

2021 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2023 Payment Adjustment FAQs

Purpose

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

Note: Third party representatives such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries can't access your performance feedback.

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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. Final performance feedback includes:
 - Measure-level performance data and scores
 - Activity-level scores
 - Patient-level measure reports (if applicable)
 - Performance category-level scores and weights
 - Final score
 - Payment adjustment information

Who Can Access Performance Feedback and Payment Adjustment Information?

MIPS Performance Feedback is accessible to clinicians and authorized representatives of practices, virtual groups, and APM Entities (including Shared Savings Program ACOs), whether they reported [traditional MIPS](#) or the [APM Performance Pathway \(APP\)](#).

- Practice representatives with the Staff User or Security Official role can view MIPS final scores and payment adjustments from individual and/or group participation (if the practice participated at the group level).
- APM Entity representatives with the Staff User or Security Official role can view the MIPS final score and associated payment adjustment for their APM Entity.
- If you're a Medicare Shared Savings Program Accountable Care Organization's (ACO) QPP Security Official or QPP Staff User contact in the [ACO Management System \(ACO-MS\)](#), then you can view the ACO's MIPS final score and associated payment adjustment by signing in to the QPP website using your ACO-MS username and password.
- Virtual group representatives with the Staff User or Security Official role can view their MIPS final score and payment adjustment from virtual group participation.
- Individual clinicians with the Clinician role can view their final score and payment adjustment from individual, group, virtual group, or APM Entity participation.

Please review [Appendix C](#) more information about what you can and can't view in performance feedback based on your access.

Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

How Do I Access Performance Feedback?

- [Sign in to the Quality Payment Program website](#)
- Click “View PY 2021 Final Performance Feedback” on the home page
- Select your organization (Practice, APM Entity, Virtual Group)
 - Practice representatives can access both individual and group feedback through the practice organization.

COVID-19’s Impact on 2021 Performance Feedback

We continued to offer [flexibilities](#) to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We applied the **MIPS automatic extreme and uncontrollable circumstances (EUC) policy** to all individual MIPS eligible clinicians for the 2021 performance year. This policy only applies to clinicians participating in MIPS as individuals.

- Clinicians who didn’t submit any data, or who only submitted data in one performance category, will automatically receive a neutral payment adjustment in 2023.
- Any performance category for which an individual clinician didn’t submit data is weighted at 0% for the 2021 performance year.
- [Appendix A](#) outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.

We also extended the deadline for our **MIPS EUC Exception application** to March 31, 2022.

- **Group and virtual groups** could request reweighting of one or more performance categories to 0%; data submission overrode performance category reweighting on a category-by-category basis.
- **APM Entities** were required to request reweighting of all performance categories and data submission **didn’t** override reweighting.
- [Appendix B](#) outlines performance category weights and payment adjustment implications based on the performance categories selected in approved applications.

Exception: Clinicians who participate in an APM – and groups and virtual groups that include these clinicians – qualify for automatic credit in the improvement activities performance category.

Submitting data for the quality and/or Promoting Interoperability performance categories triggered this automatic credit and overrode reweighting, making the category eligible for scoring.

Finally, we **reweighted the cost performance category** from 20% to 0% for the 2021 performance period **for all MIPS eligible clinicians** regardless of participation as an individual, group, virtual group, or APM Entity. (Cost is already reweighted to 0% when reporting the APM Performance Pathway (APP)).

The 20% cost performance category weight in traditional MIPS was redistributed to other performance categories.

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Accessing Performance Feedback

Before You Begin

If you don't already have a HCQIS Authorized Roles and Profile (HARP) account or access to your organization on the QPP website, you'll need to create an account, request access, and wait to be approved.

- More information is available in the [QPP Access User Guide \(ZIP\)](#)

Please note that due to a mandatory federal-wide security update, you'll need a CMS-supported version of Firefox or Chrome to access the [QPP website](#). You may encounter errors if you use a different web browser.

- Please update your browser to the latest version of [Firefox](#) or [Chrome](#)

How Can I Access My/Our MIPS Performance Feedback?

You can access performance feedback through the [QPP website](#) by signing in with the same credentials that allowed you to submit and view data during the submission period.

Please note that if you are a Shared Savings Program ACO's QPP Security Official or QPP Staff User contact in the [ACO Management System \(ACO-MS\)](#), then you can view performance feedback by signing in to the QPP website using your ACO-MS Username and Password.

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.

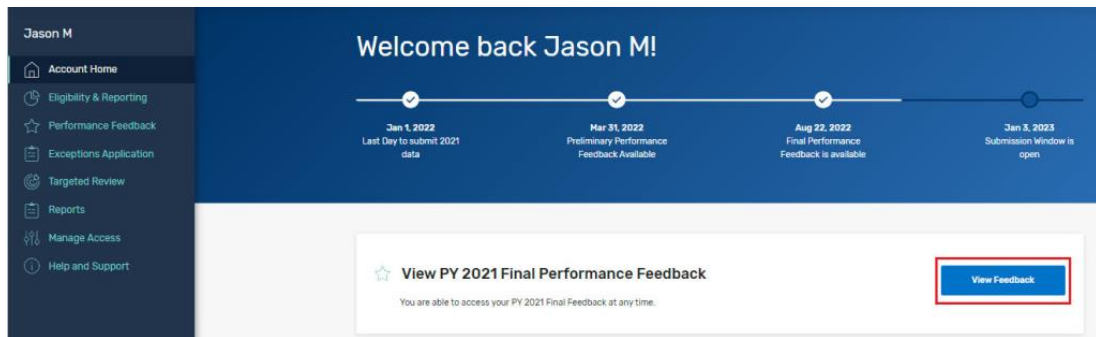
- [QPP Access User Guide](#)
- [How to Create a QPP Account video](#)
- [Connect to an Organization: Practice video](#)
- [Connect to an Organization: APM Entity video](#)
- [Connect to an Organization: Virtual Group video](#)
- [Request the Clinician Role video](#)

Note: We've updated the workflow for some of these actions since recording these videos to improve your experience.

Please review [Appendix C](#) more information about what you can and can't view in performance feedback based on your access.

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After signing in, select “View Feedback” or **Performance Feedback** from the left-hand navigation.



I'm a Clinician. What Is the Best Way for Me to Access My Performance Feedback?

The **Clinician role** 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 your APM Entity's reporting via [traditional MIPS](#) and/or the [APP](#).

Please review the **Register for a HARP Account** and **Connect as a Clinician** documents in the [QPP Access User Guide \(ZIP\)](#).

Can Third Party Intermediaries Access Performance Feedback?

Performance feedback can only be accessed by authorized practice representatives. The Centers for Medicare & Medicaid Services (CMS) doesn't grant direct access to performance feedback for third party intermediaries (including Qualified Registries and QCDRs) because it will contain sensitive information, including payment and patient information.

Third party intermediaries with 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 **won't** see:

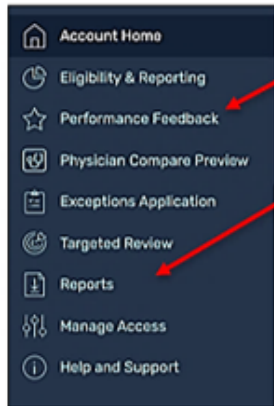
- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims. (**Reminder:** We didn't calculate cost measures for anyone for the 2021 performance year.)
- Patient-level reports for administrative claims measures.
- Final score or payment adjustment information.

To view their clients' performance feedback, third party intermediaries would need to submit a request for a role for each practice (identified by Taxpayer Identification Number, or TIN)), virtual group, or APM Entity they represent. The Security Official for each organization would decide whether to approve the request, authorizing the third party intermediary to access performance feedback and all of the other information available for the organization once signed into the QPP website.

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What's the Difference Between the Performance Feedback and Reports Tabs?

Some users may notice the **Reports** tab in their left-hand navigation panel.



You'll access your 2021 MIPS performance feedback through the **Performance Feedback** tab.

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

- Current and historical Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Detail Reports.
- Historical CMS Web Interface reports for groups that have reported quality measures through the CMS Web Interface in previous years.
- Cost field testing reports

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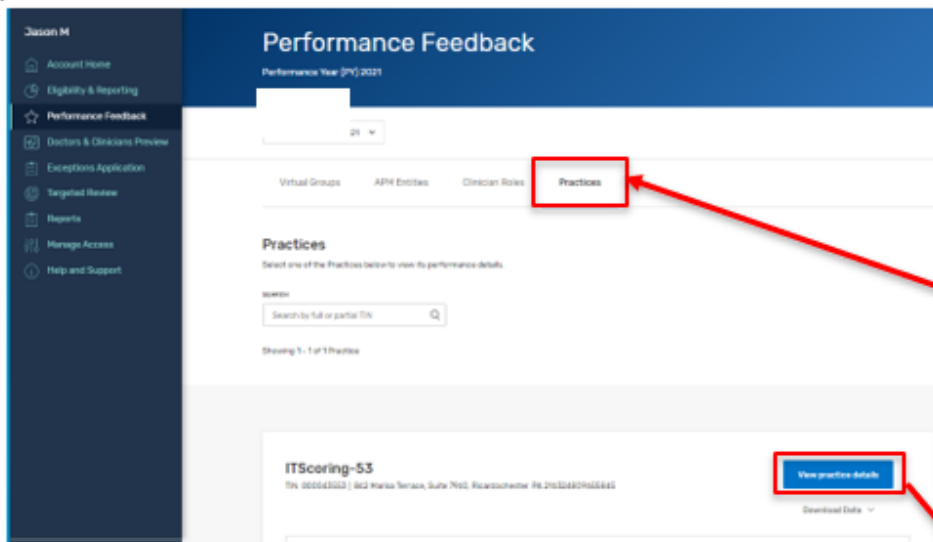
Navigating Into Performance Feedback: Practice Representatives



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.)

- Practice representatives can view feedback for individual clinicians and the group (if the practice participated as a group).

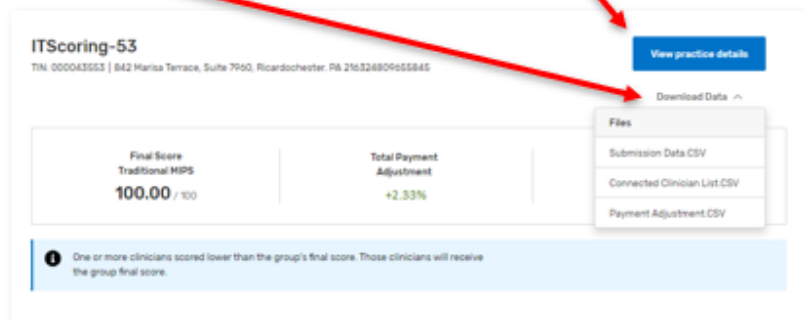
From **Performance Feedback**, select View Practice Details to access group or clinician level performance feedback.



If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **Practices** tab.

You can also select **Download Data** to access:

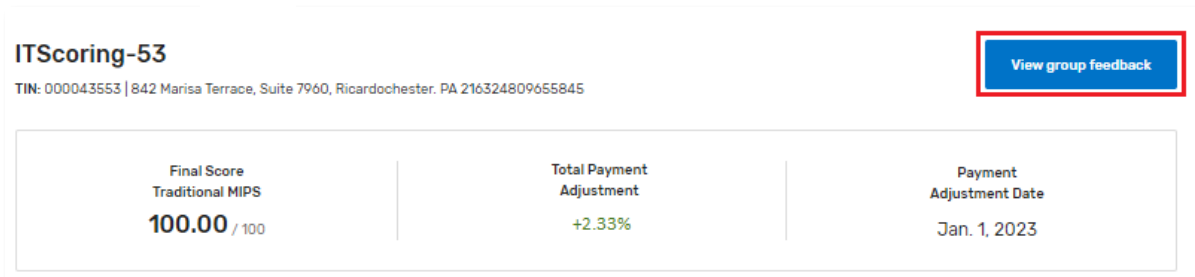
- Your **Submission Data** (data submitted for your entire practice, which may or may not contribute to your final score).
- Your [Connected Clinician List](#).
- Payment Adjustment** (list of all National Provider Identifiers (NPI) and their payment adjustment scores)



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

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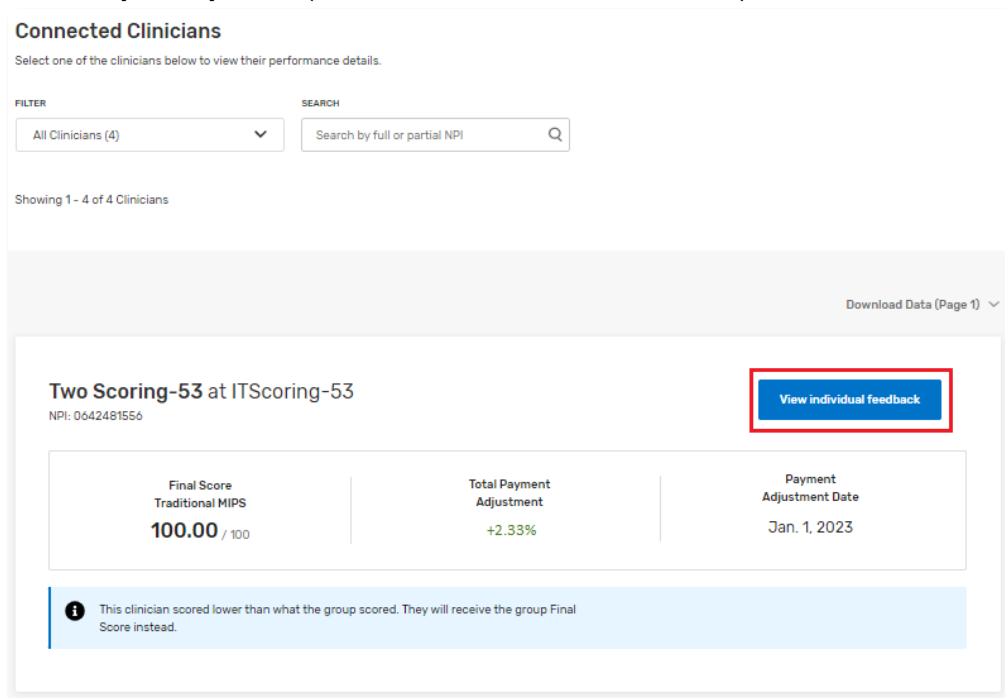
Select **View group feedback** to the right of the practice's name to access performance feedback based on **group participation** (aggregated data submitted on behalf of all clinicians in the practice).



The screenshot shows the ITScoring-53 practice page. At the top left, the practice name "ITScoring-53" is displayed, followed by the TIN: 000043553 and the address: 842 Marisa Terrace, Suite 7960, Ricardochester, PA 216324809655845. On the top right, a blue button labeled "View group feedback" is highlighted with a red rectangle. Below this, a table displays performance metrics:

| Final Score Traditional MIPS | Total Payment Adjustment | Payment Adjustment Date |
|---------------------------------|-----------------------------|----------------------------|
| 100.00 / 100 | +2.33% | Jan. 1, 2023 |

Select **View Individual Feedback** to the right of the clinician's name to access performance feedback based on **individual participation** (i.e., an individual clinician's data.)



The screenshot shows the "Connected Clinicians" page. It includes a filter dropdown set to "All Clinicians (4)" and a search bar labeled "Search by full or partial NPI". Below the search bar, it says "Showing 1 - 4 of 4 Clinicians". On the right, there is a "Download Data (Page 1)" link. The main content area shows a clinician named "Two Scoring-53 at ITScoring-53" with NPI: 0642481556. To the right of the clinician's name is a blue button labeled "View individual feedback" highlighted with a red rectangle. Below the clinician's name, a table displays performance metrics:

| Final Score Traditional MIPS | Total Payment Adjustment | Payment Adjustment Date |
|---------------------------------|-----------------------------|----------------------------|
| 100.00 / 100 | +2.33% | Jan. 1, 2023 |

Below the table, there is an information icon and a note: "This clinician scored lower than what the group scored. They will receive the group Final Score instead."

Continue with these Frequently Asked Questions or skip ahead to [walk through the rest of your feedback](#).

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

Our Practice Didn't Participate/Submit Data as a Group. What Will We See in Performance Feedback?

If your practice didn't submit data as a group for the 2021 performance year, you'll see a message indicating that your clinicians only reported as individuals:

- "All clinicians in this practice reported as individuals. They'll each receive a separate final score."

You can **View Individual Feedback** for each connected clinician.

We'll also make administrative claims quality measure scores available for informational purposes if they can be calculated.

What's a 'Connected Clinician' and Who's Included in This List?

Connected clinicians are all of the clinicians, identified by the NPI associated with your practice (TIN) through Medicare Part B claims billed between 10/1/2020 and 9/30/2021, regardless of their individual MIPS eligibility. Your connected clinicians are displayed on the Practice Details page of performance feedback and can also be accessed through the Connected Clinicians List CSV download on the main Performance Feedback page.

- Clinicians who started billing claims under your TIN between 10/1/2021 and 12/31/2021 will appear in the downloadable "Payment Adjustment CSV" file.

Our Practice Includes Clinicians Who Participated in a MIPS APM. What Performance Feedback Will We See?

When you sign in with practice credentials, you'll be able to view performance feedback based on the data your practice submitted to QPP at the group or individual level. You **won't** be able to view performance feedback scores at the APM Entity level (if applicable). As a reminder, the APM scoring standard is no longer applicable, and clinicians in MIPS APMs had the option to report traditional MIPS and/or the APP at the individual, group and/or APM Entity level.

This is the message you'll see on the Practice Details page beneath each clinician in your practice that's receiving their APM Entity's final score.

i MIPS APM Participant. If data was reported for the APM Entity, the APM Entity's performance feedback can only be accessed by representatives of the APM Entity. If the clinician is receiving the APM Entity's final score, the clinician can also access this information if they have the Clinician Role.

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 \(ZIP\)](#).

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

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Navigating into Performance Feedback: APM Entity Representatives

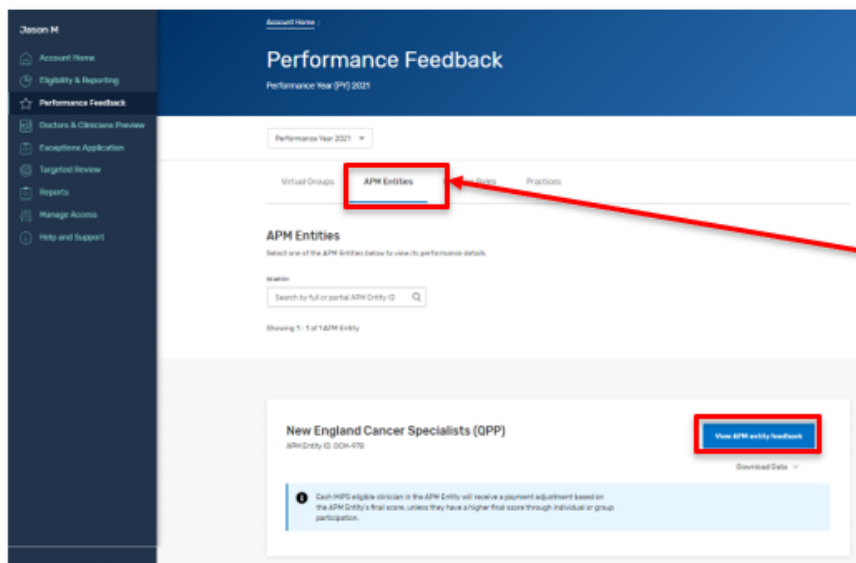


This section assumes you have either the Staff User or Security Official role for an **APM Entity** organization. (This is distinct from access to a practice and/or virtual group organization.)

The following programs and models can view 2021 MIPS performance feedback, if applicable and available:

- Shared Savings Program ACO
- Next Generation ACO
- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive End-Stage Renal Disease (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)
- Primary Care First (PCF)

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



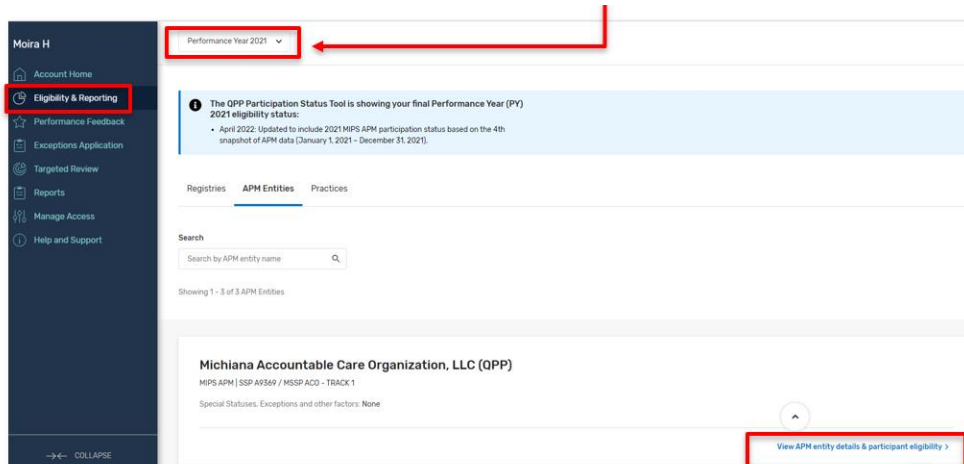
If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **APM Entities** tab.

Continue with these Frequently Asked Questions or skip ahead to [walk through the rest of your feedback](#).

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

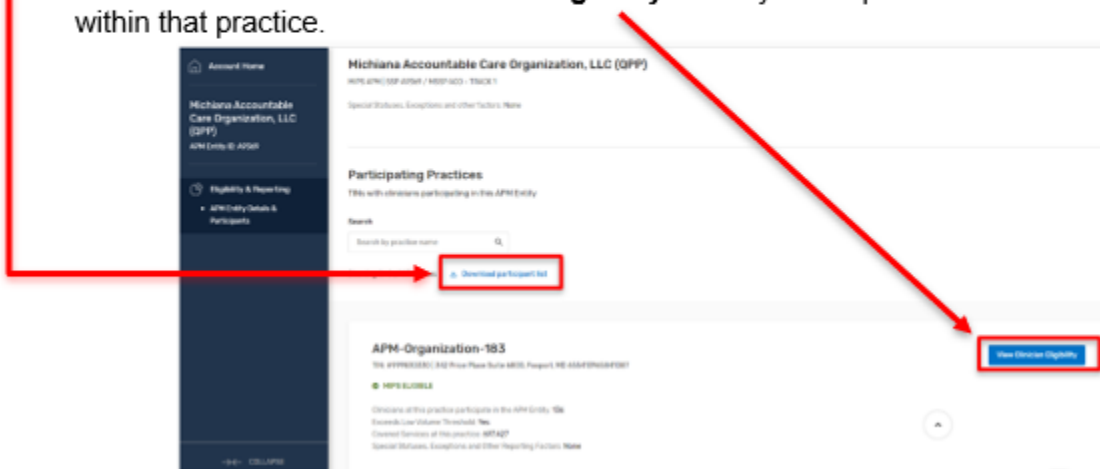
Can We Access a List of the Clinicians Associated with Our APM Entity?

Yes. You can download this list by clicking "**View Participant Eligibility**" from the **Eligibility & Reporting** tab. Make sure that you're looking at the **Performance Year 2021** page.



- Once you land on the APM Entity Details & Participants screen, you can click "**Download Participant List**" for a list of all participating practices and clinicians associated with the APM Entity.

You can also click "**View Clinician Eligibility**" for any of the practices to view the clinicians within that practice.



Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.



What Should We 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 view:

- The APM Entity's final score.
- Performance category scores (quality, improvement activities, Promoting Interoperability, as applicable).
- A report of the individual and/or group Promoting Interoperability performance category scores that contributed to the APM Entity's Promoting Interoperability score.
- Measure-level scoring for quality measures reported by the APM Entity.

Can Individual Clinicians View Our APM Entity Feedback?

Yes. Individual clinicians in the APM Entity can view their performance feedback from the APM Entity if they have the clinician role **or** have been approved as a staff user for the APM Entity.

Representatives of Shared Savings Program ACO Participant TINs and practices with clinicians receiving their APM Entity's final score **won't** be able to access the APM Entity's performance feedback unless they have been approved as a staff user for the APM Entity.

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Navigating into Performance Feedback: Individual Clinicians



Note: This section assumes you're a clinician with the Clinician role. (This is different from the Staff User role for a practice, APM Entity or virtual group organization).

From **Performance Feedback**, you'll see a list of all your associated organizations (practices, APM Entities, and virtual groups).

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

| Final Score Traditional MIPS | Total Payment Adjustment | Payment Adjustment Date |
|---------------------------------|-----------------------------|----------------------------|
| 100.00 / 100 | +2.33% | Jan. 1, 2023 |

Continue with these Frequently Asked Questions or skip ahead to [walk through the rest of your feedback](#).

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 the 2021 performance year in the [QPP Participation Status Tool](#) or on the Eligibility & Reporting page when you [sign in to the QPP website](#). Click **View Individual Feedback** to preview your final score as well as any individual data you may have submitted.

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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.

The screenshot shows the 'Performance Feedback' dashboard for 'Jason M'. The left sidebar contains navigation links: Account Home, Eligibility & Reporting, Performance Feedback (selected), Doctors & Clinicians Preview, Exceptions Application, Targeted Review, Reports, Manage Access, and Help and Support. The main content area is titled 'Performance Feedback' and 'Performance Year (PY) 2021'. It features a dropdown for 'Performance Year 2021' and tabs for 'Virtual Groups', 'APM Entities', 'Clinician Roles', and 'Practices'. The 'Virtual Groups' tab is active, displaying a search bar and a list of virtual groups. One group is shown: 'VG ID: fake01' with '1 Participating Practice'. A red box highlights the 'View group details' button. Below the button is a 'Download Data' link. A table shows performance metrics: 'Final Score Traditional MIPS' at '100.00 / 100', 'Total Payment Adjustment' at '+2.33%', and 'Payment Adjustment Date' at 'Jan. 1, 2023'. A note at the bottom states: 'All MIPS eligible clinicians in the virtual group will receive the virtual group's final score and associated payment adjustment, regardless of any data that may be submitted at the individual, group, or APM Entity level.'

Continue with these Frequently Asked Questions or skip ahead to [walk through the rest of your feedback.](#)

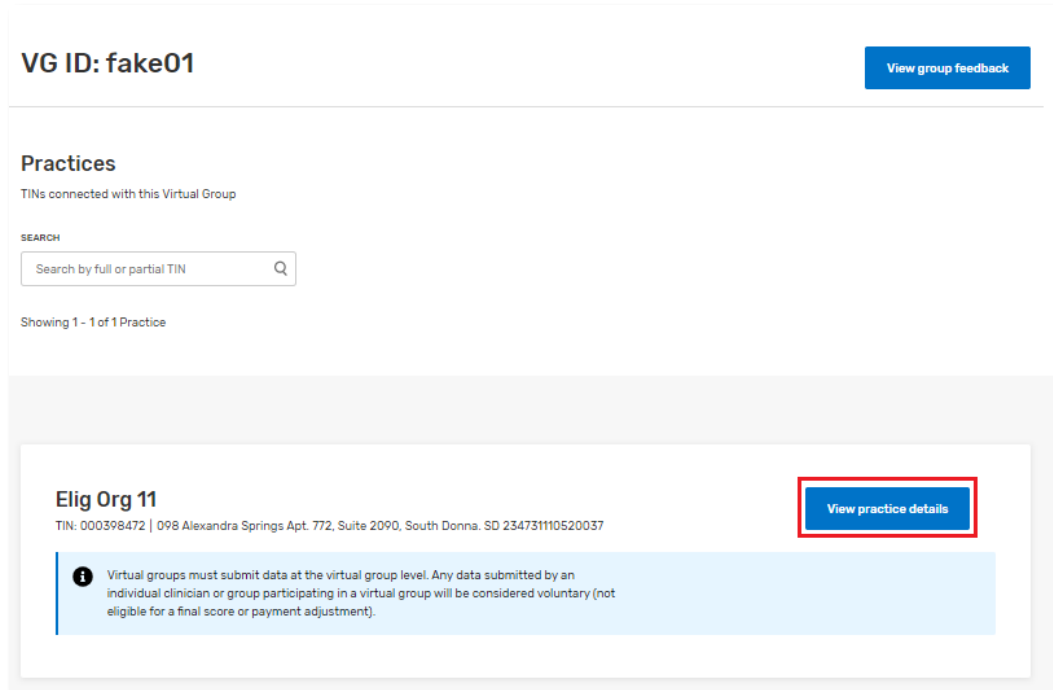
Can the Practices and/or Solo Practitioners Who Participate in Our Virtual Group Access Our Performance Feedback?

Yes, but only if they have an approved Staff User role for your virtual group. This means they are 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 \(ZIP\)](#).

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

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'll see performance feedback based on the data you submitted to QPP at the virtual group level. Please note that we updated the scoring hierarchy so that clinicians participating in a virtual group will always get the virtual group's final score, even if they participate in a MIPS APM.

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Quality Payment PROGRAM

Overview: Final Score and Payment Adjustment

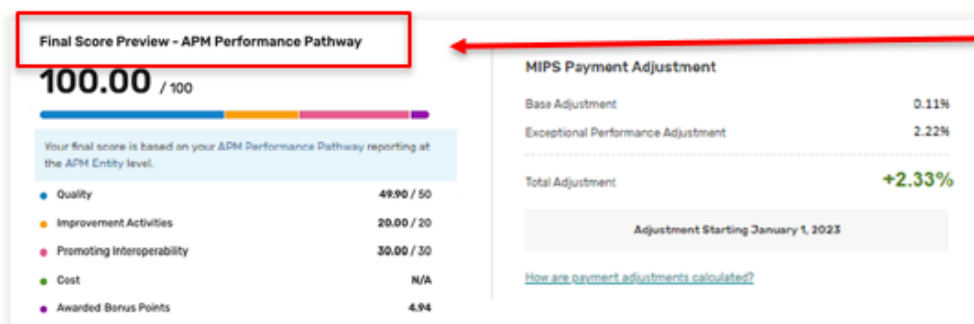
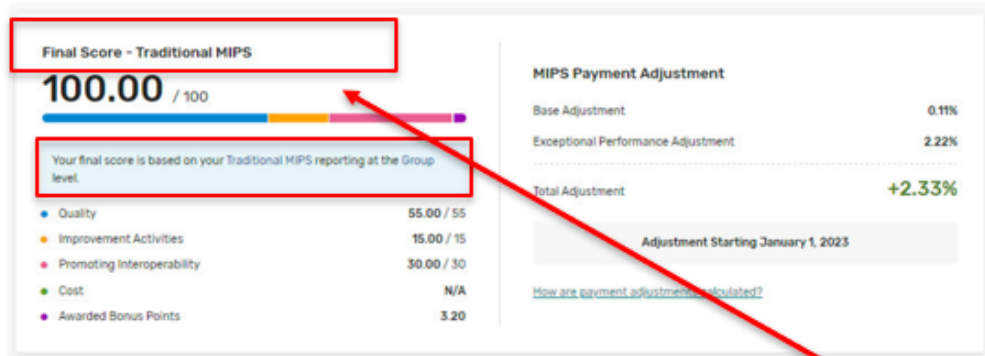
When you navigate into feedback, you'll land on the **Overview** page. From here, you can view:

- Your final score, which will be based on reporting for [traditional MIPS](#) or [the APP](#)
- Your score and the weight for each MIPS performance category
- Your payment adjustment(s) information

. How Is Our Final Score Determined?

Your final score is the sum of your performance category scores and any points awarded for the [complex patient bonus](#).

Note: If a clinician participated in MIPS multiple ways – for example, your practice reported traditional MIPS at the group level and the clinician also reported as an individual – we'll assign the highest final score that could be attributed to the clinician under that TIN/NPI combination. Users with access to an APM Entity will only be able to access performance feedback and the final score for the APM Entity. They won't see if the participating clinicians have a higher score from individual, group participation or another APM Entity.



The Final Score card also identifies which MIPS reporting framework the final score was derived from – traditional MIPS or the APP.



Who Gets the 2023 MIPS Payment Adjustment(s) That I See in Performance Feedback?

The payment adjustment information is specific to the final score that's being viewed. It's possible for clinicians to have multiple final scores under a single TIN/NPI combination, so we recommend reviewing the Payment Adjustment CSV, which can be downloaded from the main performance feedback page.

When a clinician has multiple final scores that can be attributed to their TIN/NPI combination, we apply the following hierarchy when determining which final score will determine payment adjustments:

| Scenario | Final Score Used to Determine Payment Adjustments |
|--|--|
| TIN/NPI is part of a virtual group and reported as an individual, group and/or APM Entity. | Virtual group's final score. (All other reporting is considered voluntary.) |
| TIN/NPI has a score from individual, group and/or APM Entity reporting. | The highest of the final scores, from either APM Entity, group, or individual reporting. |

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

- Clinician type/ specialty
- Medicare enrollment date
- Reaching QP thresholds if they're 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 |
|---|--|
| 85.00 – 100.00 points (Additional performance threshold = 85.00 points) | <ul style="list-style-type: none">• 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) |
| 60.01 – 84.99 points | <ul style="list-style-type: none">• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)• Not eligible for additional adjustment for exceptional performance |
| 60.00 points (Performance threshold = 60.00 points) | Neutral MIPS payment adjustment (0%) |
| 15.01 – 59.99 | Negative MIPS payment adjustment (between 0% and -9%) |
| 0 – 15 points | Negative MIPS payment adjustment of -9% |

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 the projected negative adjustments must be balanced by the projected positive adjustments. The magnitude of the payment adjustment amount is influenced by 2 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, doesn't 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 60 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 didn't submit any data will receive a neutral payment adjustment instead of the maximum negative adjustment.

While we're seeing a slight increase in 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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MIPS Payment Adjustment

| | |
|------------------------------------|---------------|
| Payment Adjustment | 0.00% |
| Exceptional Performance Adjustment | 1.86% |
| <hr/> | |
| Total Adjustment | +1.87% |

Adjustment Starting January 1, 2023

[How are payment adjustments calculated?](#)

In the example at left, the **Payment Adjustment** of 0.008% was truncated to display as “0.00%” and the **Exceptional Performance Adjustment** of 1.864% was truncated to display as “1.86%”.

When the untruncated values were added together (0.008 + 1.864%), we get a **Total Adjustment** of 1.872%, which was truncated to display as “1.87%”.

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 (Identified by TIN)?

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

ITScoring-53

TIN: 000043553 | 842 Marisa Terrace, Suite 7960, Ricardochester.
PA 216324809655845

[View practice details](#)

Final Score
100.00
out of 100

Total Payment Adjustment
+2.33%

Download Data ^

Files

Submission Data.CSV

Connected Clinician List.CSV

Payment Adjustment.CSV

One or more clinicians scored lower than the group's final score. Those clinicians will receive the group final score.

You can also filter your Connected Clinicians list by final score information once you've clicked **View Practice Details**. The list defaults to showing **All Clinicians**.

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

Connected Clinicians

Select one of the clinicians below to view their performance details.

Filter

All Clinicians (25)



All Clinicians (25)

Receiving Group Score (7)

Receiving Individual Score (18)

Search

Search by full or partial NPI



Download Data (Page 1) ▾

Receiving Individual Score

- 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.

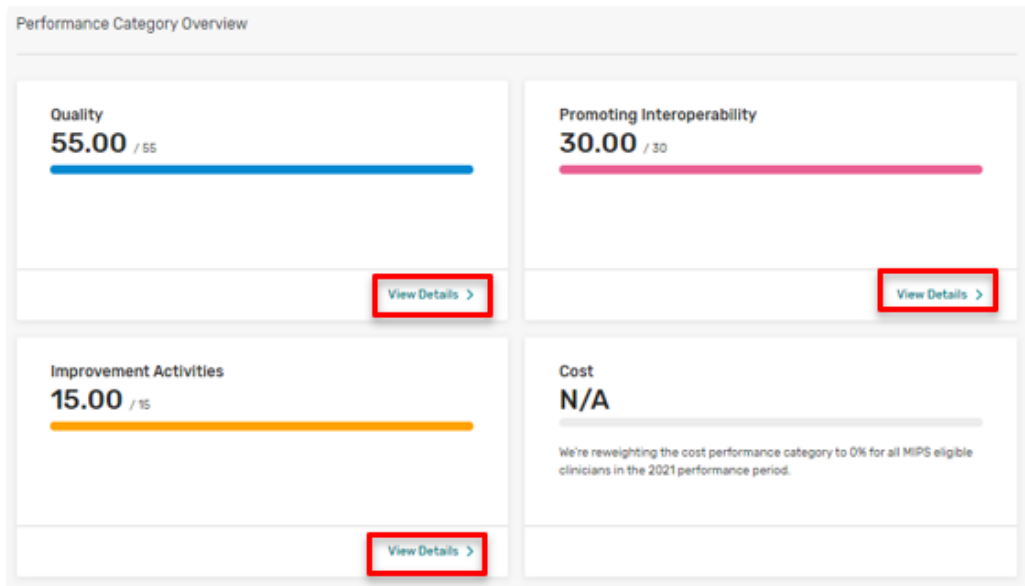
Receiving APP Score (not shown in the image on the previous page)

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

Please note: All screenshots are for illustrative purposes only.
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How Can I See More Information about the Different Performance Categories?

For individual, group and virtual group feedback, you can access the scoring details for each performance category by clicking “View Details” on the Performance Category Overview cards below.



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.

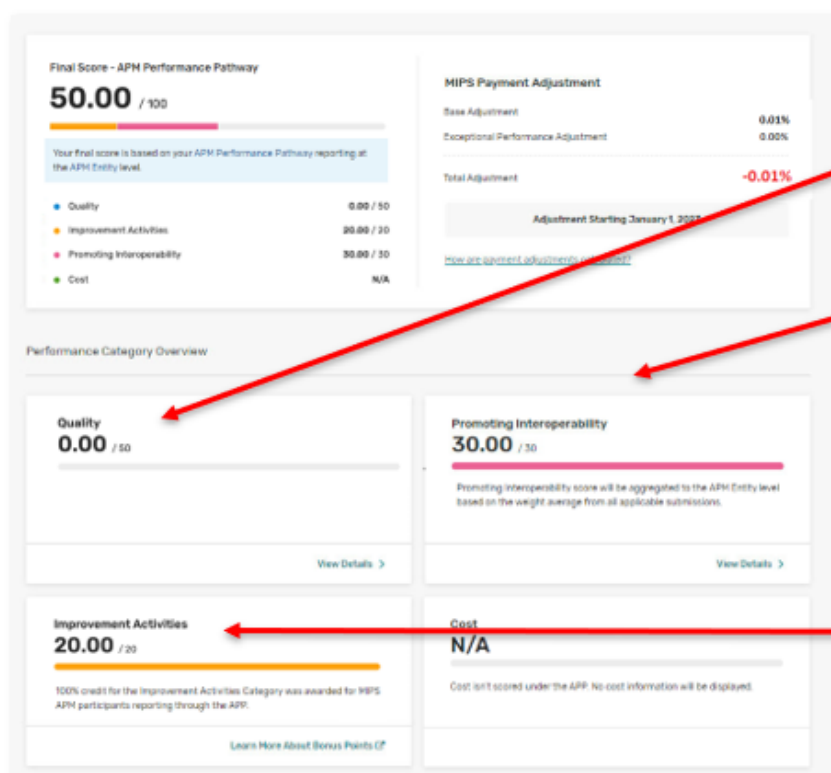
- MIPS eligible clinicians who submitted some data as individuals will see “N/A” for every performance category for which they didn’t submit data (due to the automatic EUC policy triggered by the COVID-19 pandemic).
- Groups and virtual groups will see “N/A” for every performance category they selected in an approved COVID-19 EUC application, unless data was submitted for that category.
- **Reminder:** Clinicians who participate in an APM – and groups and virtual groups that include these clinicians – qualify for automatic credit in the improvement activities performance category. Submitting data for the quality and/or Promoting Interoperability performance categories triggered this automatic credit and overrode reweighting, making the category eligible for scoring.

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We're a Participant TIN in a Shared Savings Program ACO That Reported the APP. Why Do We See a Score of Zero for the Quality Performance Category?

Participant TINs see a quality score of zero because the APP quality measures are reported by the ACO and not the group.

- Participant TINs that reported Promoting Interoperability data for the APP as a group will see a group final score based on the Promoting Interoperability data they reported and the 100% automatic credit for the improvement activities performance category.
- Participant TINs **won't** see the final score attributed to the ACO. Only authorized representatives of the ACO (users with the Staff User or Security Official role for the ACO) or MIPS eligible clinicians in the ACO with the Clinician Role can access the ACO's final score.



Participant TINs in an ACO should expect to see a quality score of zero unless they submitted the APP quality measures at the group level.

Participant TINs in an ACO should also expect to see a Promoting Interoperability score based on the data they submitted; this will be different than the ACO's Promoting Interoperability score, which is a weighted average of the scores attributed to each MIPS eligible clinician in the ACO.

Automatic credit in the improvement activities performance category assigned when data is reported for the APP.

However, the MIPS eligible clinicians in the ACO will receive the highest final score and associated payment adjustment that could be attributed to them.

What Is the Complex Patient Bonus?

The complex patient bonus is 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 complex patients.

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

All MIPS eligible clinicians, groups, virtual groups, or APM Entities 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, whether reporting traditional MIPS or the APP.

The complex patient bonus awards up to 10 bonus points, which are added to your final score and 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.

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 calculated the HCC risk scores of Medicare patients and determined the proportion of dually eligible patients treated during the second 12-month segment (October 1, 2020 – September 30, 2021) of the MIPS determination period.

- Each MIPS eligible clinician, group, virtual group, or APM Entity was evaluated for the complex patient bonus in the 2021 performance year. There was no minimum amount or percentage of dually eligible patients or patients diagnosed with a condition that has an HCC risk score required for the clinician to receive a complex patient bonus.
- As finalized in the [CY2022 Physician Fee Schedule \(PFS\) Final Rule](#), we doubled the complex patient bonus from 5 to 10 points for the 2021 performance year.

How Is the Complex Patient Bonus Calculated?

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

For PY 2021

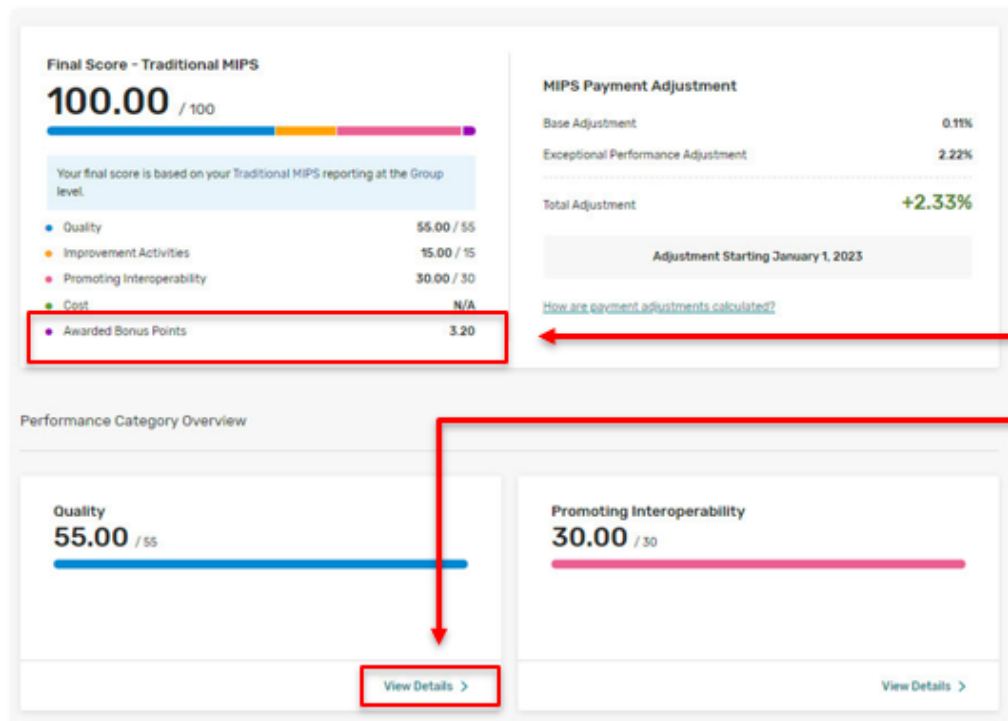
*Unique patients must have been treated between 10/1/20 and 9/30/21 to be included in the Complex Patient Bonus calculation.

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

Did you know?

We'll display the complex patient bonus (if it could be calculated) for informational purposes for:

- Clinicians who weren't eligible for MIPS at the individual level but voluntarily reported as an individual.
- Clinicians that were individually eligible but didn't submit data and are receiving a score equal to the performance threshold due to the automatic extreme and uncontrollable circumstances policy.
- Practices that weren't eligible for MIPS at the group level but voluntarily reported as a group.
- Practices that were 1) eligible for MIPS at the group level, **and** 2) didn't report as a group, **and** 3) had either [administrative claims quality measures](#) or [Items & Services](#) data available for informational purposes.



Informational complex patient bonus is displayed here.

If informational administrative claims measures scores are available as well, you'll see an option to "View Details" on the quality card.

Skip ahead to see details about performance feedback for [traditional MIPS](#) or the [APP](#). You can also skip ahead to review information about [Patient Risk Factor Data](#) and [Items & Services](#).

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Traditional MIPS: 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.

Measures that count toward Quality Performance Score

Your Measure Score includes both performance points and bonus points.

| Measure Name Expand All | Performance Rate | Measure Score | |
|---|------------------|---------------|---|
| Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care Measure ID: 141 High Priority | 100.00% | 12.00 | ▼ |
| Controlling High Blood Pressure Measure ID: 236 High Priority | 100.00% | 12.00 | ▼ |

2. Measures whose bonus points contribute to your quality performance category score. You'll see the bonus points earned by these measures.

Measures that earned bonus points only

These measure(s) fall outside of your top scoring measures but received bonus points. Your Measure Score will only include those bonus points.

| Measure Name Expand All | Performance Rate | Measure Score | |
|--|------------------|---------------|---|
| Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) Measure ID: 001 High Priority | 90.00% | 2.00 | ▼ |
| Documentation of Current Medications in the Medical Record Measure ID: 130 High Priority | 90.00% | 1.00 | ▼ |
| Sub-Total: | | 3.00 | |

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3. Measures that contribute zero points to your quality performance category score. You'll see "N/A" in the measure score.

Measures submitted but do not count towards Quality

These measures either fall outside the top six measures or exceed the maximum bonus points moreover they do not contribute to the submission. The "Points from Benchmark Decile" is the measure score that measure received.

| Measure Name Expand All | Performance Rate | Measure Score |
|---|------------------|---------------|
| Preventive Care and Screening: Influenza Immunization Measure ID: 110 | 2.06% | N/A |
| Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Measure ID: 128 | 17.79% | N/A |

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'll include any bonus points from the remaining measures, as long as you haven't exceeded the 10% cap for the applicable bonus.

When determining which measures are included in the top 6:

- We'll select the highest scoring outcome measure.
 - If you didn't have an outcome measure available, then we'll select the highest scoring high priority measure.
- We'll 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'll receive a score of 0/10 for the missing outcome or high priority measure.

When there are multiple measures with the same score, we 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 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients 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 Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure (320).

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If you submit the same measure through multiple collection types—example, as a Medicare Part B claims measure and as an electronic clinical quality measure (eCQM)—we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2 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'll see ‘—’ as the measure score for measures that were excluded from scoring because there's no benchmark, or because you didn't meet the 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.

Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

100.00%

12.00

Measure ID: 141 | High Priority

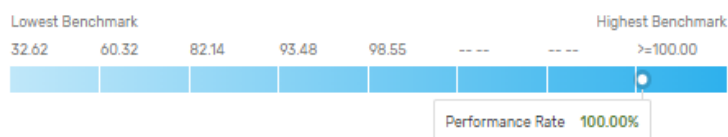


Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

100.00%

12.00

Measure ID: 141 | High Priority



Measure Type

Outcome

Details

| | |
|---------------------|------|
| Numerator | 100 |
| Denominator | 100 |
| Data Completeness | 100% |
| Eligible Population | 100 |

Performance Points

| | |
|------------------------------|-------|
| Points from Benchmark Decile | 10.00 |
|------------------------------|-------|

Bonus Points

| | |
|---|------|
| High Priority Outcome or Patient Experience | 2.00 |
| Other High Priority | 0.00 |
| End-to-End Reporting | 0.00 |

Measure Score **12.00**

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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. Please note 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 measure may earn 7 points while the other measure earns 10 points, based on the benchmarks for each measure.

I Reported 6 Measures and They All Had Benchmarks. Why Was I Only Scored on 5 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.
- 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 wasn't scored and your quality denominator – the maximum number of points available – was reduced by 10 points.

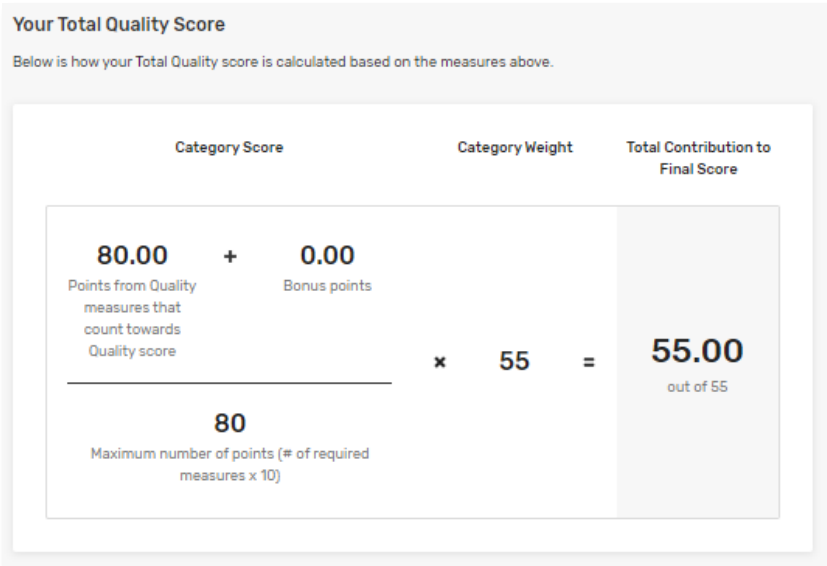
For a complete list of these impacted measures (and their collection types), refer to [Appendix D](#).

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 to you 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.



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I Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures (CQMs)) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

Clinicians who don't have 6 available quality measures and who report Medicare Part B Claims measures or MIPS CQMs may qualify for the [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 6 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) Doesn't Qualify for Denominator Reduction

Submission Less than 6 Measures

This submission has less than six measures and has not qualified for Eligibility Measure Application. The submission was scored on the measures submitted and received a zero for required measures not reported.

Submitted Measures

Measures that count toward Quality Performance Score

Your Measure Score includes both performance points and bonus points.

| Measure Name Expand All | Performance Rate | Measure Score | |
|--|------------------|---------------|---|
| Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%) Measure ID: 007 End-to-End Reporting | 100.00% | 11.00 | ▼ |

Sub-Total: 11.00

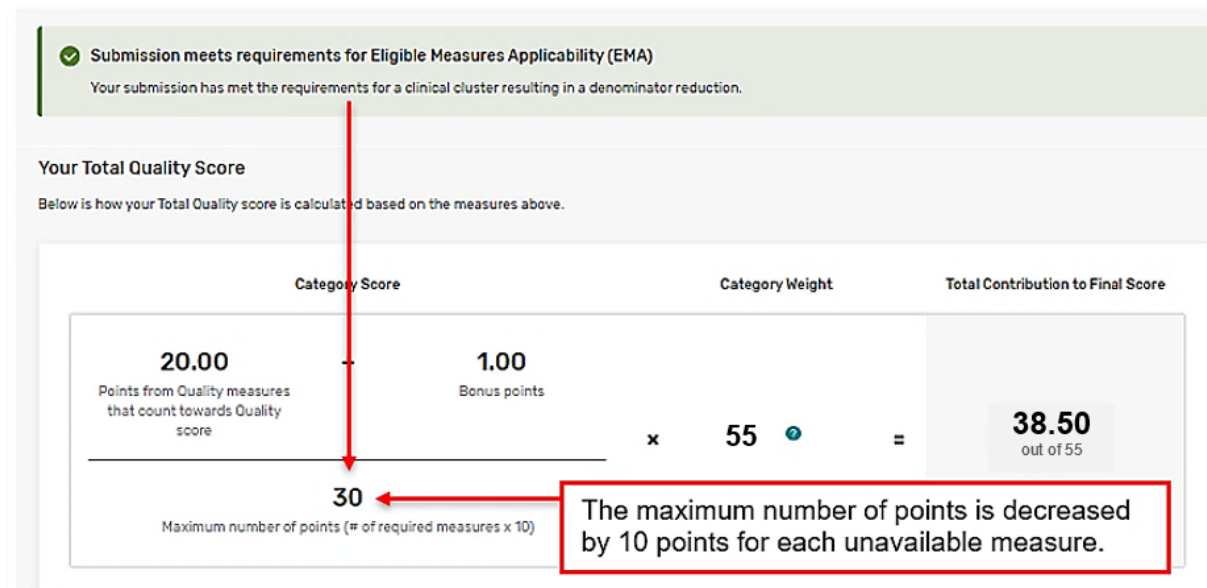
Your Total Quality Score

Below is how your Total Quality score is calculated based on the measures above.

| Category Score | Category Weight | Total Contribution to Final Score |
|--|-----------------|-----------------------------------|
| <div>10.00 + 1.00</div> <div>Points from Quality measures that count towards Quality score</div> <div>Bonus points</div> | 55 | 10.08 out of 55 |
| 60 | | |
| Maximum number of points (# of required measures x 10) | | |

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Submission (MIPS CQMs) Qualifies for Denominator Reduction



If you submitted all available Medicare Part B claims measures or MIPS 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 Unplanned Readmission measure), please contact the [QPP Service Center](#) for assistance.

Our Small Practice Reported Medicare Part B Claims Measures for Individual Clinicians. Why Were We Scored as a Group?

Under current policy, small practices that report Medicare Part B claims automatically receive a quality score at the individual and group level. The 2021 performance year is the final year that small practices will be automatically scored as a group; beginning with the 2022 performance year, small practices will only receive a group level score from Medicare Part B claims if they also submit group-level data for another performance category or categories.

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Where Can I Find Information on the Administrative Claims Quality Measures?

There are 2 administrative claims quality measures in the 2021 performance year which will only be displayed in feedback if they could be scored.

Administrative Claims Measure

The following measure will contribute to your final score in addition to your top six scoring measures.

| Measure Name Expand All | Performance Rate | Measure Score |
|--|------------------|---------------|
| Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups Measure ID: 479 | 14.3419 | 10.00 |
| Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Measure ID: 480 | 14.3419 | 10.00 |
| Sub-Total: | | 20.00 |

Click the caret to open the measure details.

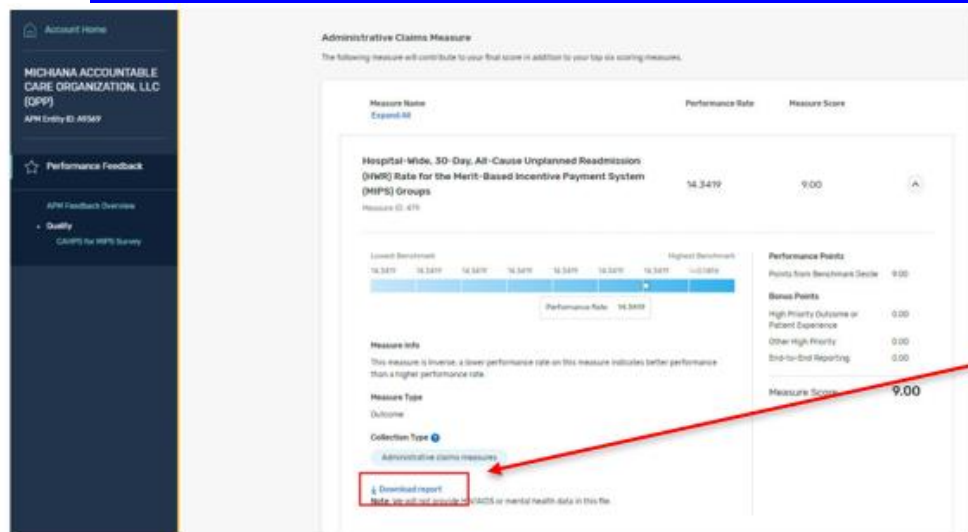
- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups.** (This measure replaced the All-Cause Hospital Readmission (ACR) measure.)
 - This measure is automatically calculated for groups, virtual groups, and APM Entities with at least 16 eligible clinicians that meet the case minimum (200 cases).
 - Review the [measure specification](#).
- **Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).**
 - This measure is automatically calculated for individuals, groups, virtual groups, and APM Entities that meet the case minimum (25 cases).
 - Review the [measure specification](#).

If you don't see these measures displayed in your feedback, then you didn't meet the criteria above.

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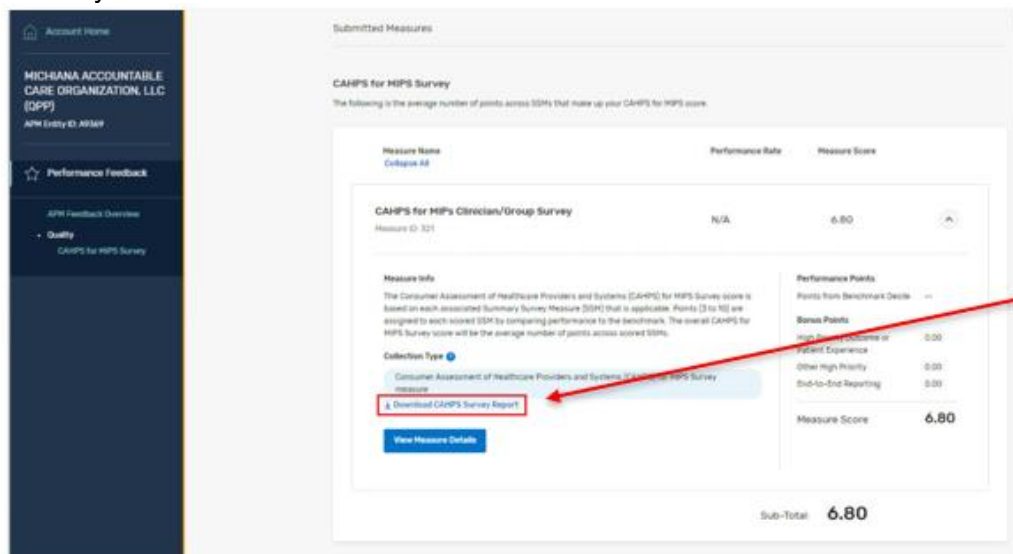
Where Can I Find Patient Level Reports for the Administrative Claims Quality Measures?

The patient level reports can be downloaded within the measure details. For more information about the reports, review the [2021 MIPS Performance Feedback Patient-Level Data Reports Supplement](#).



Where can I find the CAHPS for MIPS Survey measure reports?

The CAHPS for MIPS Survey measure report is available **for groups** on the CAHPS for MIPS card within the Quality section of feedback.



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NEW! We're displaying administrative claims measure scores (if available) for informational purposes for practices that were eligible at the group level but didn't participate as a group.

What Is Quality 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 score—calculated at the category level and representing 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's no improvement, the improvement score will be 0%. The improvement score can't be negative.

You'll be evaluated for improvement scoring for the 2021 performance year when you:

- Meet the quality performance category requirements for the current performance year (i.e., submit 6 measures/specialty measure set with at least 1 outcome/high priority measure OR submit as many measures as were available and applicable OR report all 10 measures in the CMS Web Interface; all measures must meet data completeness requirements).
- Have a quality performance category achievement score based on reported measures for the previous performance year (2020).
- Submit data under the same identifier for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

Improvement scoring isn't 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 performance period.

For example, if your 2020 performance year quality score is derived from facility-based measurement, you aren't eligible for improvement scoring for the 2020 or 2021 performance years.

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How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2020) performance year to the quality performance category achievement score for the current (2021) performance year. **Measure bonus points aren't included in improvement scoring.**

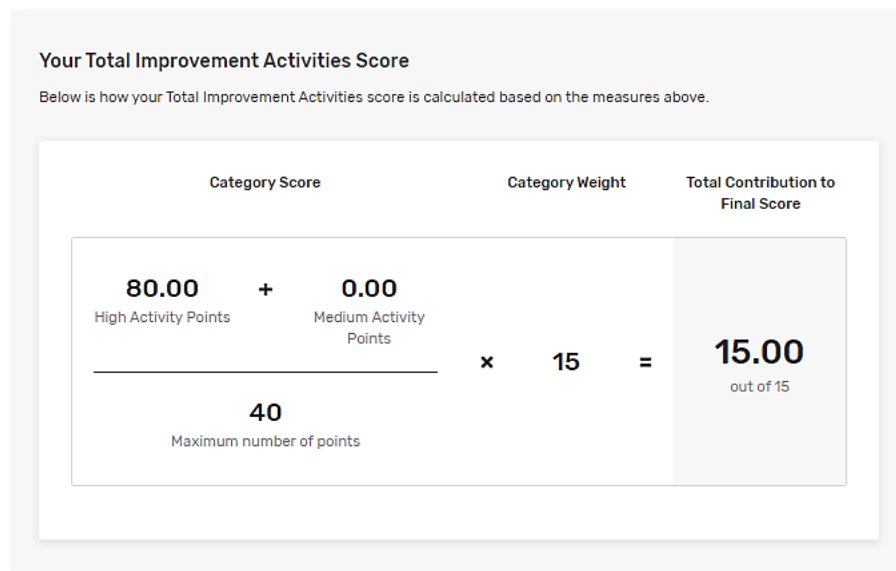
$$\text{Improvement Percent Score} = \frac{(\text{Current Performance Period Quality Performance Category Achievement Score}) - (\text{Prior Performance Period Quality Performance Category Achievement Score})}{\text{Prior Performance Period Quality Performance Category Achievement Score}} \times 10\%$$

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Traditional MIPS: 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. (The screenshot below shows the maximum points possible at 15.)



We're 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.**

We Were Approved for Reweighting of the Improvement Activities Performance Category. Why Are We Showing 7.5 out of 15 points?

Clinicians that participate in an APM, and groups that include such clinicians, automatically receive 50% credit in traditional MIPS for the improvement activities performance category when data are submitted for the quality and/or Promoting Interoperability performance categories.

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Traditional MIPS: Promoting Interoperability

The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed.

Each required measure is 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. Then we multiply the performance rate by the maximum points available for the measure, and then round the 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.

e-Prescribing

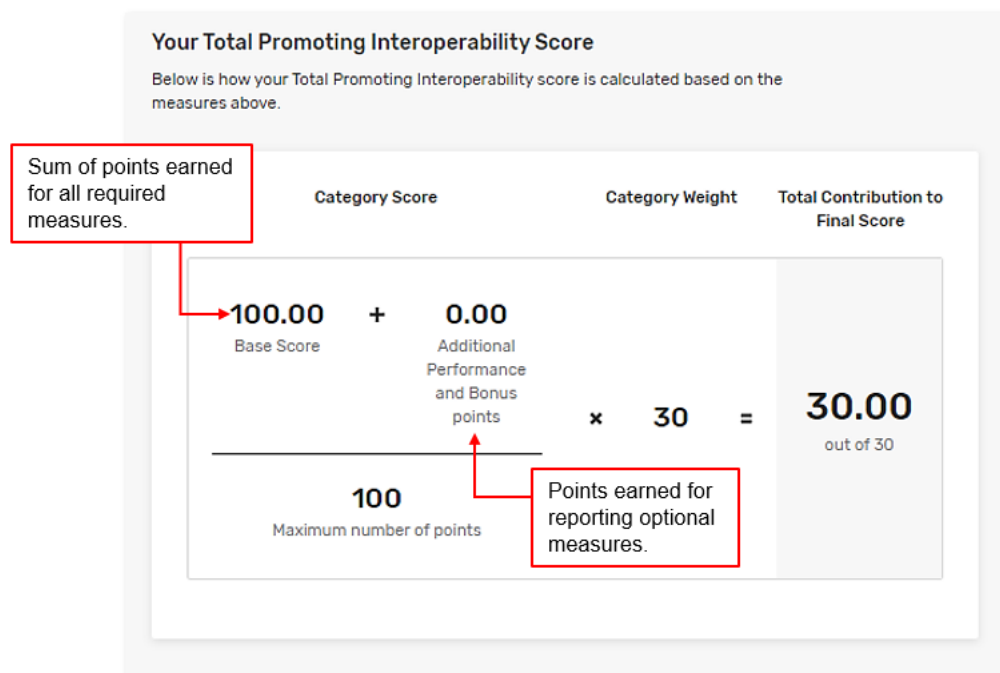
| Measure Name Expand All | Measure Score |
|--------------------------------------|---------------|
| e-Prescribing Measure ID: PI_EP_1 | 9 / 10 |

e-Prescribing

| Measure Name Collapse All | Measure Score |
|--|---------------|
| <div><div><p>e-Prescribing</p><p>Measure ID: PI_EP_1</p><p>At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.</p><p>Collection Type ⓘ</p><p>Manual Entry</p><p>Download Specifications</p></div><div><p>Numerator</p><p>187</p><p>Denominator</p><p>199</p></div></div> | 9 / 10 |

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

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.



Why Did I Receive a Performance Category Score of 0 Out of 30 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 **WASN'T** reweighted to 0%. This includes clinicians and groups who started data entry (such as entering a performance period) on the Manual Entry page during the submission period.

Note: If you didn't submit data and received a performance category score of 0 out of 30 points but should've qualified for reweighting based on your clinician type, special status, and/or exception status, please contact the [QPP Service Center](#) for assistance.

Why Did I Receive a Performance Category Score of 0 Out of 30 Points When I Submitted All of My Data?

If you reported Promoting Interoperability data through multiple submission types (for example, manual entry and file upload) and there was any conflicting data, you received a score of 0 out of 30 points for the performance category.

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What Is a CEHRT ID?

The CEHRT identification number (ID) is the CMS Certification ID for your EHR product(s) proving that it's certified by The Office of the National Coordinator for Health Information Technology (ONC) to the 2015 Edition. 2015 Edition Certified EHR Technology (CEHRT) is required for reporting your MIPS Promoting Interoperability measures.

Submissions without a valid CEHRT ID result in a performance category score of zero.

| Performance Period | CEHRT ID |
|-------------------------|------------------|
| 01/01/2021 - 06/01/2021 | XX15EXXXXXXXXXXX |

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Traditional MIPS: Cost

Why Don't I See Any Cost Measure Information?

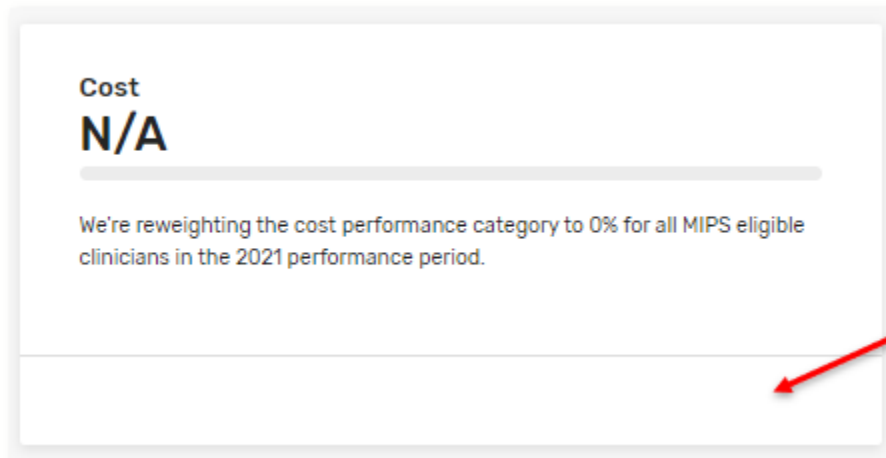
CMS is reweighting the cost performance category from 20% to 0% for the 2021 performance period for all MIPS eligible clinicians, regardless of participation as an individual, group, virtual group, or APM Entity. The 20% cost performance category weight will be redistributed to other performance categories in accordance with [§ 414.1380\(c\)\(2\)\(ii\)\(E\)](#).

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'll receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2023 MIPS payment year. This reweighting of the cost performance category applies in addition to the 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%.

Where Can I Find Patient Level Reports for Cost Measures?

As a reminder, CMS isn't scoring cost measures for the 2021 performance period; however, we're making patient level reports available to clinicians and groups for the cost measures for which they met the case minimum requirements. You can access these reports via the cost details card under feedback overview. For more information about the reports, review the [2021 MIPS Performance Feedback Patient-Level Data Reports Supplement](#).



If you don't see any cost measure reports, then you didn't meet the case minimum requirements for any of the measures.



APM Performance Pathway: Quality

How was our quality score calculated?

We use the following formula to calculate your quality performance category score.

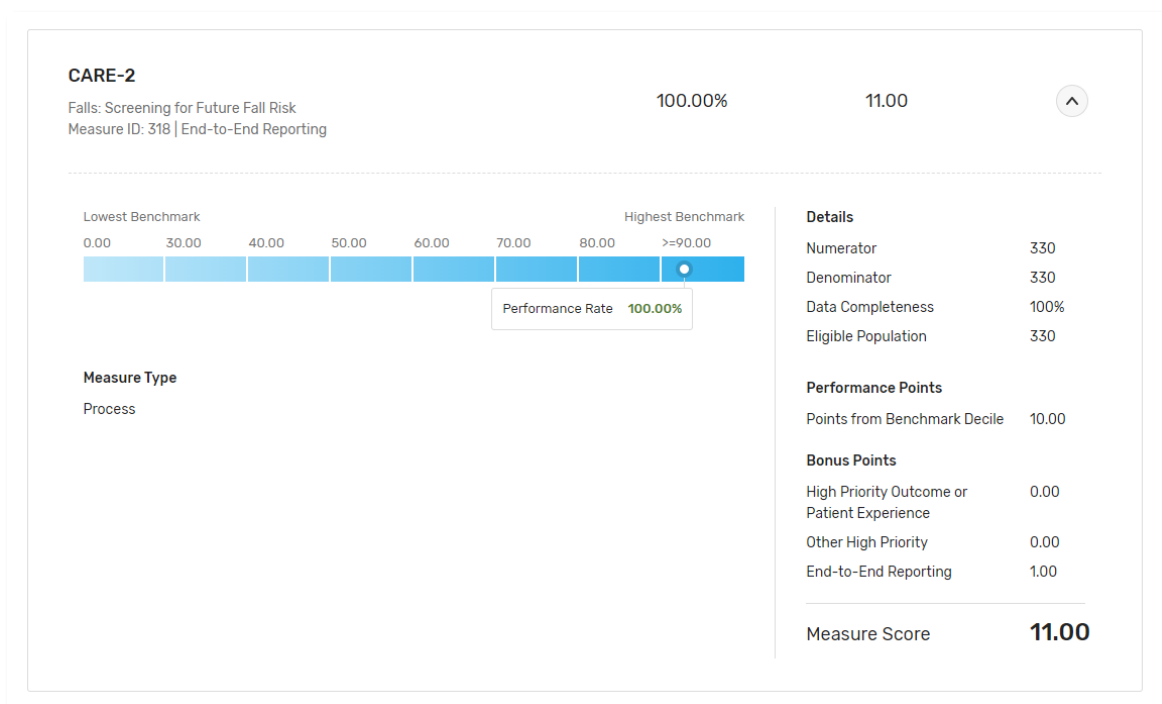


As you scroll down the page, you'll see all of the measures that contributed to your score. Because the APP requires a specific set of measures, you'll see "0.00" points for any measure that was required but unreported.

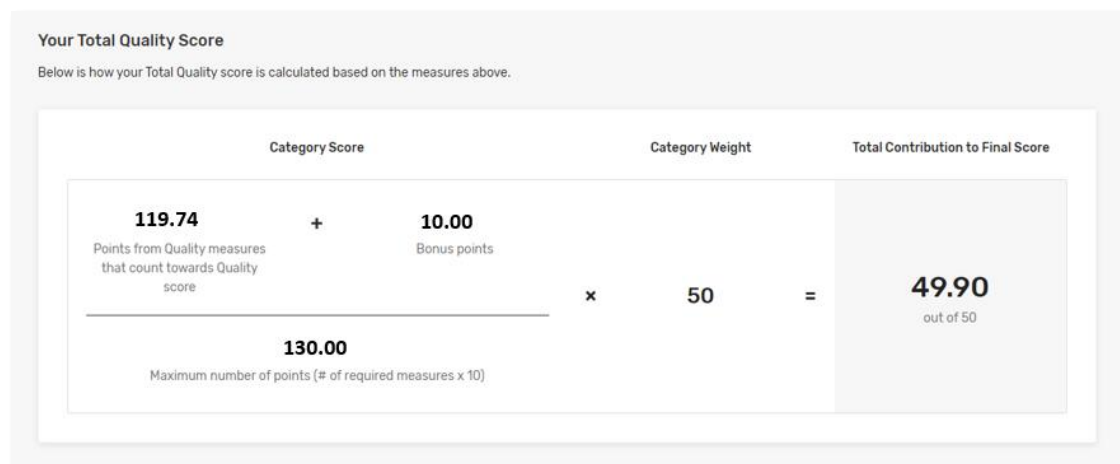
To access measure details, click the caret to the right of the measure score.

| CMS Web Interface Measures | | |
|---|------------------|---------------|
| Measures within the CMS Web Interface that do not have a correlating benchmark or have below 20 eligible patients will result in a denominator reduction. These measures will be notated with an N/A for score. | | |
| Measure Name Expand All | Performance Rate | Measure Score |
| CARE-2 Falls: Screening for Future Fall Risk Measure ID: 318 End-to-End Reporting | 100.00% | 11.00 |

Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.



At the bottom of the page, you'll see the calculation to arrive at your quality score. (In the example screenshot below, the participant didn't qualify for improvement scoring.)

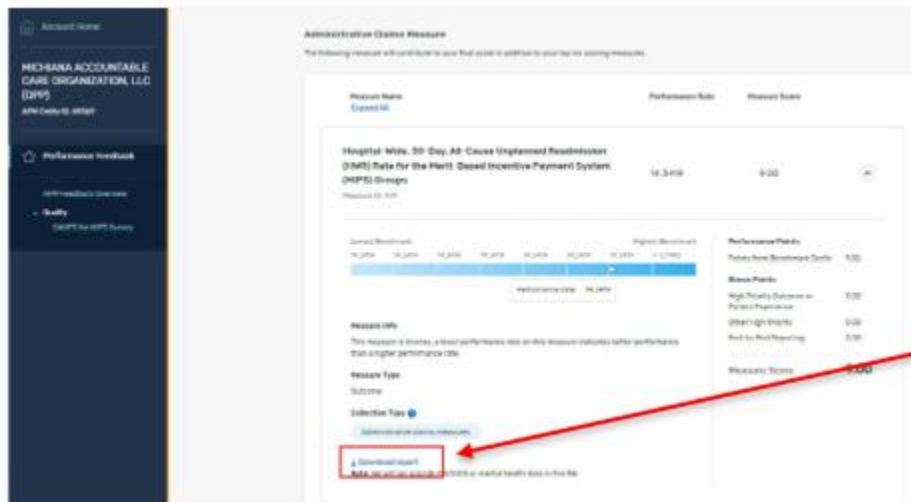


Note: If you reported via more than one method (example: web interface and eCQMs) there may be more than one set of quality measure results.

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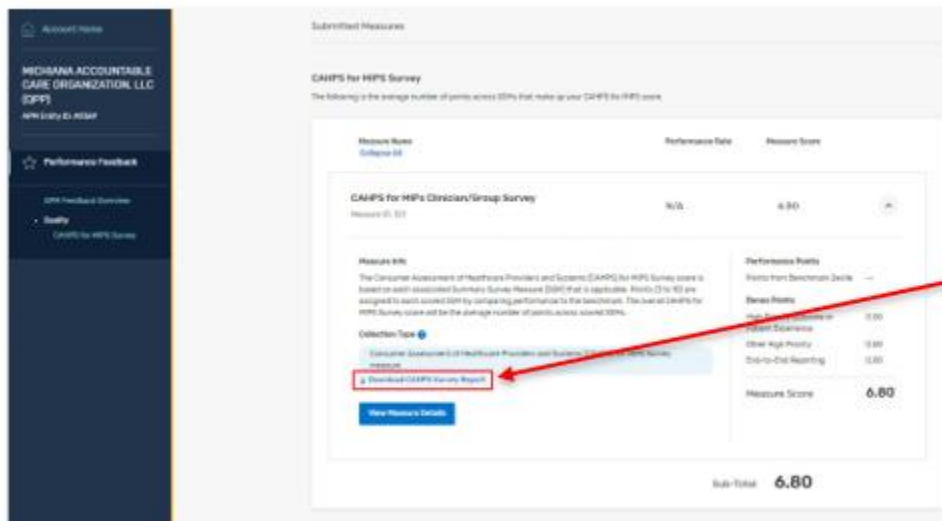
Where Can I Find Patient Level Reports for the Administrative Claims Quality Measures?

We'll provide patient level reports if you met the case minimum requirements on either of the administrative claims measures automatically calculated under the APP. The patient level reports can be viewed within the measure details. For more information about the reports, review the [2021 MIPS Performance Feedback Patient-Level Data Reports Supplement](#).



Where can I find the CAHPS for MIPS Survey measure reports?

The CAHPS for MIPS Survey measure report is available **for groups** on the CAHPS for MIPS Survey card within the Quality section of feedback. Shared Savings Program ACOs receive their CAHPS for MIPS Survey reports outside of the feedback provided on the QPP website.



Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

What Is Quality Improvement Scoring?

You can earn up to 10 additional percentage points in the quality performance category based on your rate of improvement in the quality performance category from the previous year. The improvement score — calculated at the category level and representing 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's no improvement, the improvement score will be 0%. The improvement score can't be negative.

You'll be evaluated for improvement scoring for the 2021 performance year when you:

- Meet the quality performance category requirements for the current performance year
- Have a quality performance category achievement score based on reported measures for the previous (2020) performance year.
- Submit data under the same identifier (such as ACO ID or TIN) for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2020) performance year to the quality performance category achievement score for the current (2021) performance year. **Measure bonus points aren't included in improvement scoring.**

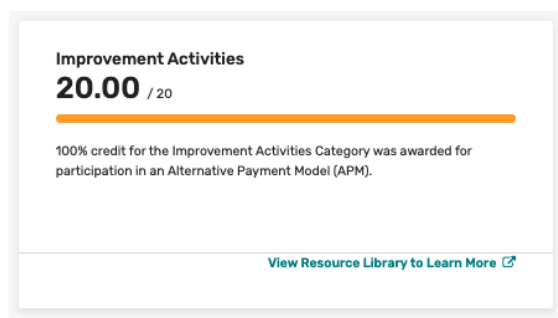
$$\text{Improvement Percent Score} = \frac{(\text{Current Performance Period Quality Performance Category Achievement Score}) - (\text{Prior Performance Period Quality Performance Category Achievement Score})}{\text{Prior Performance Period Quality Performance Category Achievement Score}} \times 10\%$$

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

APM Performance Pathway: Improvement Activities

Why Can't I Access Details about the Improvement Activities Performance Category?

There aren't any details for this performance category because clinicians, groups and APM Entities automatically received full credit under the APP as indicated by the text on the improvement activities card.

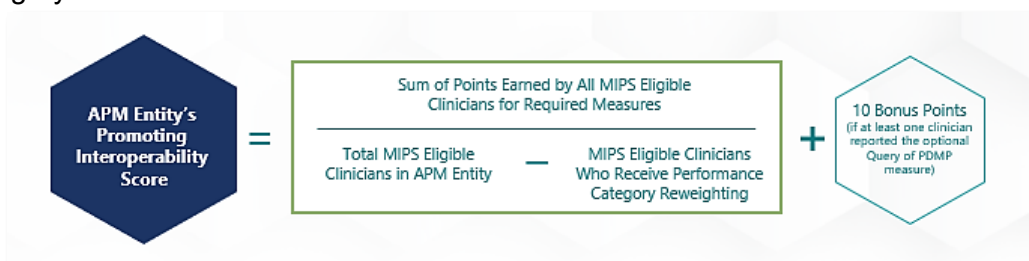


APM Performance Pathway: Promoting Interoperability

We're a Shared Savings Program ACO. How Did We Get Our Score for the Promoting Interoperability Performance Category?

When reporting the APP as an APM Entity (such as a Shared Savings Program ACO), the MIPS eligible clinicians in the Entity reported their Promoting Interoperability measures as individuals or as a group. We score the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity.

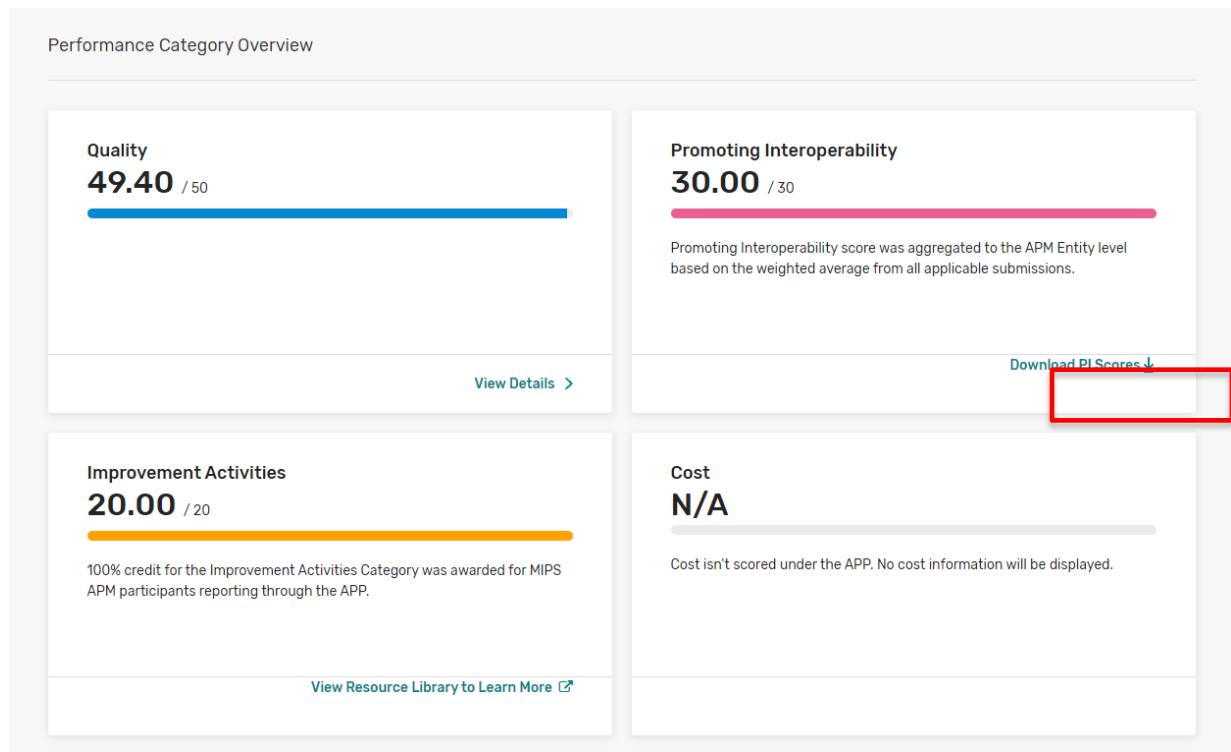
- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- The APM Entity received 10 bonus points if at least one individual or group in the APM Entity reported the optional Query of PDMP measure, but the Promoting Interoperability performance category score can't exceed 100%.



Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

How Can We View the Individual Promoting Interoperability Scores for the Clinicians in our ACO?

You can download a report of these scores from the Overview page. Click **Download PI Scores** on the Promoting Interoperability card.



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Facility-Based Scoring

Why Don't I See Any Facility-Based Scoring Information?

There's no facility-based scoring available in the 2021 MIPS performance year. As announced through the QPP listserv on 8/26/2021, CMS finalized a measure suppression policy in the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) PPS final rule for several hospital reporting programs, including the Hospital Value-Based Purchasing (VBP) Program. As a result, CMS didn't calculate a total performance score under the Hospital VBP Program for any hospital for FY 2022 due to COVID-19's effect on many measures in the program.

We use the total performance score from the Hospital VBP Program to calculate facility-based scores for facility-based clinicians and groups in the quality and cost performance categories. The FY 2022 total performance score is what we would use to determine these scores for the 2021 MIPS performance period.

- Because the FY 2022 total performance score from the Hospital VBP Program wasn't available, we couldn't calculate MIPS facility-based scores for the 2021 MIPS performance year.

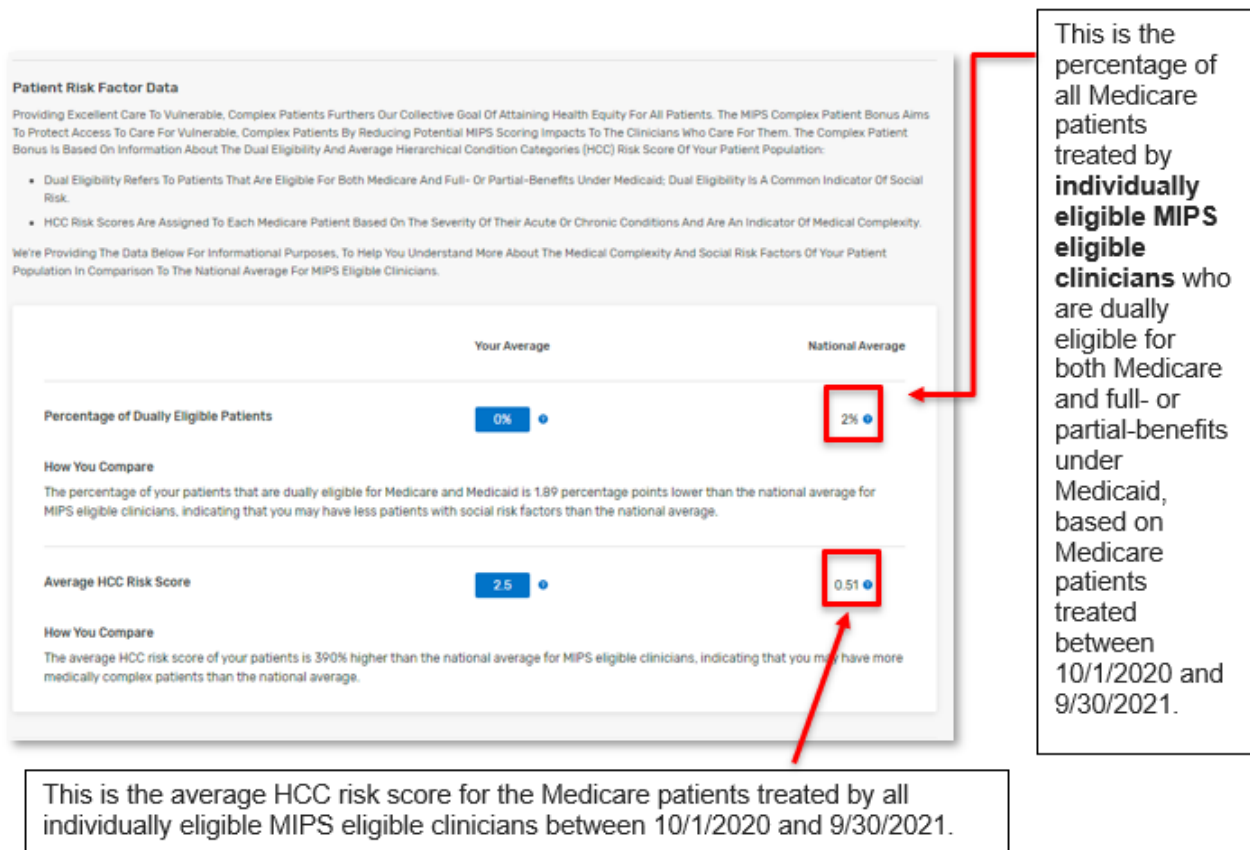
Please note: All screenshots are for illustrative purposes only.
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NEW! Patient Risk Factor Data

What is Patient Risk Factor Data?

This is a new section of performance feedback provided for **informational purposes only**. The intent is to provide individuals, groups and virtual groups with insight into the medical complexity and social risk of their patients in comparison to other MIPS eligible clinicians. This data looks at the 2 elements involved in the calculation of the complex patient bonus. Please note that the average values displayed in this section **aren't** those that will determine your eligibility for the complex patient bonus in the 2022 performance year.

This data **isn't** available for APM Entities.



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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 performance feedback provides clinicians with additional information about the healthcare and emergency department (ED) services received by their patients throughout a calendar year (CY). Please note that the Items and Services data is provided for informational purposes only and won't 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 using Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS codes represent a standard coding system for procedures, supplies, products, and services billed by healthcare providers. The data in the Items and Services section of performance feedback is aggregated by ranges of HCPCS codes.

What Is a HCPCS Code and How Are They Classified by Level?

The HCPCS is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare patients and to individuals enrolled in private health insurance programs. The codes are divided into 2 levels:

- **Level I HCPCS Codes:** Codes and descriptors copyrighted by the American Medical Association's (AMA) Current Procedural Terminology (CPT®), 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 4 numeric digits. Level II HCPCS 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 CPT Code?

CPT codes offer healthcare professionals a uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency. All CPT codes are 5 digits and can be either numeric or alphanumeric, depending on the category. As noted above, Level I of the HCPCS is comprised of CPT-4 codes, a numeric coding system maintained by the AMA.

¹ [Healthcare Common Procedure Coding System \(HCPCS\) Level II Coding Procedures \(PDF\)](#)

How Are HCPCS Codes Categorized in the Items and Services Section of Performance Feedback?

In the Items and Services section of performance feedback, the HCPCS codes are categorized as follows: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 (temporary codes) |
| 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 U | Codes for Coronavirus lab tests |
| HCPCS V | Vision, hearing and speech-language pathology services |

² <https://hcpcs.codes/section/>

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What Data Are 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, 2021, and December 31, 2021, and received by CMS within 60 days of December 31, 2021 (a “60-day runout”).

| Medical Services and Treatment | | | |
|--|---------------|----------|----------|
| The categories below are associated with medical services or treatments provided. Each individual item or services has a correlated HCPCS or CPT I code. | | | |
| Item/Service | Beneficiaries | Cost | Services |
| Anesthesia Services CPT I 00000-09999 | 200 | \$12,000 | 301 |

How Is the Number of “Beneficiaries” Displayed in the Items and Service Section of Performance Feedback Derived?

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 CY 2021 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.

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 CY 2021 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.

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How Is the “Cost” per CPT Code Range in the Items and Service Section of Performance Feedback Derived? Is the Cost Adjusted and/or Price Standardized?

The cost reflected in the Items and Services section of performance feedback is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines with dates of service between 1/1/2021-12/31/2021. These numbers are raw allowed charge amounts and aren't payment standardized, risk adjusted, nor specialty adjusted.

For individual clinicians, the number 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 CY 2021 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any provider during CY 2021.

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 CY 2021 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.


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 CY 2021 AND received at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2021.

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 CY 2021 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2021.

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Emergency Department Utilization

| Emergency Department Utilizations | |
|--|-----|
| Emergency Department Utilization numbers are for Emergency Department visits and include visits that resulted in an admission. | |
| Patients Associated with Your Practice | 107 |
| Associated Patients with Emergency Department Visits | 47 |
| Total Number of Emergency Department Visits  | 101 |

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 following method:

Patients are attributed to a single TIN/NPI based on the amount of primary care services received, and the clinician specialties that performed those services, during the performance period.


Only patients who received a primary care service during the performance period can be attributed to a TIN/NPI. A patient is attributed to a single TIN/NPI or a single entity’s CMS Certification Number (CCN) assigned to either a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in 1 of 2 steps, described below.

Note: If a patient is attributed to an FQHC or RHC’s CCN, then that patient and their services aren’t included in the provision of Items & Services data for an individual MIPS eligible clinician or group.

Step 1: If a patient received more primary care services from an individual TIN/NPI that’s classified as either a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) than from any other TIN/NPI during the performance period, then the patient is attributed to that TIN/NPI. If, during the performance period, a patient received more primary care services from an entity’s CCN than from any other TIN/NPI, then the patient is attributed to the CCN.

Step 2: If a patient didn’t receive a primary care service from a TIN/NPI classified as either a PCP, NP, PA, or CNS during the performance period, then the patient may be assigned to a

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TIN/NPI in “Step 2.” If a patient received more primary care services from a specialist physician’s TIN/NPI than from any other clinician’s TIN/NPI during the performance period, then the patient is assigned to the specialist physician’s TIN/NPI.

For a list of CMS specialty codes for PCPs and non-physician practitioners included in the first step of attribution, see [Appendix E](#). See [Appendix F](#) for a list of medical specialists, surgeons, and other physicians included in the second step of attribution. For a list of HCPCS codes that identify primary care services, please refer to [Appendix G](#).

A patient is excluded from the population measured for purposes of providing Items & Services data if:

- The patient wasn’t enrolled in both Medicare Parts A & B for every month of the performance period.
- The patient was enrolled in a private Medicare health plan during any month of the performance period.
- The patient resided outside the United States (including territories) during any month of the performance period.
- The patient was enrolled in Medicare Parts A & B for a partial year because he/she newly enrolled in Medicare or he/she died during the performance period.

The case minimum for provision of Items & Services data is 20. For a MIPS eligible clinician participating in MIPS as an individual, 20 patients must be assigned to the individual MIPS eligible clinician’s TIN/NPI for Items & Services data to be provided. For groups of clinicians participating in MIPS as a group, a total of 20 patients must be assigned to TIN/NPIs across the TIN/NPIs under the group’s TIN for Items & Services data to be provided.

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 ED visit in CY 2021. An ED visit is defined as any CY 2021 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 2021.

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General

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.) You can also download a spreadsheet with all of your submitted data (even if it didn't count towards your final score.)

What If We Find an Error with our Payment Adjustment/Performance Feedback?

If you believe an error has been made in your 2023 MIPS payment adjustment calculation, you have until 8 p.m. ET on 10/21/2022 to request a targeted review.

However, we encourage you to contact the QPP Service Center 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.

Contact the Quality Payment Program Service Center at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET) or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. For Shared Savings Program ACOs, please reach out to your ACO Coordinator with your QPP Service Center ticket number for assistance with resolving your inquiry.

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 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. For more information on the targeted review process, please review the 2021 Targeted Review User Guide.

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.

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Where Can I Learn More?

- [Quality Payment Program website](#)
- [2021 Traditional MIPS Scoring Guide \(PDF\)](#)
- [2021 APM Performance Pathway Toolkit \(ZIP\)](#)

Please contact the QPP Service Center at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET) or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

| Date | Comment |
|------------|-------------------|
| 08/22/2022 | Original Posting. |

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Appendix A: Automatic Extreme and Uncontrollable Circumstances Policy

Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2021 performance category reweighting policies that apply to individual clinicians under the MIPS automatic EUC policy, including those that submit MIPS data as individuals. (This doesn't 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 | 70% | 30% | 0% | 0% | Positive, Negative, or Neutral |
| Quality and Improvement Activities | 85% | 0% | 15% | 0% | Positive, Negative, or Neutral |
| Improvement Activities and Promoting Interoperability | 0% | 85% | 15% | 0% | Positive, Negative, or Neutral |
| Submit Data for 3 Performance Categories | | | | | |
| Quality and Improvement Activities and Promoting Interoperability | 55% | 30% | 15% | 0% | Positive, Negative, or Neutral |

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Appendix B: Extreme and Uncontrollable Circumstances Exception Application

Performance Category Reweighting Scenarios

The table below identifies the performance category reweighting scenarios applicable to groups and virtual groups with an approved EUC application for the 2021 performance year. (APM Entities could also submit EUC applications but were required to request reweighting in all performance categories.)

Please note that we have updated the table to reflect the 0% reweighting of the cost performance category for everyone in the 2021 performance year.

- The quality, improvement activities, and/or Promoting Interoperability performance categories could be reweighted due to an approved EUC application.
- The Promoting Interoperability performance category could also be reweighted due to clinician type, an approved hardship exception or special status.

| Reweighting Scenario | Quality Category Weight | Promoting Interoperability Category Weight | Improvement Activities Category Weight | Cost Category Weight | Payment Adjustment |
|---|-------------------------|--|--|----------------------|--------------------------------|
| No additional reweighting from an approved EUC application, approved Promoting Interoperability hardship exception, clinician type or special status | | | | | |
| No Cost | 55% | 30% | 15% | 0% | Positive, Negative, or Neutral |
| Reweight 2 Performance Categories | | | | | |
| No Cost and No Promoting Interoperability | 85% | 0% | 15% | 0% | Positive, Negative, or Neutral |
| No Cost and No Quality | 0% | 85% | 15% | 0% | Positive, Negative, or Neutral |
| No Cost and No Improvement Activities | 70% | 30% | 0% | 0% | Positive, Negative, or Neutral |
| Reweight 3 Performance Categories | | | | | |
| No Quality, No Cost, No Improvement Activities | 0% | 100% | 0% | 0% | Neutral |
| No Quality, No Cost, No Promoting Interoperability | 0% | 0% | 100% | 0% | Neutral |
| No Cost, No Improvement Activities, No Promoting Interoperability | 100% | 0% | 0% | 0% | Neutral |
| Reweight 4 Performance Categories | | | | | |
| All performance categories reweighted to 0% | 0% | 0% | 0% | 0% | Neutral |

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

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 CAN'T |
|---|--|---|
| Staff User or Security Official for a Practice (Includes solo practitioners) | <ul style="list-style-type: none"> ✓ View and download group-level ("practice") performance feedback ✓ View and download clinician-level performance feedback (excluding APM participants) ✓ View and download payment adjustment data ✓ Access patient-level reports for administrative claims cost and quality measures | <ul style="list-style-type: none"> ✗ View performance feedback for your virtual group ✗ View APM Entity level performance feedback <p>Example: If you're a participant TIN in a Shared Savings Program ACO, you won't be able to view performance feedback or payment adjustment information for the ACO. You'll only be able to view feedback on the data submitted at the individual or group level.</p> |
| Staff User or Security Official for an APM Entity | <ul style="list-style-type: none"> ✓ View and download MIPS performance feedback for the entire APM Entity ✓ View and download Promoting Interoperability scores for each MIPS eligible clinician in the APM Entity ✓ View and download payment adjustment data for all clinicians in the APM ✓ Access patient-level reports for administrative claims cost and quality measures | <ul style="list-style-type: none"> ✗ View final scores and payment adjustment data for the MIPS eligible clinicians in the APM Entity that didn't receive the APM Entity's final score |
| Staff User or Security Official for a Registry (QCDR or Qualified Registry) | <ul style="list-style-type: none"> ✓ View preliminary scoring for your clients based on the data you submitted for them (same information that was available during the submission period) | <ul style="list-style-type: none"> ✗ View performance feedback or payment adjustment information for your clients, which may include: <ul style="list-style-type: none"> ○ 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 |
| Clinician Role | <ul style="list-style-type: none"> ✓ View your performance feedback and payment adjustments applicable to all of your TIN/NPI combinations ✓ View and download payment adjustment data | <ul style="list-style-type: none"> ✗ View performance feedback for other clinicians |

Please note: All screenshots are for illustrative purposes only. Screenshots don't represent real clinicians, organizations, or payment adjustments.

| With This Access | You CAN | You CAN'T |
|--|--|---|
| Staff User or Security Official for a Virtual Group | <ul style="list-style-type: none"> ✓ View virtual group-level performance feedback ✓ View payment adjustment ✓ Access patient-level reports for administrative claims cost and quality measures | <ul style="list-style-type: none"> ✗ View performance feedback about data submitted voluntarily by individuals or practices in your virtual group ✗ |

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Appendix D: Quality Measures with Scoring Changes

The following measures have MIPS scoring changes due to clinical guideline changes during the 2020 performance period, or because specifications were determined during or after the performance period to have substantive changes. CMS hasn't identified any MIPS quality measures requiring performance data to be truncated to a 9-month performance period for 2021 due to the annual ICD-10 code update.

| Quality Measure ID/ Name | Collection Type | Reason for Measure Change | Impact to Scoring, Submission and Feedback Expectations |
|--|--|---|---|
| Measure 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | Medicare Part B Claims | The 2021 Medicare Part B Claims measure specification includes quality data codes (3051F and 3052F) that weren't activated during the annual Current Procedural Terminology (CPT) Category II update process. | Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring. |
| Measure 111: Pneumococcal Vaccination Status for Older Adults | Medicare Part B Claims MIPS Clinical Quality Measure (CQM) | Guidelines have been revised to allow 20-valent pneumococcal conjugate vaccine by itself or the 15-valent vaccine followed by the 23-valent vaccine for adults aged 65 years or older who haven't received a pneumococcal conjugate vaccine before — or whose vaccination status is unknown — and people aged 19 to 64 years who have an underlying medical condition or other risk factors and who also haven't received a pneumococcal vaccine. | Performance period was truncated to 9 months (January – September 2021). |
| Measure 111: Pneumococcal Vaccination Status for Older Adults | Electronic Clinical Quality Measure (eCQM) | Guidelines have been revised to allow 20-valent pneumococcal conjugate vaccine by itself or the 15-valent vaccine followed by the 23-valent vaccine for adults aged 65 years or older who haven't received a pneumococcal conjugate vaccine before — or whose vaccination status is unknown — and people aged 19 to 64 years who have an underlying medical condition or other risk factors and who | Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring. |

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| | | | |
|--|------------------------|---|---|
| | | also haven't received a pneumococcal vaccine. | |
| Measure 117: Diabetes: Eye Exam | Medicare Part B Claims | The 2021 Medicare Part B Claims measure specification includes quality data codes (2023F, 2025F, and 2033F) that weren't activated during the annual Current Procedural Terminology (CPT) Category II update process. | Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring. |
| Measure 128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | eCQM | Misalignment was identified between the numerator header in the measure narrative and the numerator logic. | Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring. |
| Measure 134: Preventive Care and Screening: Screening for Depression and Follow Up Plan | CMS Web Interface | CMS determined that coding changes made to the 2021 PREV-12 were substantive changes to the measure. | Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring. |

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Appendix E: Specialty Codes for PCPs and Non-Physician Practitioners Included in the First Step Attribution

| Specialty Description (CMS Specialty Code) |
|--|
| Primary Care Physicians |
| General Practice (01) |
| Family Practice (08) |
| Internal Medicine (11) |
| Geriatric Medicine (38) |
| Non-physician Practitioners |
| Clinical Nurse Specialist (89) |
| Nurse Practitioner (50) |
| Physician Assistant (97) |

Note: For claims for either FQHC or RHC services: All primary care services are considered in the first step of attribution unless the FQHC or RHC participates in an ACO but the attending physician does not. If the FQHC or RHC participates in an ACO but the attending physician does not, then the service is considered in the first step only if the attending physician is a PCP as defined in the table (Medicare Shared Savings Program 2014).

Appendix F: Medical Specialists, Surgeons, and Other Physicians Included in the Second Step Attribution

| Specialty Description (CMS Specialty Code) | |
|--|--|
| Medical Specialists | Other Physicians |
| Addiction Medicine (79) | Anesthesiology (05) |
| Allergy/Immunology (03) | Chiropractic (35) |
| Cardiac Electrophysiology (21) | Diagnostic Radiology (30) |
| Cardiology (06) | Emergency Medicine (93) |
| Critical Care (Intensivists) (81) | Interventional Radiology (94) |
| Dermatology (07) | Nuclear Medicine (36) |
| Dentist (C5) | Optometry (41) |
| Endocrinology (46) | Pain Management (72) |
| Gastroenterology (10) | Pathology (22) |
| Geriatric Psychiatry (27) | Pediatric Medicine (37) |
| Hematology (82) | Podiatry (48) |
| Hematology/Oncology (83) | Radiation Oncology (92) |
| Hospice and Palliative Care (17) | Single or Multispecialty Clinic or Group Practice (70) |
| Infectious Disease (44) | Sports Medicine (23) |
| Interventional Cardiology (C3) | Unknown Physician Specialty (99) |
| Interventional Pain Management (09) | |
| Medical Oncology (90) | |
| Nephrology (39) | |
| Neurology (13) | |

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Appendix F (continued)

| Specialty Description (CMS Specialty Code) | |
|--|--|
| Neuropsychiatry (86) | |
| Osteopathic Manipulative Medicine (12) | |
| Physical Medicine and Rehabilitation (25) | |
| Preventive Medicine (84) | |
| Psychiatry (26) | |
| Pulmonary Disease (29) | |
| Rheumatology (66) | |
| Sleep Medicine (C0) | |
| Surgeons | |
| Cardiac Surgery (78) | |
| Colorectal Surgery (28) | |
| General Surgery (02) | |
| Gynecological/Oncology (98) | |
| Hand Surgery (40) | |
| Maxillofacial Surgery (85) | |
| Neurosurgery (14) | |
| Obstetrics/Gynecology (16) | |
| Ophthalmology (18) | |
| Oral Surgery (Dentists Only) (19) | |
| Orthopedic Surgery (20) | |
| Otolaryngology (04) | |
| Peripheral Vascular Disease (76) | |
| Plastic and Reconstructive Surgery (24) | |
| Surgical Oncology (91) | |
| Thoracic Surgery (33) | |
| Urology (34) | |
| Vascular Surgery (77) | |

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Appendix G: Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes

| HCPCS Codes | Brief description |
|--------------|--|
| 99201–99205 | New patient, office, or other outpatient visit |
| 99211–99215 | Established patient, office, or other outpatient visit |
| 99304–99306 | New patient, nursing facility care |
| 99307–99310 | Established patient, nursing facility care |
| 99315–99316 | Established patient, discharge day management service |
| 99318 | New or established patient, other nursing facility service |
| 99324–99328 | New patient, domiciliary or rest home visit |
| 99334–99337 | Established patient, domiciliary or rest home visit |
| 99339–99340 | Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home |
| 99341–99345 | New patient, home visit |
| 99347–99350 | Established patient, home visit |
| 99487, 99489 | Complex chronic care management |
| 99495–99496 | Transitional care management |
| 99490 | Chronic care management |
| G0402 | Initial Medicare visit |
| G0438 | Annual wellness visit, initial |
| G0439 | Annual wellness visit, subsequent |
| G0463 | Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only) |

Note: Services billed with HCPCS code 99304–99318 that are performed in a skilled nursing facility (place of service code 31) will not be considered as primary care services.

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