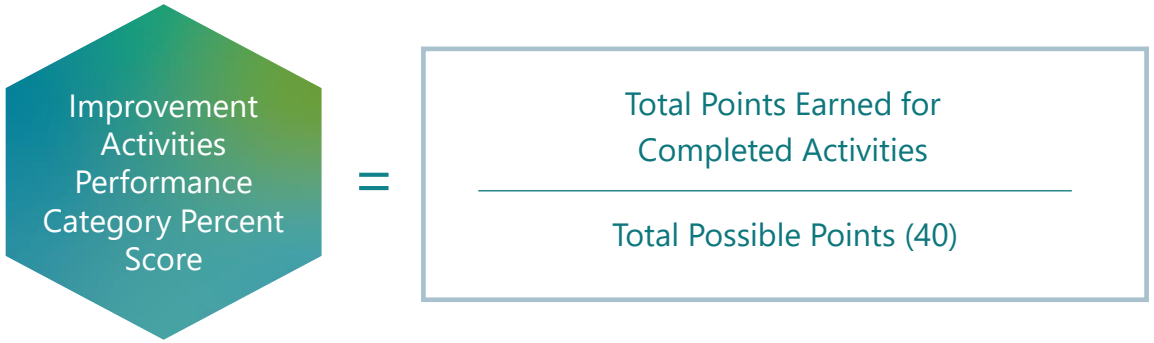
Can the Denominator (Maximum Number of Points) be Lower than 40?

No, you will always be scored out of 40 points in the Improvement Activities performance category, though you may receive more points per activity based on your circumstances.

How is my Improvement Activities Performance Category Percent Score Calculated?

The Improvement Activities performance category is 15% of your final score for the 2020 performance year.

The maximum score is 100% of the category weight.



MIPS Improvement Activities Performance Category

How is my Improvement Activities Performance Category Percent Score Calculated? *(continued)*

Scoring Example

Let's continue our previous example of the small practice reporting as a group. They cannot attest to having participated in CAHPS as an improvement activity because they did not meet beneficiary sampling requirements. They selected 2 improvement activities, 1 medium-weighted and 1 high-weighted. Because they are a small practice, they earn double points for each activity reported.

Even if you submit additional activities, you cannot earn more than 100% in the performance category.

Improvement Activities Performance Category Percent Score **100%** = Total Points Earned for Completed Activities: 20 + 40 / Total Possible Points: 40

How Does Scoring Work if I'm in a Patient-centered Medical Home?

If you're in a certified or recognized patient-centered medical home (PCMH) or comparable specialty practice, you'll earn full credit (100%) for the Improvement Activities performance category. You **must attest** to your status as a PCMH or comparable specialty practice during the PY 2020 submission period in order to receive full credit for the Improvement Activities performance category.

If reporting as a group or virtual group, at least 50% of the practice sites within a group's TIN must be recognized as a PCMH or comparable specialty practice.

Can the Improvement Activities Performance Category be Reweighted?

We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the Quality Payment Program COVID-19 Response Fact Sheet, 2020 MIPS Exceptions Application Fact Sheet, or the Exceptions Application webpage for more information.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

MIPS Promoting Interoperability Performance Category

MIPS Promoting Interoperability Performance Category

Quality Payment PROGRAM

Overview

The 2020 Promoting Interoperability performance category focuses on 4 objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. These objectives are comprised of 6 required measures and attestations.

30% of final score
Unless you qualify for reweighting in the quality or improvement activities performance categories

UPDATED 5/20/2021

2015 Edition CEHRT is required for participation in this performance category

What are the Data Submission Requirements for the Promoting Interoperability Performance Category?

There's a single set of measures and objectives you must report for the 2020 performance period as outlined in the table below.

When you report on required measures that have a numerator/denominator, you must submit at least a 1 in the numerator if you do not claim an exclusion.

Objectives	Measures	Requirements
e-Prescribing	**e-Prescribing**	Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)	Optional measure cannot be reported if an exclusion is claimed for the required e-Prescribing measure
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	Required unless an exclusion is claimed
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	Required (no exclusion available)
Public Health and Clinical Data Exchange	**Report to 2 different public health agencies or clinical data registries for any of the following:** • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Required unless an exclusion(s) is claimed

What are the Data Submission Requirements for the Promoting Interoperability Performance Category? *(continued)*

In addition to reporting the previously listed measures, you must also:

- Use 2015 Edition CEHRT to meet the measures above and collect your data (certified by the last day of the performance period)
- Submit a "yes" to the Prevention of Information Blocking attestation
- Submit a "yes" to the ONC Direct Review attestation
- Submit a "yes" that you have completed the Security Risk Analysis measure during 2020
- Submit the CMS identification code for your EHR product(s) as proof that it is certified by ONC to the 2015 Edition (you can find this information at https://chpl.healthit.gov/#/search)

If any of these requirements are **not met**, you will get 0 points in the Promoting Interoperability performance category.

Data Aggregation and Multiple Submissions

We recommend a single submission (file upload, API **or** attestation; by you **or** a third party) to report your promoting interoperability data.

Any conflicting data submitted for a single measure or required attestation will result in a score of 0 for the Promoting Interoperability performance category.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2020?

For the 2020 performance period, each required measure will be scored based on the performance data you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Query of PDMP measure (optional) and the Public Health and Clinical Data Exchange objective's measures, which require a "yes" or "no" submission. Each measure will contribute to your total Promoting Interoperability performance category score.

NOTE: If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2020? *(continued)*

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance.

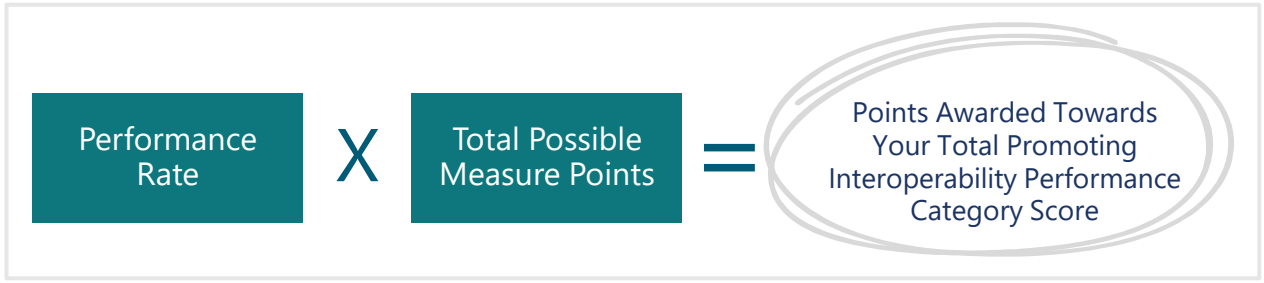
For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure.

- **Exception:** The bonus measure in the e-Prescribing objective will earn 5 points if submitted.
- **Exception:** When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as at the clinician reported on at least 1 patient.

Objectives	Measures	Available Points
e-Prescribing	**e-Prescribing**	1 – 10 points
	Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	1 – 20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	1 – 20 points
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	1 – 40 points
Public Health and Clinical Data Exchange	**Report to 2 different public health agencies or clinical data registries for any of the following:** • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	10 points (for the entire objective)

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2020? *(continued)*

Let's look at how we score a measure, based on your performance rate and the total points available.



This example shows the number of points the Provide Patients Electronic Access to Their Health Information measure contributed to a clinician's Promoting Interoperability performance category score

The Public Health and Clinical Data Exchange objective is scored differently because these measures are submitted with a "yes" or "no" instead of numerator and denominator values.

You will receive 10 points in this objective when:

- You submit a "yes" to 2 measures in the objective*
- You submit a "yes" to 1 measure and claim an exclusion for a second measure

*You can report the same measure twice as long as you're actively engaged with 2 different agencies or registries.

MIPS Promoting Interoperability Performance Category

How Many Points Can I Earn in the Promoting Interoperability Performance Category?

While there are 105 total points available, clinicians, groups, and virtual groups cannot earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

Can the Denominator (Maximum Number of Points) Be Lower than 100?

No, you will always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

Please see Appendix D for detailed information about how points are reallocated when an exclusion(s) is claimed.

How is the Promoting Interoperability Performance Category Scored?

We'll add the scores for each of the individual measures (or objective) together and divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category percent score.

REMINDER: You will receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation; report on a required measure; or claim an exclusion for a required measure (where applicable).

MIPS Promoting Interoperability Performance Category

How is the Promoting Interoperability Performance Category Scored? *(continued)*

Scoring Example

Let's continue our example of the small practice participating as a group. While small practices can apply for a hardship exception, this group has EHR technology certified to the 2015 Edition and can submit data.

Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	Not reported	5 bonus points	N/A
Support Electronic Referral Loops by Sending Health Information	180 / 250 (.72)	20 points → 25 points (5 points re-allocated from e-Prescribing)	.72 x 25 = 18 points
Support Electronic Referral Loops by Receiving and Incorporating Health Information	176 / 200 (.88)	20 points → 25 (5 points re-allocated from e-Prescribing)	.88 x 25 = 22
Provide Patients Electronic Access to Their Health Information	187 / 220 (.85)	40 points	.85 x 40 = 34 points
Report to 2 different public health agencies or clinical data registries for any of the following: • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• Reported "yes" to Immunization Registry Reporting measure • Claimed exclusion for Clinical Data Registry Reporting measure	10 points	10 points (this objective is all or nothing)
Promoting Interoperability Performance Category Score			84 points / 100 points = 84%

MIPS Promoting Interoperability Performance Category

Can the Promoting Interoperability Performance Category be Reweighted?

There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score. Note that submitting promoting interoperability data will override any automatic or approved reweighting.

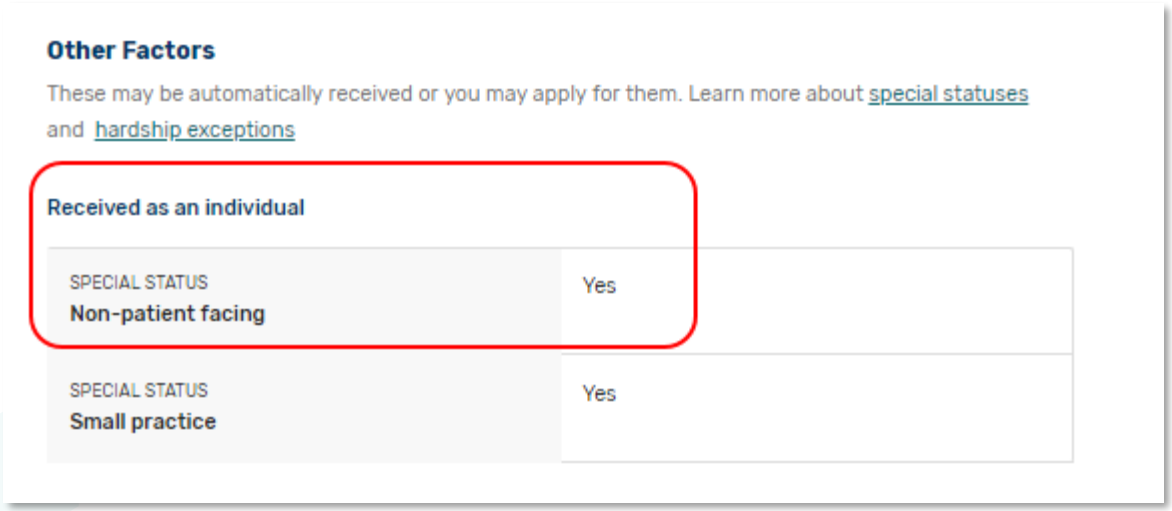
1. We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request reweighting for multiple performance categories through the Extreme and Uncontrollable Circumstances (EUC) application. Please check the Quality Payment Program COVID-19 Response Fact Sheet, 2020 MIPS Exceptions Application Fact Sheet, or the Exceptions Application webpage for more information.
2. You submit a Promoting Interoperability Hardship Exception Application, citing one of the following specified reasons for review and approval:
   - Insufficient internet connectivity
   - Extreme and uncontrollable circumstances
   - Lack of control over the availability of CEHRT
   - Small Practice
   - Decertified EHR

   If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about Hardship Exceptions.
3. You qualify for automatic reweighting if you are any of the following (see the QPP Participation Status Tool):

MIPS Promoting Interoperability Performance Category

Can the Promoting Interoperability Performance Category be Reweighted? *(continued)*

You will find your special status designations (for individual and/or group reporting) in the Other Factors section of your eligibility details in the QPP Participation Status Tool.



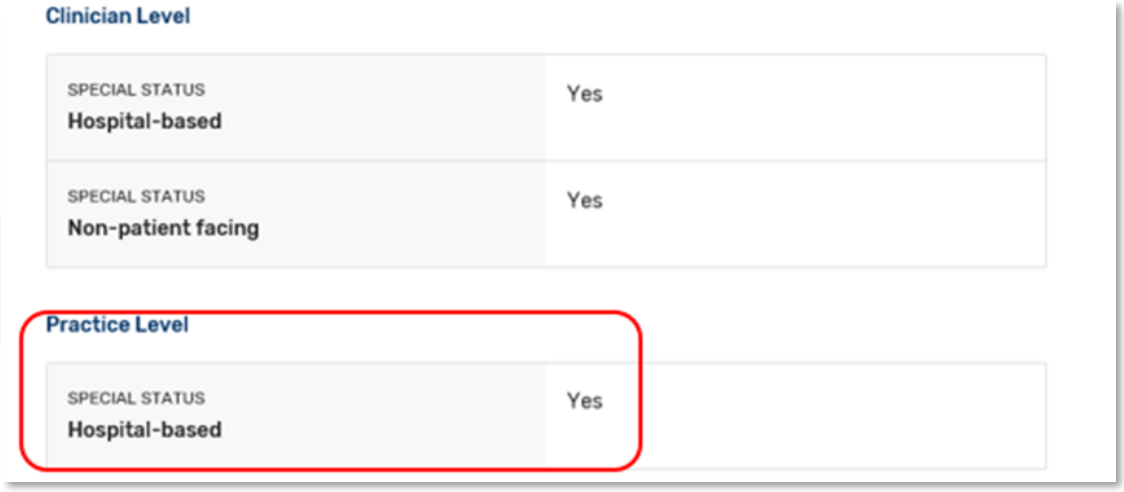
NOTE: *If you have an approved exception or qualify for automatic reweighting, we'll* ***reweight the category to 0% and redistribute the 25% weight usually to the Quality performance category*** *so you can earn up to 100 points in your MIPS Final Score. However, you can still report if you want to. If you submit data on the measures for the Promoting Interoperability performance category either as an individual, a group, or virtual group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 25% of the final score.*

MIPS Promoting Interoperability Performance Category

How Does Reweighting Work If We're Participating as a Group or Virtual Group?

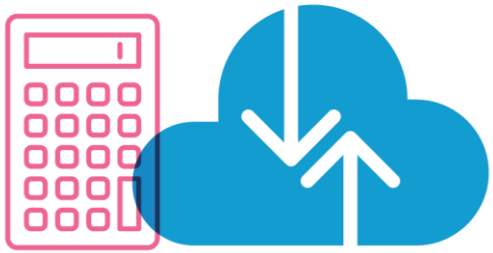
A group or virtual group's Promoting Interoperability performance category score will be reweighted when:

- The group or virtual group has an approved hardship exception or qualifies for automatic reweighting; OR
- All of the MIPS eligible clinicians in the group or virtual group individually qualify for reweighting (for any reason)



Just as with individual participation, groups and virtual groups who qualify for reweighting but submit data for this performance category will be scored just like any other clinician in MIPS, and their Promoting Interoperability performance category will be weighted at 25% of the final score.

NOTE: *Groups and virtual groups are identified as non-patient facing or hospital-based when more than 75% of the MIPS eligible clinicians in the group (or virtual group) have that status as individuals. These groups and virtual groups qualify for automatic reweighting.*



MIPS Final Score and Payment Adjustment

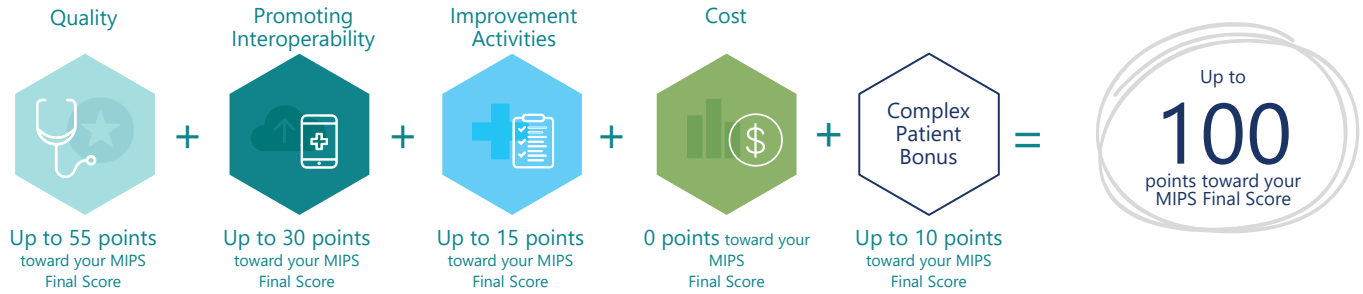
MIPS Final Score and Payment Adjustment

How is My Final Score Calculated?

UPDATED: 5/20/2021: We have updated the final score calculation to reflect a 0% weight for the cost performance category.

We multiply your performance category score by the category's weight, and multiply that by 100, to determine the number of points that contribute to your final score for each performance category. Then we add the points for each performance category to any complex patient bonus you may have received to arrive at your final score.

2020 MIPS Performance Category Weights



As part of our COVID-19 response, we have finalized to double the complex patient bonus for the 2020 performance period. You can earn up to 10 bonus points added to your final score.

MIPS Final Score and Payment Adjustment

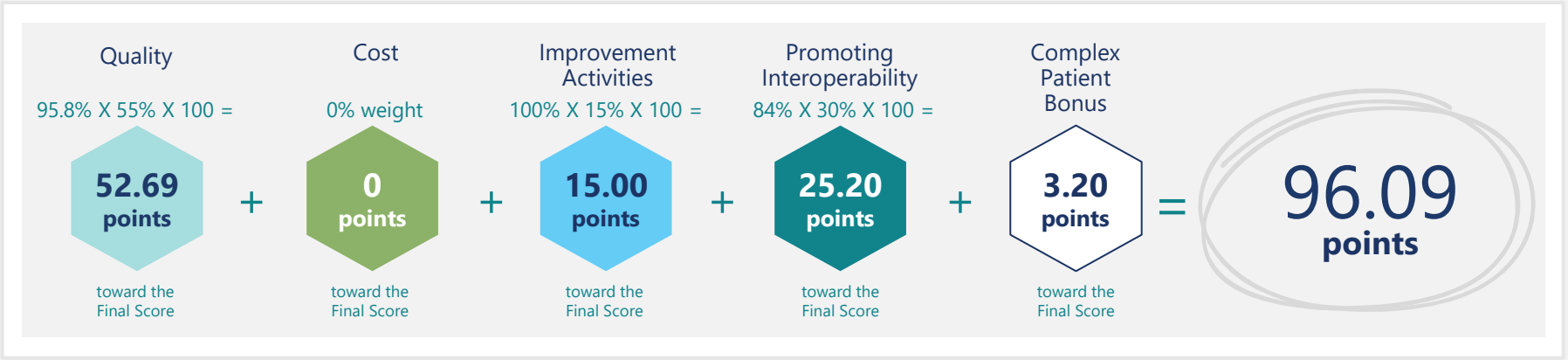
How is My Final Score Calculated?

UPDATED: 5/20/2021: We have updated the scoring example to reflect a 0% weight for the cost performance category.

Scoring Example

Let's continue our example of the small practice reporting as a group and review how the final score is calculated.

The MIPS Final Score cannot exceed 100 points.



What is the Complex Patient Bonus?

The Complex Patient Bonus is added to the MIPS Final Score and based on the overall medical complexity and social risk for the patients treated by a clinician or group. We recognize that there can be challenges and additional costs associated with the care you provide to these patients. The Complex Patient Bonus awards up to 10 bonus points for the 2020 performance period only, which is added to your final score, based on the complexity of the patients you treat. This bonus is based on a combination of the average Hierarchical Condition Category (HCC) risk score of the Medicare patients you treat and the proportion of dually eligible patients you treat.

All MIPS eligible clinicians, groups, and virtual groups that care for complex patients and submit data for at least one MIPS performance category (Quality, Promoting Interoperability, or Improvement Activities) are eligible for the complex patient bonus of up to 10 bonus points to their final score.

NOTE: The Cost performance category is not included in the submission requirements because we evaluate and calculate cost measures for you.

As part of our COVID-19 response, we will double the complex patient bonus for the 2020 performance period. If this proposal is finalized, You can earn up to 10 bonus points added to your final score.

How is the Complex Patient Bonus Determined?

We use 2 indicators to measure patient complexity:

Medical complexity is measured by the average Hierarchical Condition Category (HCC) risk score of Medicare patients treated

AND

Social risk is measured by the proportion of patients treated who are dually eligible to receive Medicare and either full or partial Medicaid benefits

We calculate the HCC risk scores of Medicare patients and determine the proportion of dual eligible patients treated during the second 12-month segment (October 1, 2019 – September 30, 2020) of the MIPS determination period.

Each MIPS eligible clinician, group, and virtual group will be evaluated for the complex patient bonus.

There is no minimum amount or percentage of 1) dually eligible patients; or 2) patients diagnosed with a condition that has an HCC risk score required for the clinician to be scored for the complex patient bonus.

MIPS Final Score and Payment Adjustment

What is the Complex Patient Bonus? *(continued)*

How is a Clinician's HCC Risk Score Determined?

A beneficiary's risk score is based on:

- Age and gender;
- Diagnoses from the previous year; and
- Whether they are eligible for Medicaid, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home).

We use claims data from CY 2019 (1/1/2019 – 12/31/2019) to calculate the risk score for each beneficiary you treated between 10/1/19 and 9/30/20.

Your HCC risk score is the average of the risk scores assigned to these Medicare patients.

How is my Proportion of Dual Eligible Patients Determined?

We will calculate the number of your dually eligible patients using claims data from 10/1/2019 to 9/30/2020.

The proportion will be a comparison of unique patients who are dually eligible for Medicare and Medicaid seen by the MIPS eligible clinician to all unique Medicare patients seen by the MIPS eligible clinician during this time period.

How is the Complex Patient Bonus Calculated?

$$\left(\frac{\text{[sum of all risk scores for the unique beneficiaries treated*]}}{\text{[number of unique beneficiaries treated]}} + \left(\frac{\text{[unique patients treated who were dually eligible for Medicare and full- and partial-benefit Medicaid]}}{\text{[unique Medicare beneficiaries treated]}} \times 5 \right) \right) \times 2 = \text{Complex Patient Bonus}$$

For PY 2020

*Unique beneficiaries and patients (both dually-eligible and HCC) must be treated between 10/1/19 and 9/30/20 to be included in the Complex Patient Bonus calculation.

When participating as an individual or group: The complex patient bonus is calculated for individual MIPS eligible clinicians and groups by adding the dual eligible ratio (multiplied by 5) to the beneficiary weighted average HCC risk score.

When participating as a virtual group: The complex patient bonus is calculated for virtual groups by adding the beneficiary weighted average HCC risk score for all MIPS eligible clinicians to the average dual eligible ratio for all MIPS eligible clinicians, multiplied by 5. This calculation will be made, if technically feasible, for TINs in a virtual group.

MIPS Final Score and Payment Adjustment

How Does my MIPS Final Score Determine my Payment Adjustment?

Your MIPS Final Score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be. Why? MIPS is required by law to be a budget neutral program, which generally means that the amount of the payment adjustments will be dependent on the overall participation and performance of clinicians in the program for that year.

Final Score	Payment Adjustment
85.00 – 100.00 points (Additional performance threshold = 85.00 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)
45.00 – 84.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
45.00 points (Performance threshold = 45.00 points)	• Neutral MIPS payment adjustment (0%)
11.26 – 44.99 points	• Negative MIPS payment adjustment (between -9% and 0%)
0 – 11.25 points	• Negative MIPS payment adjustment of -9%

There are 2 components of the MIPS payment adjustments. The first applies to all MIPS eligible clinicians, and the second is an additional payment adjustment for exceptional performance that applies only to those MIPS eligible clinicians with a final score of 85 points or higher.

- **MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality. Clinicians with a final score at the performance threshold of 45 points earn a neutral adjustment. Clinicians with a final score above the performance threshold of 45 points earn a positive adjustment (subject to a scaling factor). Clinicians with a final score below the performance threshold of 45 points will be subject to a negative adjustment. The maximum negative adjustment is -9%. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.
- **Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 85 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled; it will depend on the scores and the number of clinicians receiving a score of 85 points or higher. **Note:** This 2022 performance year/2024 payment year will be the last year this additional payment adjustment is available.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. Eastern Time or by e-mail at: QPP@cms.hhs.gov.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out resources available in the QPP Resource Library.

Resources

The following resources are or will be available on the QPP Resource Library.

General:

- 2020 MIPS Group Participation Guide
- 2020 MIPS 101 Guide
- Quality Payment Program COVID-19 Response

Quality:

- 2020 Quality Benchmarks
- Medicare Shared Savings Program Quality Measure Benchmarks for the 2020/2021 Performance Years
- 2020 Quality Quick Start Guide
- 2020 MIPS Quality User Guide
- 2020 MIPS Quality Measures List
- 2020 CMS Web Interface Quick Start Guide
- 2020 CAHPS for MIPS Survey Overview Fact Sheet
- 2020 Medicare Part B Claims Measure Specifications
- 2020 MIPS Clinical Quality Measure Specifications
- 2020 QCDR Measure Specifications
- 2020 CMS Web Interface Measure Specifications

Cost:

- 2020 Cost Quick Start Guide
- 2020 MIPS Cost User Guide
- 2020 Cost Measure Information Forms (specifications)

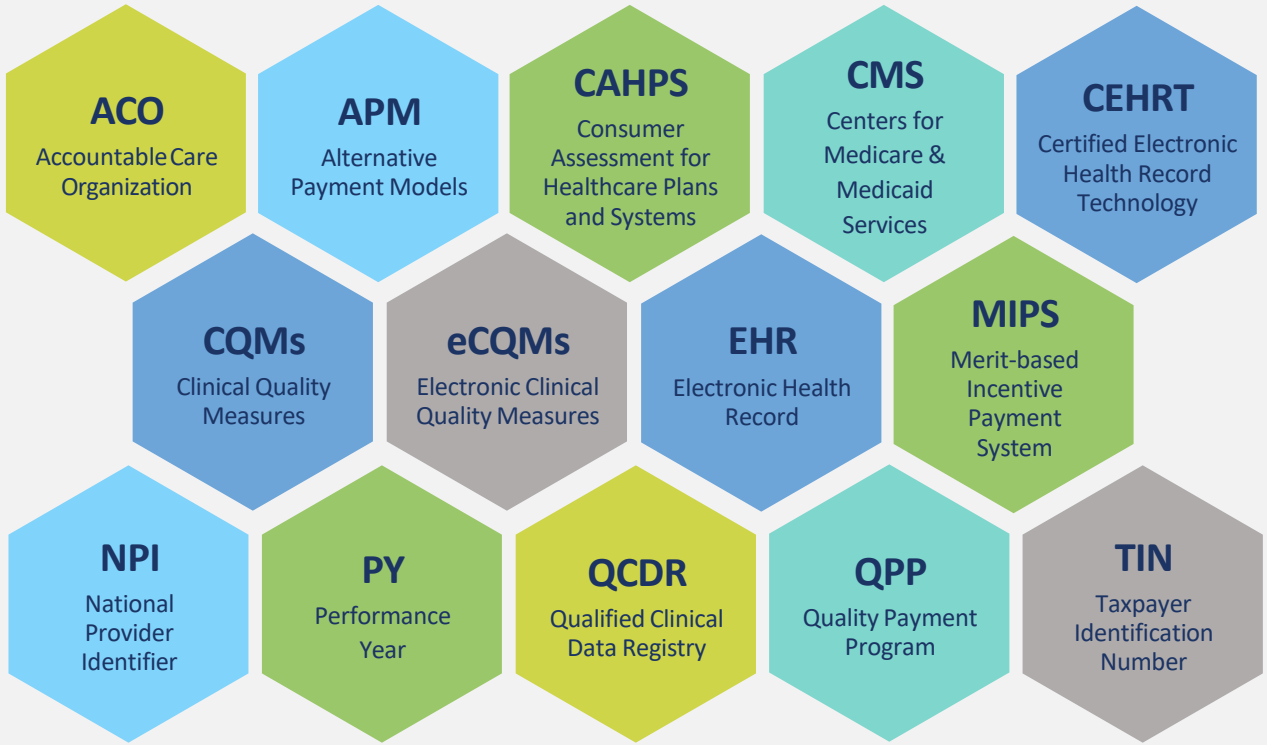
Improvement Activities:

- 2020 Improvement Activities Quick Start Guide
- 2020 MIPS Improvement Activities User Guide
- 2020 Improvement Activities Inventory

Promoting Interoperability:

- 2020 Promoting Interoperability Quick Start Guide
- 2020 Promoting Interoperability User Guide
- 2020 Promoting Interoperability Measure Specifications

Glossary


ACO
Accountable Care Organization
APM
Alternative Payment Models
CAHPS
Consumer Assessment for Healthcare Plans and Systems
CMS
Centers for Medicare & Medicaid Services
CEHRT
Certified Electronic Health Record Technology
CQMs
Clinical Quality Measures
eCQMs
Electronic Clinical Quality Measures
EHR
Electronic Health Record
MIPS
Merit-based Incentive Payment System
NPI
National Provider Identifier
PY
Performance Year
QCDR
Qualified Clinical Data Registry
QPP
Quality Payment Program
TIN
Taxpayer Identification Number

Version History

If we need to update this document, changes will be identified here.

Date	Change Description
5/20/2021	• Updated performance category weights (slides 8, 11, 39) , cost performance category information (slide 32), and final score calculation (slides 49, 50) to reflect that the cost performance category will be weighted at 0% for all MIPS eligible clinicians in the 2020 performance year.
2/25/2021	• Updated COVID-19 slide to reference the automatic extreme and uncontrollable circumstances policy and the deadline extension for the exception application. • Updated slides 12, 14, 19, 22, 24 and 29 to account for CMS' decision to suppress the All-Cause Hospital Readmission measure for the 2020 performance period. • Added Appendix E (measures with MIPS scoring changes due to suppression) • Updated slides 6, 52, 53 and 54 to note that the proposed policy to double the complex patient bonus for the 2020 performance period was finalized.
11/9/2020	Original posting

Appendices

Appendix A: Scoring Quality Measures

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

1. **Find the benchmark and figure achievement points based on collection type for the measure.**
   - Achievement points are figured by mapping the performance rate to the benchmark for the measure, specific to collection type.
   - **Example:** Small practice reporting as a group submits Measure 236 as an eCQM.

Measure Reported	Type of Measure	Collection Type	Measure Performance Rate	Cases Reported
Measure 236 – Controlling High Blood Pressure	Intermediate Outcome	eCQM	66.74 (mapped to highlighted decile below)	90

   - This is an extract from the 2020 benchmarking file showing the range of performance rates associated with each decile for each collection type (Remember that Measure 236 is scored according the flat benchmark methodology, which is reflected in the 2020 Historical Quality Benchmarks file):

Measure Name	Measure ID #	Collection Type	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	Medicare Part B Claims	Intermediate Outcome	Y	20 – 20.99	30 – 39.99	40 – 40.99	50 – 50.99	60 – 60.99	70 – 70.99	80 – 80.99	>=90
Controlling High Blood Pressure	236	eCQM	Intermediate Outcome	Y	20 – 20.99	30 – 39.99	40 – 40.99	50 – 50.99	60 – 60.99	70 – 70.99	80 – 80.99	>=90
Controlling High Blood Pressure	236	MIPS CQM	Intermediate Outcome	Y	20 – 20.99	30 – 39.99	40 – 40.99	50 – 50.99	60 – 60.99	70 – 70.99	80 – 80.99	>=90

Appendix A: Scoring Quality Measures *(continued)*

2. Figure achievement points in a decile.

– Determine the decile that the performance rate falls in:
Measure performance rate = 66.74

Measure Name	Controlling High Blood Pressure
Measure ID#	236
Collection Type	eCQM
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 3	20 – 29.99
Decile 4	30 – 39.99
Decile 5	40 – 49.99
Decile 6	50 – 59.99
Decile 7	60 – 69.99
Decile 8	70 – 79.99
Decile 9	80 – 89.99
Decile 10	>=90

– Apply the following formula based on the measure performance and decile range:

$$\text{decile \#}\ X + \frac{[\,q\ \text{performance rate} - a\ \text{bottom of decile range}\,]}{[\,b\ \text{top of decile range} - a\ \text{bottom of decile range}\,]} = \text{Achievement Points}$$

NOTE: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

$$\text{decile \#}\ 7 + \frac{[\,66.74 - 60\,]}{[\,69.99 - 60\,]} = 0.67 = 7.7$$

...which is rounded to 0.7

Appendix A: Scoring Quality Measures *(continued)*

3. **Repeat assignment of achievement points for each submitted measure.**

   - **Example:** Small group submits 7 eCQMs and 2 claims measures, meeting data completeness for all measures.

Measures Reported	Collection Type	Type of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
Measure 236 Controlling High Blood Pressure	eCQM	Outcome	66.74	86	7.7	Compare to benchmark; required outcome measure (no bonus points available); meets end-to-end bonus point criteria;
Measure 130 Documentation of Current Medications in the Medical Record	eCQM	Process	96.74	90	5.9	Compare to benchmark; meets end-to-end bonus point criteria
Measure 111 Pneumococcal Vaccination for Elderly	eCQM	Process	22.12	112	4.9	Compare to benchmark; meets end-to-end bonus point criteria
Measure 111 Pneumococcal Vaccination for Elderly	Medicare Part B Claims	Process	70.56	113	5.5	Compare to benchmark
Measure 113 Colorectal Cancer Screening	eCQM	Process	36.32	13	3.0	Apply 3-point floor because it's below 20 case minimum; meets end-to-end bonus point criteria
Measure 119 Diabetes: Attention for Nephropathy	eCQM	Process	77.19	43	5.5	Compare to benchmark; meets end-to-end bonus point criteria
Measure 110 Preventive Care and Screening: Influenza Immunization	eCQM	Process	0.09	32	3	Compare to benchmark; apply 3-point floor due to poor performance; meets end-to-end bonus point criteria
Measure 238 Use of High-Risk Meds in Elderly	eCQM	Process*	2.01	40	6.6	Compare to benchmark; meets end-to-end bonus point criteria
Measure 317 Preventive Care—High Blood Pressure	Medicare Part B Claims	Process	35.81	160	4.2	Compare to benchmark

*This is an inverse measure.

Appendix A: Scoring Quality Measures *(continued)*

4. Sort and group measures based on achievement and bonus points.

a. First identify the highest scoring outcome measure based on achievement points, then identify the next 5 highest scoring measures based on achievement points.

The following measures contribute achievement points AND bonus points toward the Quality performance category score.				
Measures Sorted by Performance	**Collection Type**	**Performance Rate**	**Achievement Points**	**Bonus Points**
1. Outcome/High-priority: **Measure 236**	eCQM	66.74	7.7	1
2. **Measure 238**	eCQM	2.01	6.6	1
3. **Measure 130**	eCQM	96.74	5.9	1
4. **Measure 111**	Medicare Part B Claims	70.56	5.5	0
5. **Measure 119**	eCQM	77.19	5.5	1
6. **Measure 317**	Medicare Part B Claims	35.81	4.2	0

b. Identify measures that contribute bonus points only to the Quality performance category score.

The following measures do not contribute achievement points but DO contribute bonus points toward the Quality performance category score.					
Measures Sorted by Performance	**Collection Type**	**Performance Rate**	**Achievement Points**	**Bonus Points**	**Comment**
Measure 111	eCQM	22.12	N/A	1	Higher scoring than Measure 317, but Measure 111 was also reported as a claims measure – the higher scoring collection type (claims) was counted toward the top 6
Measure 110	eCQM	0.09	N/A	1	Not 1 of the top 6 scored measures

c. Identify measures that won't contribute any points to the Quality performance category score.

The following measure does not contribute achievement points or bonus points toward the Quality performance category score.					
Measures Sorted by Performance	**Collection Type**	**Performance Rate**	**Achievement Points**	**Bonus Points**	**Comment**
Measure 113	eCQM	36.32	N/A	N/A	• Not 1 of the top 6 scored measures • Group has already reached the 10% cap on the end-to-end bonus points.

Appendices

Appendix B: Reweighting the Performance Categories (Individuals, Groups and Virtual Groups)

The table below outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Updated 5/20/2021: We updated this table to reflect the 0% weighting of the cost performance category for all MIPS eligible clinicians (regardless of how they participate) for the 2020 MIPS performance year/2022 MIPS payment year.

Performance Category Redistribution for the 2022 MIPS Payment Year				
Reweighting Scenario	**Quality**	**Cost**	**Improvement Activities**	**Promoting Interoperability**
Cost reweighted for all MIPS eligible clinicians				
General weighting for all performance categories	55%	0%	15%	30%
Reweighting 2 Performance Categories				
No Cost and no Promoting Interoperability *Cost and Promoting Interoperability → Quality*	85%	0%	15%	0%
No Cost and no Quality *Cost and Quality → Promoting Interoperability*	0%	0%	15%	85%
No Cost and no Improvement Activities *Cost and Improvement Activities → Quality and Promoting Interoperability*	70%	0%	0%	30%

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you will receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix C: End-to-End Electronic Reporting (eCQMs and MIPS CQMs)

The table below outlines the submission options for submitting eCQMs or MIPS CQMs that meet the criteria to earn end-to-end electronic reporting bonus points

Collection Type	Submission Type	Format/Specification	Specification Indicators	Benchmark
eCQM	Login and Upload	QRDA III	N/A	eCQM
eCQM	Direct Login and Upload	QPP JSON	'submissionMethod=electronicHealthRecord'	eCQM
MIPS CQM (no eCQM equivalent)*	Direct Login and Upload	QPP JSON	'submissionMethod=registry' 'isendtoendreported=true'	MIPS CQM

*If you submit a MIPS CQM with an eCQM equivalent, your submission will be rejected if it includes an indicator of end-to-end electronic reporting.

If you are reporting a mixture of eCQMs and MIPS CQMs using the QPP JSON format, you must submit these types as separate measurement sets:

- One measurement set of eCQMs (indicate EHR as the submission method) and a separate measurement set of MIPS CQMs (indicate Registry as the submission method).

Please refer to the Submission API documentation in the Developer Tools section of the QPP website for the most current information.

Appendix D: Reallocation of Points for Promoting Interoperability Measure(s)

The table below outlines where points are redistributed when an exclusion is claimed.

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed…
e-Prescribing	**e-Prescribing**	Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure
	Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	N/A	N/A
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	Yes	…the 20 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Yes	…the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	No	N/A
Public Health and Clinical Data Exchange	**Report to 2 different public health agencies or clinical data registries for any of the following:** • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Yes	…the 10 points are still available in this objective if you **claim 1 exclusion** and submit a 'yes' attestation for one of the 5 measures in the objective. …the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you **claim 2 exclusions**.

Appendix E: Quality Measures with MIPS Scoring Changes

The following measures are impacted by MIPS scoring changes due to clinical guideline changes during the 2020 performance period or specifications determined during or after the performance period to have substantive changes. CMS has not identified any MIPS quality measures requiring performance data to be truncated to a 9-month performance period for 2020 due to the annual ICD-10 code update.

Quality Measure ID/ Name	Collection Type	Issue	Reason for Measure Change	Impact to scoring, submission and feedback expectations
Measure 69 Hematology: Multiple Myeloma: Treatment with Bisphosphonates	MIPS Clinical Quality Measures (CQM)	Suppressed	Updated National Comprehensive Cancer Network® (NCCN) Guidelines for Multiple Myeloma	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 134/PREV-12 Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS Web Interface	Suppressed	Substantive change: removal of Systematized Nomenclature of Medicine (SNOMED) codes	Excluded from scoring (Denominator reduced by 10 points) if data completeness is met. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring

(Continued on next page)

Appendix E: Quality Measures with Scoring Changes *(continued)*

Quality Measure ID/ Name	Collection Type	Issue	Reason for Measure Change	Impact to scoring, submission and feedback expectations
Measure 419 Overuse of Imaging for the Evaluation of Primary Headache	Medicare Part B Claims	Suppressed	Necessary quality data code was inadvertently inactivated during the Healthcare Common Procedure Coding System (HCPCS) update process	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 370/MH-1 Depression Remission at 12 Months	CMS Web Interface	Suppressed	Measure doesn't have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 438/PREV-13 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	Suppressed	Measure doesn't have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 458 All-cause Hospital Readmission	Administrative Claims	Suppressed	Specific to MIPS, the measure steward has indicated that the measures' risk adjustment models need to be updated to account for factors outside of the clinician's control	Excluded from scoring, will not be attributed to quality performance category. There will be no feedback for this measure.