

## Merit-based Incentive Payment System (MIPS)

Traditional MIPS Scoring Guide for the  
2021 Performance Year

Updated: 04/25/2022



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## How to Use This Guide



**Please Note:** : This guide provides a general summary about traditional MIPS scoring. It is for informational purposes only and does not intend to grant rights, impose obligations, or take the place of either the statute or regulations. We urge you to review the specific statutes, regulations, and other relevant materials for their complete and accurate contents. **This guide does not review reporting requirements or scoring policies for the Alternative Payment Model (APM) Performance Pathway (APP).** In this guide, we often use the term “individual” to refer to a MIPS eligible clinician participating in the program as an individual.

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## Hyperlinks

Hyperlinks to the [QPP website](#) are included throughout the guide to direct you to more information and resources.



## Overview

## COVID-19 and 2021 Participation

The 2019 Coronavirus (COVID-19) public health emergency continues to impact all clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2021 performance year, we'll continue to use our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, virtual groups, and APM Entities to [submit an application](#) requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency. The Extreme and Uncontrollable Circumstances application deadline for the 2021 performance year is December 31, 2021 at 8 p.m. ET.

Due to the anticipated need for continued COVID-19 clinical trials and data collection, MIPS eligible clinicians, groups, virtual groups, and APM Entities that meet the improvement activity criteria will be able to receive credit for the COVID-19 Clinical Reporting with or without Clinical Trial improvement activity for the 2021 performance year.

For more information about the impact of COVID-19 on QPP participation, see the Quality Payment Program's [COVID-19 Response webpage](#).

### **UPDATED 04/25/2022:**

CMS is reweighting the cost performance category to 0% for the 2021 performance period for all MIPS eligible clinicians regardless of their participation as an individual, group, or virtual group due to COVID-19's impact on cost measure performance for the 2021 performance period. The 20% cost performance category weight will be redistributed to another performance category or categories in accordance with [§ 414.1380\(c\)\(2\)\(ii\)\(E\)](#).

Cost will be reweighted to 0% for all groups and virtual groups reporting [traditional MIPS](#), even if they didn't request reweighting of this performance category through an extreme and uncontrollable circumstances (EUC) exception application.

## What is the Quality Payment Program?

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



\* Note: If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

## What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in QPP, a program authorized by MACRA. The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and reward them for improving the quality of patient care and health outcomes.

Under MIPS, we evaluate your performance across multiple performance categories that lead to improved quality and value in our healthcare system.

If you're [eligible for MIPS in 2021](#):

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points. **We have updated this resource to reflect the 0% weight of the cost performance category for all MIPS eligible clinicians in the 2021 performance year.**
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2021 performance year and applied to payments for covered professional services beginning on January 1, 2023.

### To learn more about how to participate in MIPS:

- Visit the [How MIPS Eligibility is Determined](#) and [Participation Overview](#) webpages on [the QPP website](#).
- View the [2021 MIPS Eligibility and Participation Quick Start Guide \(PDF\)](#).
- Check your current MIPS participation status using the [QPP Participation Status Tool](#).



## Getting Started: Reviewing MIPS Terms

### Collection Type\*

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

- Electronic clinical quality measures (eCQMs).
- MIPS clinical quality measures (MIPS CQMs) (formerly referred to as “Registry measures”).
- Qualified Clinical Data Registry (QCDR) measures.
- Medicare Part B Claims measures (available to small practices).
- CMS Web Interface measures (available to groups, virtual groups, and APM Entities with 25 or more clinicians).
- Consumer Assessment of Healthcare, Providers and Systems (CAHPS) for MIPS Survey measure (available to groups, virtual groups, and APM Entities with 2 or more clinicians).
- Administrative claims measures.

\* The term “Collection Type” is unique to the quality performance category and doesn’t apply to the other three performance categories.

### Submitter Type

**Submitter Type** refers to the MIPS eligible clinician, group, virtual group, APM Entity, or third-party intermediary (acting on behalf of a MIPS eligible clinician, group, virtual group, or APM Entity) that submits data on measures for the quality and Promoting Interoperability performance categories and activities for the improvement activities performance category.

### Submission Type\*\*

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

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

\*\*For the cost performance category, there is no submission type for cost data because we collect and calculate your cost measures from administrative claims data submitted for payment.

### Data Aggregation and Multiple Submissions

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

- [Quality performance category](#)
- [Improvement activities performance category](#)
- [Promoting Interoperability performance category](#)



## **Traditional MIPS: Quality Performance Category**

# Traditional MIPS Quality Performance Category

## What are the Quality Performance Category Requirements?

You can select from **more than 200** available MIPS quality measures finalized for the 2021 performance period. You'll need to collect and submit data for each quality measure for the entire calendar year of 2021 (January 1 – December 31, 2021).

We'll aggregate MIPS quality measures collected through multiple collection types into a single quality performance category score. **NOTE:** The CMS Web Interface measures won't be scored in combination with other collection types, except for the CAHPS for MIPS Survey measure and/or administrative claims measures.

Individual, Group, and Virtual  
Group Participation

Quality



\*55% of MIPS  
Score

APM Entity Participation

55% of MIPS  
Score

\*Updated to reflect reweighted performance category. See [Appendix F](#) for more information.

To meet the quality performance category requirements, an individual, group, virtual group, or APM Entity can:

**Submit at least 6 MIPS quality measures for the 12-month performance period:**

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

**Submit a defined specialty measure set.**

If the specialty measure set has less than 6 measures, you'll need to submit all measures within the specialty set to meet quality reporting requirements.

OR

OR

**Submit all 10 CMS Web Interface measures.**

This option is available to groups, virtual groups, and APM Entities with 25 or more eligible clinicians that registered for the CMS Web Interface. The CAHPS for MIPS Survey measure can be submitted as an additional high priority measure.



## What are the Quality Performance Category Requirements? (Continued)

There are 2 new MIPS quality measures that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- **Hospital-Wide All-Cause Unplanned Readmission Measure.**
  - This measure replaces the All-Cause Readmission measure beginning with the 2021 performance period.
  - This measure has a case minimum of 200 cases and will apply to groups, virtual groups, and APM Entities.
- **Hip Arthroplasty and/or Knee Arthroplasty Complication Measure.**
  - This measure has a case minimum of 25 cases and will apply to individuals, groups, virtual groups, and APM Entities.
  - This measure has a 3-year performance period (consecutive 36-month timeframe). For the 2021 MIPS performance year, the Hip Arthroplasty and Knee Arthroplasty Complication Measure's performance period starts on October 1, 2018 (3 years prior to the performance period) and ends on September 30, 2021 (current performance period), with a 3-month numerator assessment period.

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

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

## What Is Facility-Based Measurement?

### UPDATED AUGUST 2021

In response to the impact of the ongoing COVID-19 public health emergency, CMS finalized a measure suppression and special scoring policies for Fiscal Year (FY) 2022 in the 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. The outcome of these policies is that we won't calculate FY 2022 scores for the Hospital VBP Program.

We use the total performance score from the Hospital VBP Program to calculate Merit-based Incentive Payment System (MIPS) 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 year.

- **Because the FY 2022 total performance score from the Hospital VBP Program won't be available, we won't be able to calculate MIPS facility-based scores for the 2021 performance period.**

### What does this mean for MIPS reporting?

Facility-based clinicians and groups will need to submit MIPS quality measures to CMS to receive a score other than 0 for the quality performance category.

We'll automatically calculate a score for the cost performance category for facility-based clinicians and groups that meet the case minimum for at least one MIPS cost measure; there are no data collection or submission requirements for the cost performance category. If the facility-based clinician or group doesn't meet the case minimum for any cost measures, the cost performance category will be reweighted to 0% and the weight redistributed to other performance categories.

- Facility-based clinicians and groups without available and applicable measures can request performance category reweighting by submitting an extreme and uncontrollable circumstances (EUC) application.
- Please be sure to cite "COVID-19" as the triggering event, as the decision to suppress measures in the Hospital VBP Program was in response to the COVID-19 PHE.

For more information, please review the [2021 Facility-Based Quick Start Guide \(PDF\)](#).



# Traditional MIPS Quality Performance Category

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

Are you submitting your quality measures through the CMS Web Interface? [Skip ahead](#).

### How are Measures Assessed in the Quality Performance Category for the 2021 Performance Period?

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

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



**Whenever possible, we use historical data to establish benchmarks.** Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years prior to the applicable performance period. The historical benchmarks for the 2021 MIPS performance period were established from quality data submitted for the 2019 MIPS performance period.

**Administrative Claims Measures:** We intend to calculate performance period benchmarks for the 2 new administrative claims measures.

For more information about the 2021 quality benchmarks, please review the information included in the [2021 Quality Benchmarks \(ZIP\)](#).

**Did you know?** If you submit eQCMs, you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eCQM data. The CEHRT used to collect the data must be certified to the 2015 Edition, the 2015 Edition Cures Update criteria, or a combination of both by December 31, 2021.

#### **CAHPS for MIPS Survey Measure:**

We established historical benchmark for each summary survey measure (SSM) in the CAHPS for MIPS Survey measure. Refer to the [2021 Quality Benchmarks \(ZIP\)](#).

Each SSM is awarded 3 to 10 points by comparing performance to the benchmark.

The final CAHPS for MIPS Survey measure score is calculated as the average number of points across all scored SSMs.

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQMs, and/or MIPS CQMs (Continued)

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

For a measure without a historical benchmark, we'll try to calculate a benchmark based on 2021 performance data submitted on those measures.

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

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

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

### What Does Data Completeness Mean?

Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the eligible population (denominator).

- For Medicare Part B Claims measures, we identify the eligible population (denominator) for you based on the claims you submit.
- For eQMs, MIPS CQMs, and QCDR measures, you (or your third party intermediary) identify the eligible population in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking"), would not be considered true, accurate, or complete and may subject you to audit.

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQMs, and/or MIPS CQMs (Continued)

### How are Measures Scored?

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

A benchmark is available.

AND

The volume of cases you've submitted is sufficient ( $\geq 20$  cases for most measures).

AND

You've met data completeness requirements (submitted performance data for at least 70% of the denominator eligible encounters).

**Did you know?** In 2020, we established an alternate benchmarking methodology for scoring the following quality measures when we determine that their historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient: **Measure 001 (Diabetes: Hemoglobin A1c (HbA1c) Poor Control ( $>9\%$ ))**; and **Measure 236 (Controlling High Blood Pressure)**.

- We're **suppressing** the Medicare Part B claims collection type for **Measure 001** for the 2021 performance period. Refer to [Appendix E](#).
- We'll use **flat benchmarks** to score the Medicare Part B Claims and MIPS CQM collection types for Measure 236.
- We'll continue to use the **historical, performance-based benchmark** to score the MIPS CQM and eCQM collection types for Measure 001 and the eCQM collection type for Measure 236.

The 2021 Quality Benchmarks (ZIP) includes these flat benchmarks.





# Traditional MIPS Quality Performance Category

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs (Continued)

### Measure Achievement Points

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

**3 – 10  
points\***

You'll continue to receive between 3 and 10 achievement points for quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.

**3 points**

You'll continue to earn 3 points for quality measures that meet data completeness requirements, but don't have a benchmark or meet the case minimum.

**3 points**

#### **Small practices only:**

You'll continue to receive 3 point for measures that don't meet data completeness requirements.

**0 (out of 10  
points)**

You'll receive 0 points for measures that don't meet data completeness requirements. This doesn't apply to small practices (15 or fewer clinicians).

**0 (out of 10  
points)**

You'll continue to receive 0 points for measures that are required, but unreported. (You must report performance data for the measure to be considered reported).

**\*Exception:** There are specified, topped out measures that are capped at 7 points. (These measures are identified in the 2021 MIPS Quality Historical Benchmarks Excel file – see column Q – in the [2021 Quality Benchmarks \(ZIP\)](#)).

# Traditional MIPS Quality Performance Category

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs (Continued)

### Measure Bonus Points

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

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

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

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQMs, and/or MIPS CQMs (Continued)

### What if I Submit More Than 6 Measures?

If you submit more than 6 measures, only 6 of those measures will contribute to the measure achievement points for your quality performance category score. However, we'll include any bonus points from the remaining measures provided you haven't exceeded the 10% cap for the applicable bonus.

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

- We'll select the highest scoring outcome measure.
  - If no outcome measure is available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we'll select your 5 highest scoring measures, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

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

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

- **Example:** You submit 7 measures, and your 2 lowest scoring measures (after the outcome measure) were Measure 113 Colorectal Cancer Screening and Measure 425 Photodocumentation of Cecal Intubation, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top 6 because its measure ID (113) has a lower value than the Photodocumentation of Cecal Intubation measure (425).

### Data Aggregation and Multiple Submissions:

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

If you submit the same measure through multiple collection types (i.e., as a Medicare Part B Claims measure and as an eQm), we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points from 2 collection types of the same measure.

# Traditional MIPS Quality Performance Category

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs (Continued)

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

#### Maximum Points by Participation Level Individuals:

##### 60 points

For 6 required MIPS  
quality measures

##### 70 Points

For 6 required MIPS  
quality measures + Hip  
Arthroplasty and Knee  
Arthroplasty  
Complication  
measure

Individuals, groups, virtual groups and APM Entities that don't submit at least 1 available measure will receive 0 points in this performance category unless you qualify for the performance category to be [reweighted](#).

#### Maximum Points by Participation Level Groups/Virtual Groups/APM Entities:

##### 60 points

For 6 required MIPS  
quality measures

##### 70 Points

For 6 required MIPS  
quality measures +  
Hospital-Wide All-  
Cause Unplanned  
Readmission  
measure

##### 70 points

For 6 required MIPS  
quality measures + Hip  
Arthroplasty and Knee  
Arthroplasty  
Complication  
measure

##### 80 Points

For 6 required MIPS quality  
measures + Hospital-Wide  
All-Cause Unplanned  
Readmission measure + Hip  
Arthroplasty and Knee  
Arthroplasty Complication  
measure

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs (Continued)

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

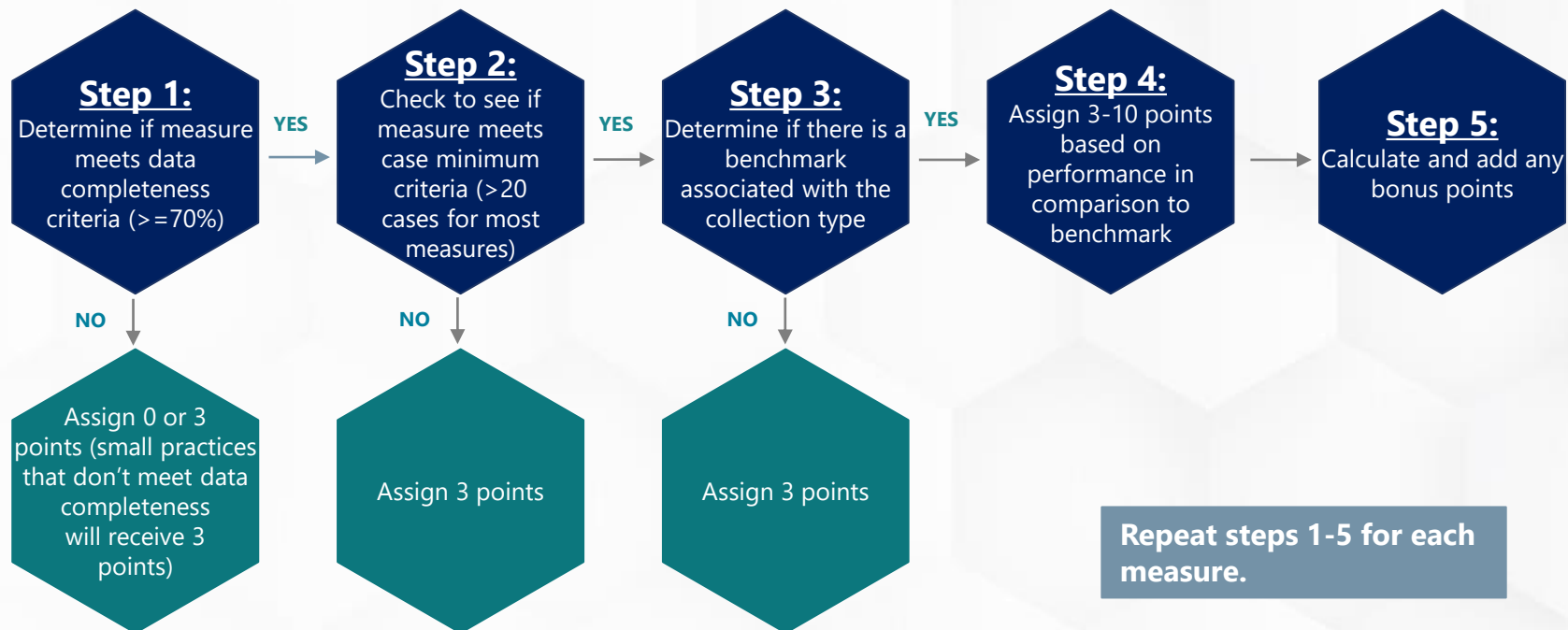
Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower than 60 points.

IF...	THEN...
You submit a complete specialty measure set with fewer than 6 measures by either Medicare Part B Claims or MIPS CQMs.	We'll lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B Claims measures or MIPS CQMs <b>AND</b> the EMA process determines no additional measures were available.  <b>How?</b> We compare the measures you submitted with a predefined list of clinically related measures.	We'll lower the denominator by 10 points for each measure that isn't available.  <b>NOTE:</b> If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the quality performance category and you'll earn a score of 0 out of 10 for each of these measures.
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available.  To the extent feasible, we'll identify suppressed measures by the beginning of the submission period.  Refer to <a href="#">Appendix E</a> for a list of affected measures.	We'll lower the denominator by 10 points for each impacted measure.  <b>Why?</b> So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification or held accountable for measure implementation issues that are outside of your control.  However, when 9 consecutive months of data is available, we'll truncate the performance period and score the measure instead of suppressing the measure and reducing the denominator.
Your group, virtual group, or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements <b>AND</b> submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS Survey measure.

# Traditional MIPS Quality Performance Category

## Submitting Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs (Continued)

### What Are the Steps to Score Medicare Part B Claims Measures, QCDR Measures, eQCMs, and/or MIPS CQMs?



[Appendix A](#) gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.  
[Skip ahead](#) to review how we calculate the quality performance category score.

## Submitting CMS Web Interface Measures

**REMINDER:** This guide focuses on scoring for traditional MIPS and doesn't address scoring policies for Shared Savings Program Accountable Care Organizations (ACOs) reporting CMS Web Interface measures for the APP.

### How Are the CMS Web Interface Measures Assessed in the Quality Performance Category for the 2021 Performance Period?

When you submit data for the 10 required measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. Groups, virtual groups, and APM Entities submitting their quality measures through the CMS Web Interface will be assessed against benchmarks established under the Shared Savings Program. The benchmarks used for the CMS Web Interface are identified in the [Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs \(PDF\)](#).

**NOTE:** CMS Web Interface measures can't be combined with other collection types, except the CAHPS for MIPS Survey measure and administrative claims measures.

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

Unlike other collection types, a performance period benchmark will not be calculated if there isn't an existing benchmark for MIPS scoring. CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet reporting requirements for such measures.

The following CMS Web Interface measures don't have a benchmark for the 2021 performance period:

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

There are a total of 7 CMS Web Interface measures that can be scored against a benchmark. Please note that we will identify any measures suppressed for the 2021 performance period at the end of the year.

## Submitting CMS Web Interface Measures (Continued)

### How are CMS Web Interface Measures Scored?

#### Measure Achievement Points

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

**3 – 10  
points**

You'll continue to receive between 3 and 10 achievement points for quality measures that meet case minimum and data completeness requirements and can be scored against a benchmark.

**0**

(0 out of 10 points)

You'll continue to receive 0 points (0 out of 10) for measures that don't meet data completeness requirements.

**N/A**

(0 out of 0 points)

You won't be scored on measures for which your sample is fewer than 20 Medicare patients, provided you report on all the patients in the sample.

**N/A**

(0 out of 0 points)

You won't be scored on measures without an existing benchmark provided that data completeness requirements are met.

Like other collection types, the CMS Web Interface measures have a case minimum of 20 patients. However, data completeness requirements for the CMS Web Interface measures differ from other collection types:

- Organizations are required to submit all data for a minimum of the first 248 consecutively ranked patients per each measure (or 100% of the patients in the sample if there are fewer than 248 patients assigned to a measure).
- For each patient that's skipped for a valid reason, your organization must submit all data on the next consecutively ranked patient until the target sample of 248 is reached or until the sample has been exhausted.



## Submitting CMS Web Interface Measures (Continued)

### Measure Bonus Points

You can earn 1 bonus point per CMS Web Interface measure submitted according to CMS Web Interface **end-to-end electronic reporting** criteria. For the 2021 performance period, this means submitting data collected in your CEHRT directly to CMS via the CMS Web Interface Application Programming Interface (API) or Excel upload.

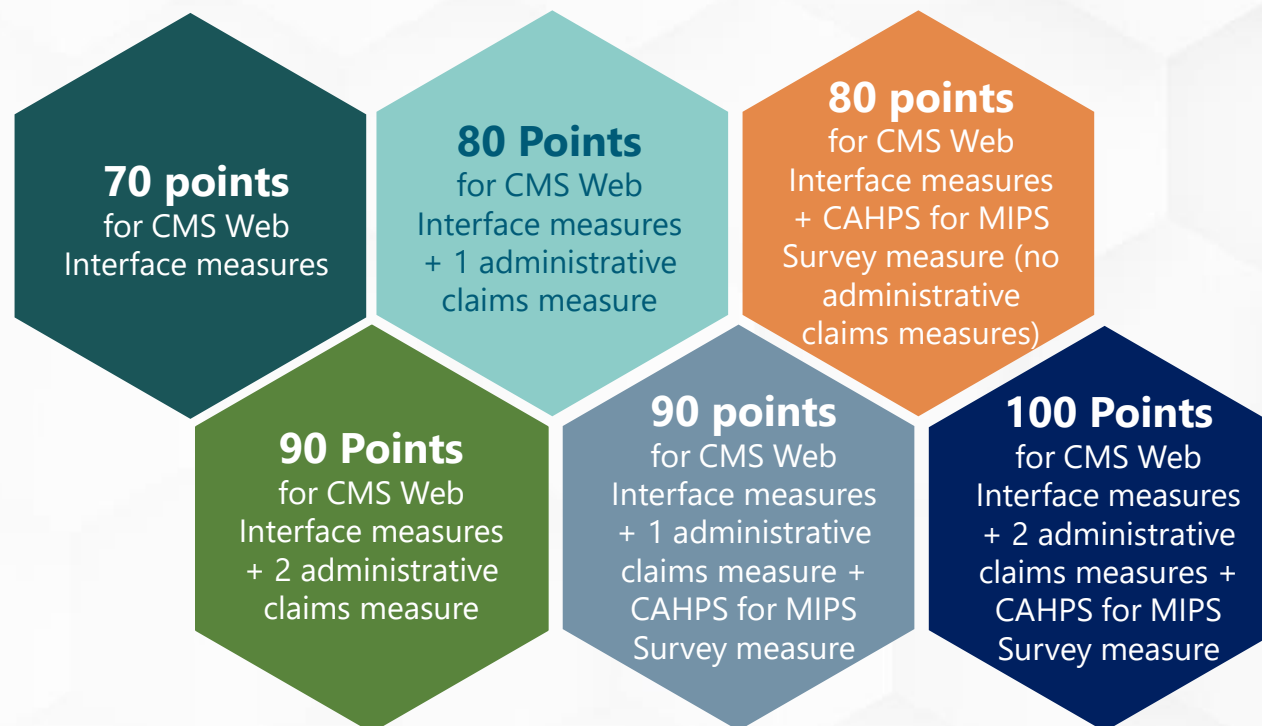
#### Did you know?

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

## Submitting CMS Web Interface Measures (Continued)

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

### Maximum Points by Participation Level Groups/Virtual Groups/APM Entities:



## Submitting CMS Web Interface Measures (Continued)

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

Yes, your denominator will be lowered if:

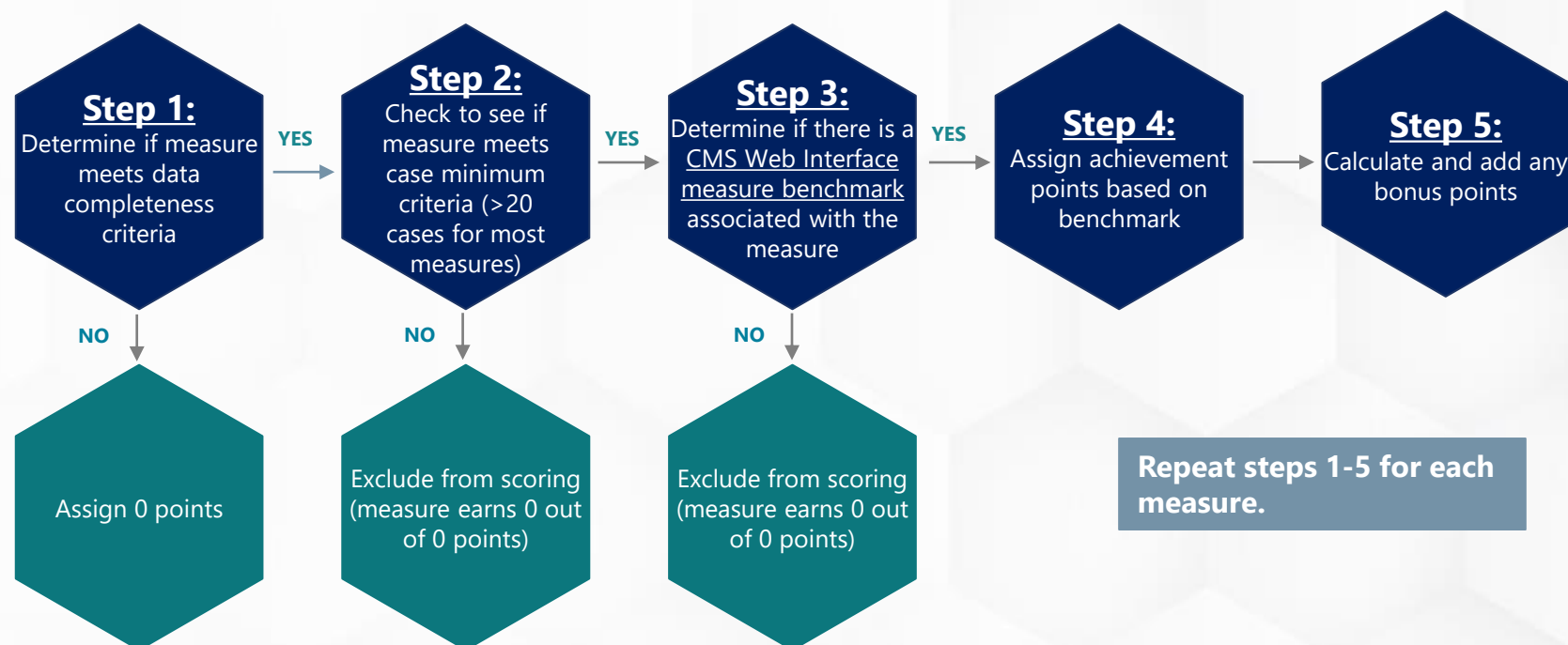
- You have fewer than 20 Medicare patients in a measure's sample (doesn't meet case minimum).  
AND
- You submit complete data for all of the Medicare patients in the sample (meet data completeness requirements).

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



## Submitting CMS Web Interface Measures (Continued)

What are the Steps to Score CMS Web Interface Measures?



# Traditional MIPS Quality Performance Category

## Calculating the Quality Performance Category Score

### Scoring for Individuals, Groups, Virtual Groups, and APM Entities

For individuals, groups, virtual groups, and APM entities that aren't a small practice, the following is calculated:

The diagram illustrates the calculation of the Quality Performance Category Score for non-small practices. It features a large blue hexagon on the left labeled "Quality Performance Category Score (Not to exceed 100%)". This is followed by an equals sign, then a large green-bordered box containing a fraction. The numerator of the fraction is "Total Measure Achievement Points" plus "Measure Bonus Points". The denominator is "Total Available Measure Achievement Points\*". To the right of the green box is a plus sign, followed by a smaller white hexagon labeled "Improvement Score".

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

For individuals, groups, virtual groups, and APM entities that are part of a small practice, the following is calculated:

The diagram illustrates the calculation of the Quality Performance Category Score for small practices. It features a large blue hexagon on the left labeled "Quality Performance Category Score (Not to exceed 100%)". This is followed by an equals sign, then a large green-bordered box containing a fraction. The numerator of the fraction is "Total Measure Achievement Points" plus "Measure Bonus Points" plus "Small Practice Bonus (6 points)". The denominator is "Total Available Measure Achievement Points\*". To the right of the green box is a plus sign, followed by a smaller white hexagon labeled "Improvement Score".

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

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

## Calculating the Quality Performance Category Score (Continued)

### Scoring for Individuals, Groups, Virtual Groups, and APM Entities (continued)

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

#### For example:

- If your quality performance category denominator is 60 points, then you can earn up to 12 measure bonus points total, 6 points from each bonus category, but the category score can't be greater than 100%.
- A total of 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure (these bonus points are available to small practices through individual, group, virtual group, and APM Entity participation).
- Your quality performance category score is then multiplied by the 55% quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100% of the category weight. **If the quality performance category is weighted at 55%, there is a maximum of 55 points that the quality performance category can contribute to your MIPS final score.**

## How is my Quality Performance Category Score Calculated?

### What is Improvement Scoring?

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

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

1. Full participation in the quality category for the current performance period:
  - Submits 6 measures (with at least 1 outcome/high priority measure).
  - Submits a complete specialty measure set (which may have fewer than 6 measures, submit all measures in the set).
  - Submits all the measures in the CMS Web Interface.All submitted measures must meet data completeness requirements.
2. Data sufficiency standard is met, meaning there is data available and can be compared:
  - There is a quality performance category achievement score (the score earned by measures based on performance excluding bonus points) for the previous performance period (2020 performance period) and the current performance period (2021 performance period).
  - Data was submitted under the same identifier for the two consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

### Did you know?

Improvement scoring is not available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period. For example, if your PY 2020 quality score is derived from facility-based measurement, you aren't eligible for improvement scoring in PY 2020 or PY 2021.

## How is my Quality Performance Category Score Calculated? (Continued)

### Scoring Example

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

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

Because they're a **small practice**, they qualify for **6 bonus points**.

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

- Their 2021 achievement score =  $36.1/50 = 72.2\%$
- Their 2020 achievement score =  $62.2\%$
- The increase in their achievement score =  $72.2\% - 62.2\% = 10\%$
- Their improvement score =  $(10\% \div 62.2\%) \times 10 = 1.6\%$



# Traditional MIPS Quality Performance Category

## How is my Quality Performance Category Score Calculated? (Continued)

### Scoring Example (continued)

$$\text{Quality Performance Category Score } 95.8\% = \left( \frac{36.1 \text{ Total Measure Achievement Points} + 5 \text{ Measure Bonus Points} + 6 \text{ Small Practice Bonus}}{50 \text{ Total Available Measure Achievement Points}^*} \right) + \text{Improvement Score } 1.6\%$$

=0.942 or 94.2%

### Why is Their Denominator 50?

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

### Can the Quality Performance Category be Reweighted?

There are a few scenarios that would allow the quality performance category can be reweighted.

1. We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the [Quality Payment Program COVID-19 Response Fact Sheet \(PDF\)](#), [2021 MIPS Exceptions Application User Guides \(ZIP\)](#) or the [Exceptions Application](#) webpage for more information.
2. In the rare case when there are no quality measures applicable and available to you, you won't be scored on this performance category, and it will be reweighted to 0% of your final score. We anticipate that reweighting of the quality performance category would be rare because there are quality measures applicable and available for most clinicians.
  - Please contact the Quality Payment Program if this applies to you, so that we can evaluate whether you have applicable and available quality measures to submit. You can contact the Quality Payment Program by phone (1-866-288-8292) or e-mail ([qpp@cms.hhs.gov](mailto:qpp@cms.hhs.gov)). Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Please refer to [Appendix B](#) for more information on the reweighting of the quality performance category, including the extreme and uncontrollable circumstances policy.



## **Traditional MIPS: Cost Performance Category**

# Reweight the Cost Performance Category to 0% for the 2021 Performance Period

## UPDATED 04/25/2022

CMS is reweighting the cost performance category to 0% for the 2021 performance period for all MIPS eligible clinicians regardless of their participation as an individual, group, or virtual group due to COVID-19's impact on cost measure performance for the 2021 performance period. The 20% cost performance category weight will be redistributed to another performance category or categories in accordance with [§ 414.1380\(c\)\(2\)\(ii\)\(E\)](#).

- Cost will be reweighted to 0% for all groups and virtual groups reporting [traditional MIPS](#), even if they didn't request reweighting of this performance category through an extreme and uncontrollable circumstances (EUC) exception application.
- Cost is already reweighted to 0% for:
  - Individual MIPS eligible clinicians due to the MIPS automatic EUC policy.
  - Alternative Payment Model (APM) Entities reporting traditional MIPS.
  - Groups and APM Entities reporting the [APM Performance Pathway \(APP\)](#).

As a reminder, if a MIPS eligible clinician, group, virtual group or APM Entity is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100%, or all performance categories are weighted at 0%), they will receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2023 MIPS payment year.

For more information, please refer to the QPP listserv announcing cost reweighting, distributed on 04/25/2022, in [Appendix F](#) of this document.

### Individual, Group, and Virtual Group Participation

Cost



\*0% of MIPS Score

### APM Entity Participation

0% of MIPS Score

\*Updated to reflect reweighted performance category. See [Appendix F](#) for more information.



## **Traditional MIPS: Improvement Activities Performance Category**

# MIPS Improvement Activities Performance Category

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

You can earn up to 40 points in the [improvement activities](#) performance category by attesting to between 2 and 4 improvement activities.

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

You don’t have to submit any supporting documentation when you attest to completing an improvement activity, but you must keep documentation of the efforts you (or the group or virtual group) undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the [2021 MIPS Data Validation Criteria \(ZIP\)](#).

Individual, Group, and Virtual  
Group Participation

Improvement Activities



15% of MIPS  
Score

APM Entity Participation

15% of MIPS  
Score

## Data Aggregation and Multiple Submissions

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

## Participating as a Group, Virtual Group or APM Entity

If reporting as a group, virtual group or APM Entity, at least 50% of the eligible clinicians in the group, virtual group, or APM Entity must implement the same activity during any continuous 90-day period (or as the period specified in the activity description) in the same performance year in order to attest to that activity.

## How are Activities Assessed and Scored?

Improvement activities are assigned to 1 of 2 categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities. High weighted activities address areas with the greatest impact on beneficiary care, safety, health, and well-being, or require significant investment of time and resources.

**Generally speaking, clinicians, groups, virtual groups, and APM Entities that don't have certain special status designation(s) will receive the following points for their submitted activities:**



Medium-weighted activities =  
**10 points**



High-weighted activities =  
**20 points**

**To earn the maximum score of 40 points for the improvement activities performance category, you can pick any of these:**



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



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



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

**NOTE:** MIPS APM participants reporting traditional MIPS will automatically receive 50% credit for the improvement activities performance category for the 2021 performance year provided data is submitted for another performance category.

# MIPS Improvement Activities Performance Category

## How are Activities Assessed and Scored? (Continued)

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

### Other Factors

These may be automatically received or you may apply for them. Learn more about [special statuses](#) and [hardship exceptions](#)

#### Received as an individual

SPECIAL STATUS  
Small practice

Yes

#### Received as a group

SPECIAL STATUS  
Small practice

Yes

MIPS eligible clinicians, groups, and virtual groups with certain special status designations will receive the following points for their submitted activities:



Medium-weighted activities =  
**20 points**



High-weighted activities =  
**40 points**

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

**40  
points**

=



+



OR



2 medium-  
weighted activities

1 high-weighted  
activity

To learn more, see the [2021 MIPS Improvement Activities User Guide \(PDF\)](#) or review the [2021 Improvement Activities Inventory \(ZIP\)](#).

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

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

## Can the Maximum Number of Points be Lower than 40?

No, you'll always be scored out of 40 points in the improvement activities performance category, though you may receive more points per activity based on your circumstances.

## How is My Improvement Activities Performance Category Score Calculated?

The improvement activities performance category is 15% of your final score for the 2021 performance year. The maximum score is 100% of the category weight.

$$\text{Improvement Activities Performance Category Score} = \frac{\text{Total Points Earned for Completed Activities}}{\text{Total Possible Points (40)}}$$



## How is My Improvement Activities Performance Category Score Calculated? (Continued)

The improvement activities performance category is 15% of your final score for the 2021 performance year. The maximum score is 100% of the category weight.

### Scoring Example

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

**Even if you submit additional activities, you can't earn more than 100% in the performance category.**

$$\begin{array}{c} \text{Improvement} \\ \text{Activities} \\ \text{Performance} \\ \text{Category} \\ \text{Score} \\ \mathbf{100\%} \end{array} = \begin{array}{c} \text{Total Points Earned for Completed Activities} \\ \mathbf{20 + 40} \\ \hline \text{Total Possible Points: } \mathbf{40} \end{array}$$


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

If you're in a certified or recognized patient-centered medical home or comparable specialty practice, you'll earn full credit (100%) for the improvement activities performance category. You **must attest** to your status as a patient-centered medical home or comparable specialty practice during the PY 2021 submission period in order to receive full credit for the improvement activities performance category.

## Can the Improvement Activities Performance Category be Reweighted?

We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the [Quality Payment Program COVID-19 Response Fact Sheet \(PDF\)](#), [2021 MIPS Exceptions Application User Guides \(ZIP\)](#) or the [Exceptions Application webpage](#) for more information.

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



## **Traditional MIPS: Promoting Interoperability Performance Category**

# MIPS Promoting Interoperability Performance Category

## Overview

The Promoting Interoperability performance category focuses on 4 objectives:

- e-Prescribing
- Health Information Exchange
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange (HIE)

These objectives are comprised of 5 or 6 required measures and attestations (dependent on which measure(s) you choose to report for the HIE measure objective).

Individual, Group, and Virtual  
Group Participation

Promoting Interoperability



\*30% of MIPS  
Score

APM Entity Participation

30% of MIPS  
Score

\*Updated to reflect reweighted performance category. See [Appendix F](#) for more information.

When participating as an APM Entity, Promoting Interoperability is still reported at the individual or group level.

2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the two are required for participation in this performance category.

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

There's a single set of measures and objectives you must report for the 2021 performance period as outlined in the table below.

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

Objectives	Measures		Requirements
<b>e-Prescribing</b>	e-Prescribing		Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		Optional measure cannot be reported if an exclusion is claimed for the required e-Prescribing measure
<b>Health Information Exchange</b>	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 is reported
		Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 is reported
	Option 2	<b>NEW:</b> HIE Bi-Directional Exchange*	Required (no exclusion available), unless option 1 is reported
<b>Provider to Patient Exchange</b>	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
<b>Public Health and Clinical Data Exchange</b>	Report to 2 different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> <li>Immunization Registry Reporting</li> <li>Electronic Case Reporting</li> <li>Public Health Registry Reporting</li> <li>Clinical Data Registry Reporting</li> <li>Syndromic Surveillance Reporting</li> </ul>		Required unless an exclusion(s) is claimed

**\*HIE Bi-Directional Exchange measure is a new measure available for reporting in PY 2021.**

This measure serves as an **alternative** measure to the 2 existing required HIE objective. You're expected to report either option 1 (the 2 original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective.

**You wouldn't submit both options.**

## What are the Data Submission Requirements for the Promoting Interoperability Performance Category? (Continued)

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

- Use 2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the two to meet the measures above and collect your data (certified by the last day of the performance period)
- Submit a "yes" to the Prevention of Information Blocking attestation
- Submit a "yes" to the ONC Direct Review attestation
- Submit a "yes" that you have completed the Security Risk Analysis measure during 2021
- Submit the CMS EHR Certification identification code for your EHR product(s) as proof that it is certified by ONC to the 2015 Edition (you can find this information at <https://chpl.healthit.gov/#/search>)

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

## Data Aggregation and Multiple Submissions

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

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

## How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021?

For the 2021 performance period, each required measure will be scored based on the performance data you report.

For measures with a numerator and denominator, we calculate the performance rate on the submitted numerator and denominator.

The Query of PDMP measure (optional/bonus measure), Public Health and Clinical Data Exchange objective measures, and the new optional HIE Bi-Directional Exchange measure require a “yes” or “no” submission.

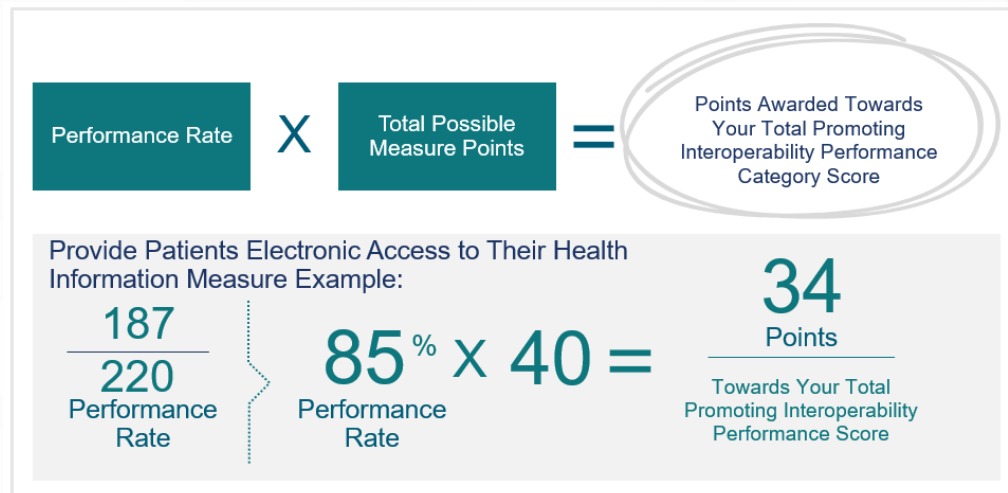
Each measure will contribute to your total Promoting Interoperability performance category score.

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

## How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021? (Continued)

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance. For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure.

Below is an example featuring the Provide Patients Electronic Access to Their Health Information measure, which is worth 40 points.



When we calculate the performance rates, measure and objective scores, and the Promoting Interoperability performance category score, we generally round to the nearest whole number.

### Example 1:

Score = 8.53  $\rightarrow$  Round up to 9

### Example 2:

Score = 8.33  $\rightarrow$  Round down to 8

### Important to Note:

- The Query of Prescription Drug Monitoring Program (PDMP) bonus measure in the e-Prescribing objective will earn 10 points if submitted.
- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as at numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category.)



## How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
<b>e-Prescribing</b>	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		Optional	10 bonus points	YES/NO
<b>Health Information Exchange</b>	Option 1	Support Electronic Referral Loops by Sending Health Information	Required (unless option 2 is reported)	1 – 20 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 20 points	Numerator/ Denominator
	Option 2	<b>NEW:</b> HIE Bi-Directional Exchange*	Required* (unless option 1 is reported)	40 points	YES/NO
<b>Provider to Patient Exchange</b>	Provide Patients Electronic Access to Their Health Information		Required	1 – 40 points	Numerator/ Denominator
<b>Public Health and Clinical Data Exchange</b>	Report to 2 different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> <li>Immunization Registry Reporting</li> <li>Electronic Case Reporting</li> <li>Public Health Registry Reporting</li> <li>Clinical Data Registry Reporting</li> <li>Syndromic Surveillance Reporting</li> </ul>		Required	10 points for the entire objective	YES/NO

\* HIE Bi-Directional Exchange measure is a new measure available for reporting in PY 2021. This measure serves as an **alternative** measure to the two-existing required HIE objective. You're expected to report either option 1 (the two original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective. You wouldn't submit both options

## Scoring of the Public Health and Clinical Data Exchange Objective and HIE Bi-Directional Exchange Measure

The Public Health and Clinical Data Exchange objective and the new optional HIE Bi-Directional Exchange measure are scored differently because these measures are submitted with a "yes" or "no" instead of numerator and denominator values.

**For the Public Health and Clinical Data Exchange objective, you'll receive 10 points for this objective when:**

You submit a "yes" to 2 measures in the objective\*.

OR

You submit a "yes" to 1 measure and claim an exclusion for a second measure.

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

**For the new HIE Bi-Directional Exchange measure (Option 2), you'll receive 40 points for this measure when:**

You submit a "yes" to participating in bi-directional exchange.

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

While there are 110 total points available, clinicians, groups, and virtual groups can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

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

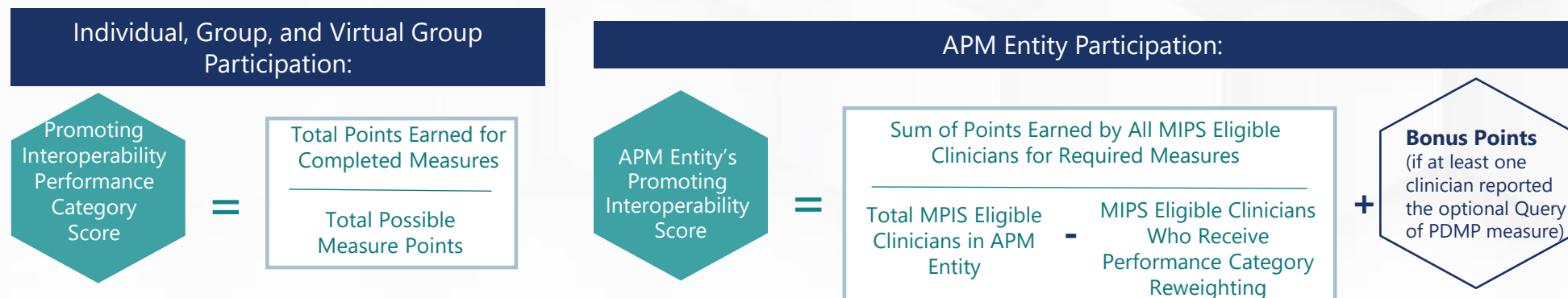
No, you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

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

## How is the Promoting Interoperability Performance Category Scored?

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

**REMINDER:** You'll receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation; report (submit at least 1 in the numerator) on a required measure; or claim an exclusion for a required measure (where applicable).



## Promoting Interoperability Performance Category Scoring Example

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

Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	Not reported	10 bonus points	N/A
Support Electronic Referral Loops by Sending Health Information	180 / 250 (0.72)	20 points → 25 points re-allocated from e-Prescribing	$0.72 \times 25 = 18$ points
Support Electronic Referral Loops by Receiving and Reconciling Health Information	176 / 200 (0.88)	20 points → 25 points (5 points re-allocated from e-Prescribing)	$0.88 \times 25 = 22$
Provide Patients Electronic Access to Their Health Information	187 / 220 (0.85)	40 points	$0.85 \times 40 = 34$ points
Report to 2 different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> <li>Immunization Registry Reporting</li> <li>Electronic Case Reporting</li> <li>Public Health Registry Reporting</li> <li>Clinical Data Registry Reporting</li> <li>Syndromic Surveillance Reporting</li> </ul>	<ul style="list-style-type: none"> <li>Reported "yes" to Immunization Registry Reporting measure</li> <li>Claimed exclusion for Clinical Data Registry Reporting measure</li> </ul>	10 points	10 points (this objective is all or nothing)
Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	Not reported	10 bonus points	N/A
<b>Promoting Interoperability Performance Category Score</b>			<b>84 points / 100 points = 84%</b>

## Can the Promoting Interoperability Performance Category be Reweighted?

There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

Note that submitting Promoting Interoperability data will override any automatic or approved reweighting.

1. We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request reweighting for multiple performance categories through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the [Quality Payment Program COVID-19 Response Fact Sheet \(PDF\)](#), [2021 Extreme and Uncontrollable Circumstances Exception Application Guide \(PDF\)](#), or the [Exceptions Application](#) webpage for more information.
2. You submit a [Promoting Interoperability Hardship Exception Application](#), citing one of the following specified reasons for review and approval:
  - Insufficient internet connectivity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of CEHRT
  - Small Practice
  - Decertified EHR

If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about [Hardship Exceptions](#).

3. You qualify for automatic reweighting if you are any of the following (see the [QPP Participation Status Tool](#)):



## Can the Promoting Interoperability Performance Category be Reweighted?

An individual clinician's Promoting Interoperability performance category will be reweighted when the clinician:

- Has an approved hardship exception; OR
- Qualifies for automatic reweighting.

The image below is from the Other Reporting Factors section on the [QPP Participation Status Tool](#).

**Other Reporting Factors**

Learn more about [how other reporting factors are determined](#) and [special statuses](#).

Clinician Level	
SPECIAL STATUS Hospital-based	Yes

**NOTE:** If you have an approved exception or qualify for automatic reweighting, we'll reweight the category to 0% and typically redistribute the 30% weight to the quality performance category so you can earn up to 100 points in your MIPS final score. However, you can still report if you want to.

If you submit data on the measures for the Promoting Interoperability performance category either as an individual, a group, or virtual group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 30% of the final score.

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

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

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

The image below is from the Other Reporting Factors section on the [QPP Participation Status Tool](#).

**Other Reporting Factors**

Learn more about [how other reporting factors are determined](#) and [special statuses](#).

**Clinician Level**

SPECIAL STATUS Hospital-based	Yes
----------------------------------	-----

**Practice Level**

SPECIAL STATUS Hospital-based	Yes
----------------------------------	-----

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

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

## How Does Reweighting Work If We're Participating as an APM Entity?

Individual MIPS eligible clinicians and groups in the APM Entity that qualify for automatic reweighting or have an approved Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category.

They will be excluded from the calculation when determining the APM Entity's score, but they'll still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire Entity for the 2021 performance period. This could occur when all of the clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.



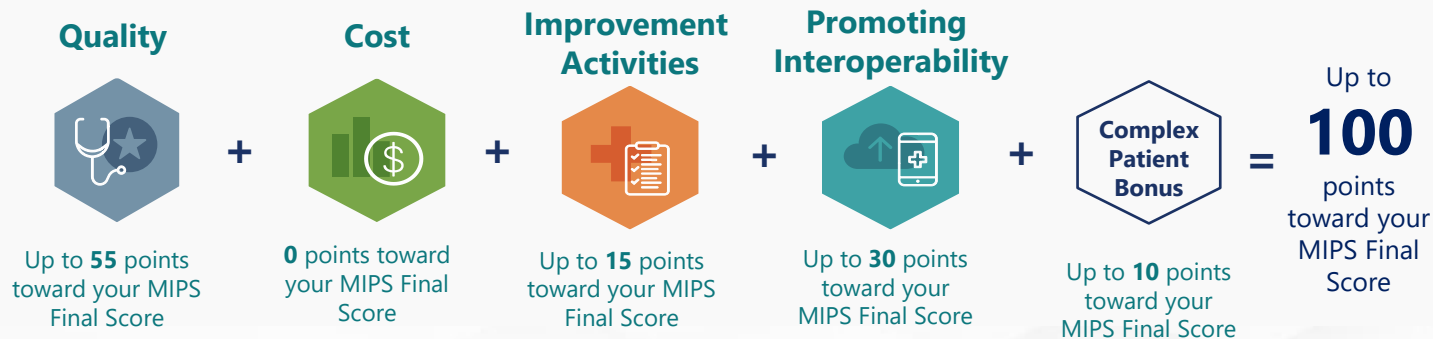


## MIPS Final Score

## How is My Final Score Calculated?

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

### Traditional MIPS Performance Category Weights in 2021:

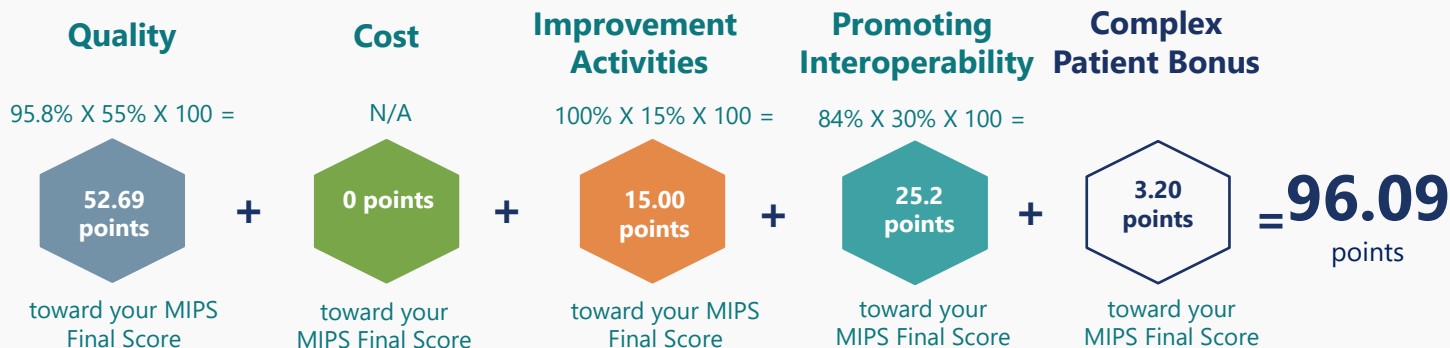


The MIPS final score can't exceed 100 points.

## Scoring Example

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

### Traditional MIPS Performance Category Weights in 2021:



## What is the Complex Patient Bonus?

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

All MIPS eligible clinicians, groups, 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 of up to 10 bonus points to their final score.

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

As finalized in the CY 2022 PFS Final Rule, we're doubling the complex patient bonus from 5 to 10 points for the 2021 performance year.

## How is the Complex Patient Bonus Determined?

We use 2 indicators to measure patient complexity:

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

AND

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

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

**Each MIPS eligible clinician, group, virtual group, or APM Entity will be evaluated for the complex patient bonus.** There is 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 be scored for the complex patient bonus.

## How is a Clinician's HCC Risk Score Determined?

### A beneficiary's risk score is based on:

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

### How is my Proportion of Dual Eligible Patients Determined?

- We'll calculate the number of your dually eligible patients using claims data from 10/1/2020 to 9/30/2021.
- The proportion will be a comparison of unique patients who are dually eligible for Medicare and Medicaid seen by the MIPS eligible clinician to all unique Medicare patients seen by the MIPS eligible clinician during this time period.

## How is the Complex Patient Bonus Calculated?

As finalized in the CY 2022 PFS Final Rule, we're doubling the complex patient bonus from 5 to 10 points for the 2021 performance year.

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

For PY 2021

\*Unique beneficiaries and patients (both dually-eligible and HCC) must be treated between 10/1/20 and 9/30/21 to be included in the Complex Patient Bonus calculation.

**When participating as an individual or group:** The complex patient bonus is calculated for individual MIPS eligible clinicians and groups by adding the dual eligible ratio (multiplied by 5) to the beneficiary weighted average HCC risk score. This sum will be multiplied by 2 for the 2021 performance year.

- **When participating as a virtual group or APM Entity:** The complex patient bonus is calculated for virtual groups or APM Entities by adding the beneficiary weighted average HCC risk score for all MIPS eligible clinicians to the average dual eligible ratio for all MIPS eligible clinicians, multiplied by 5. This sum will be multiplied by 2 for the 2021 performance year. This calculation will be made, if technically feasible, for TINs in a virtual group or APM Entity.



## **MIPS Final Score and Payment Adjustment**

## How Does My MIPS Final Score Determine My Payment Adjustment?

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

Final Score	Payment Adjustment
<b>85.00 – 100.00 points</b> (Additional performance threshold = 85.00 points)	<ul style="list-style-type: none"><li>• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)</li><li>• Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)</li></ul>
<b>60.01 – 84.99 points</b>	<ul style="list-style-type: none"><li>• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)</li><li>• Not eligible for additional adjustment for exceptional performance</li></ul>
<b>60.00 points</b> (Performance threshold = 60.00 points)	<ul style="list-style-type: none"><li>• Neutral MIPS payment adjustment (0%)</li></ul>
<b>15.01 – 59.99 points</b>	<ul style="list-style-type: none"><li>• Negative MIPS payment adjustment (between -9% and 0%)</li></ul>
<b>0 – 15.00 points</b>	<ul style="list-style-type: none"><li>• Negative MIPS payment adjustment of -9%</li></ul>

## How Does My MIPS Final Score Determine My Payment Adjustment? (Continued)

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

- 1. MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality. Clinicians with a final score at the performance threshold of 60 points earn a neutral adjustment. Clinicians with a final score above the performance threshold of 60 points earn a positive adjustment (subject to a scaling factor). Clinicians with a final score below the performance threshold of 60 points will be subject to a negative adjustment. The maximum negative adjustment is -9%. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.
- 2. Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 85 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled; it will depend on the scores and the number of clinicians receiving a score of 85 points or higher.

**Did you know?** The 2022 performance year/2024 payment year will be the last year the additional payment adjustment for exceptional performance is available.





## **Resources, Glossary, and Version History**

## Where Can You Go for Help?

The following resources are available on the [QPP Resource Library](#) and other QPP and CMS webpages:

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m.-8 p.m. ET or by email at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).

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

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

## Resources

The following resources are available on the [QPP Resource Library](#) :

- **General:**

- [2021 Group Participation Guide \(PDF\)](#)
- [2021 MIPS Eligibility & Participation User Guide \(PDF\)](#)
- [2021 Eligibility & Participation Quick Start Guide \(PDF\)](#)
- [2021 MIPS Measures and Activities Specialty Guide \(ZIP\)](#)

- **Quality:**

- [2021 Quality Benchmarks \(ZIP\)](#)
- [2021 Quality Quick Start Guide \(PDF\)](#)
- [2021 MIPS Quality User Guide \(PDF\)](#)
- [2021 MIPS Quality Measures List \(XLSX\)](#)
- [Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs \(PDF\)](#)
  - Please note that this also applies to groups, virtual groups, and APM Entities reporting traditional MIPS
- [2021 CAHPS for MIPS Overview Fact Sheet \(PDF\)](#)
- [2021 Medicare Part B Claims Measure Specifications \(ZIP\)](#)
- [2021 MIPS Clinical Quality Measure Specifications \(ZIP\)](#)
- [2021 QCDR Measure Specifications \(ZIP\)](#)
- [2021 CMS Web Interface Measure Specifications \(ZIP\)](#)

- **Cost:**

- [2021 Cost Quick Start Guide \(PDF\)](#)
- [2021 MIPS Cost Measure Codes Lists \(ZIP\)](#)
- [2021 MIPS Summary of Cost Measures \(PDF\)](#)
- [2021 Cost Measure Information Forms \(ZIP\)](#)

- **Improvement Activities:**

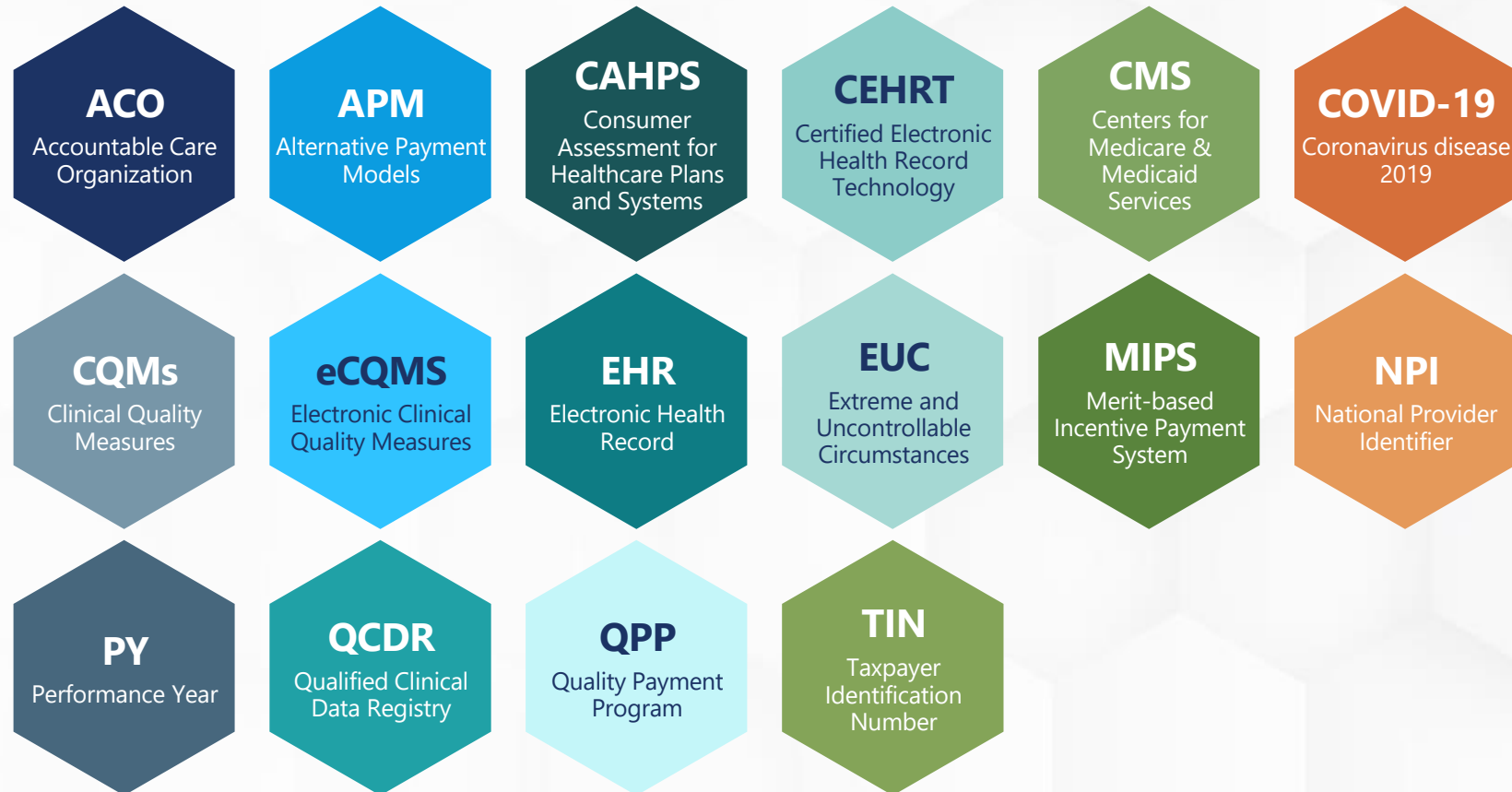
- [2021 Improvement Activities Quick Start Guide \(PDF\)](#)
- [2021 Improvement Activities Inventory \(ZIP\)](#)

- **Promoting Interoperability:**

- [2021 Promoting Interoperability Quick Start Guide \(PDF\)](#)
- [2021 Promoting Interoperability Measure Specifications \(ZIP\)](#)



## Glossary



## Version History

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

Date	Description
04/25/2022	We updated this resource based on CMS's announcement to reweight the cost performance category to 0% for the 2021 performance period, though we left most of the content untouched for historical reference.
2/14/2022	Updated Appendix E to reflect additional measures suppressed (Measure 111 – eCQM, Measure 128 – eCQM, Measure 134 – CMS Web Interface) or truncated (Measure 111 – MIPS CQM and Medicare Part B claims) for PY 2021.
11/23/2021	Updated to reflect policy finalized in the CY 2022 PFS Final Rule around doubling the complex patient bonus for PY 2021.
8/31/2021	Updated to reflect that facility-based scoring won't be available for PY 2021.
7/27/2021	Original Version



# Appendices

## Appendix A: Scoring Quality Measures

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

### 1. Find the benchmark and figure achievement points based on collection type for the measure.

- Achievement points are figured by mapping the performance rate to the [benchmark](#) for the measure, specific to collection type.
- Example:** Small practice reporting as a group submits Measure 236 as an eCQM.

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

- This is an extract from the [2021 benchmarking file](#) showing the range of performance rates associated with each decile for each collection type (Remember that Measure 236 is scored according the flat benchmark methodology, which is reflected in the [2021 Historical Quality Benchmarks](#) file):

Measure Name	Measure ID #	Collection Type	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	Medicare Part B Claims	Intermediate Outcome	Y	20 – 20.99	30 – 39.99	40 – 40.99	50 – 50.99	60 – 60.99	70 – 70.99	80 – 80.99	>=90
<b>Controlling High Blood Pressure</b>	236	eCQM	Intermediate Outcome	Y	51.69 - 57.07	57.08 - 61.32	61.33 - 64.79	<b>64.8 - 68.44</b>	68.45 - 72.03	72.04 - 76.35	76.36 - 82.37	>= 82.38
Controlling High Blood Pressure	236	MIPS CQM	Intermediate Outcome	Y	20 – 20.99	30 – 39.99	40 – 40.99	50 – 50.99	60 – 60.99	70 – 70.99	80 – 80.99	>=90

## Appendix A: Scoring Quality Measures (Continued)

### 2. Figure achievement points in a decile.

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

Measure Name	Controlling High Blood Pressure
Measure ID#	236
Collection Type	eCQM
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 3	51.69 – 57.07
Decile 4	57.08 – 61.32
Decile 5	61.33 – 64.79
Decile 6	64.8 – 68.44
Decile 7	68.45 – 72.03
Decile 8	72.04 – 76.35
Decile 9	76.36 - 82.37
Decile 10	>=82.38

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

$$\text{decile \# } X + \frac{\left[ \begin{array}{c} q \\ \text{performance} \\ \text{rate} \end{array} - \begin{array}{c} a \\ \text{bottom of} \\ \text{decile range} \end{array} \right]}{\left[ \begin{array}{c} b \\ \text{bottom of next} \\ \text{highest} \\ \text{decile range} \end{array} - \begin{array}{c} a \\ \text{bottom of} \\ \text{decile range} \end{array} \right]} = \text{Achievement Points}$$

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

$$\text{decile \# } 6 + \frac{\left[ 66.74 - 64.8 \right]}{\left[ 68.45 - 64.8 \right]} = 0.5315 = 6.5$$

...which is rounded to 0.5



## Appendix A: Scoring Quality Measures (Continued)

### 1. Repeat assignment of achievement points for each submitted measure.

- **Example:** Small practice submits 7 eQMs and 2 Medicare Part B Claims measures, meeting data completeness for all measures.

Measures Reported	Collection Type	Types of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
<b>Measure 236</b> Controlling High Blood Pressure	eQIM	Outcome	66.74	86	6.5	Compare to benchmark; required outcome measure (no bonus points available); meets end-to-end bonus point criteria.
<b>Measure 130</b> Documentation of Current Medications in the Medical Record	eQIM	Process	96.74	90	5.9	Compare to benchmark; meets end-to-end bonus point criteria
<b>Measure 111</b> Pneumococcal Vaccination for Elderly	eQIM	Process	22.12	112	3.1	Compare to benchmark; meets end-to-end bonus point criteria
<b>Measure 111</b> Pneumococcal Vaccination for Elderly	Medicare Part B Claims	Process	70.56	113	3.2	Compare to benchmark
<b>Measure 113</b> Colorectal Cancer Screening	eQIM	Process	36.32	13	3.0	Apply 3-point floor because it's below 20 case minimum; meets end-to-end bonus point criteria
<b>Measure 119</b> Diabetes: Attention for Nephropathy	eQIM	Process	77.19	43	4.1	Compare to benchmark; meets end-to-end bonus point criteria
<b>Measure 110</b> Preventive Care and Screening: Influenza Immunization	eQIM	Process	0.09	32	3.0	Compare to benchmark; apply 3-point floor due to poor performance; meets end-to-end bonus point criteria
<b>Measure 239</b> Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	eQIM	Process	32.56	40	5.4	Compare to benchmark; meets end-to-end bonus point criteria
<b>Measure 436</b> Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Medicare Part B Claims	Process	97.25	160	3.3	Compare to benchmark

## Appendix A: Scoring Quality Measures (Continued)

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

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

**The following measures contribute achievement points AND bonus points toward the quality performance category score.**

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points
1. Outcome/High-priority: <b>Measure 236</b>	eCQM	66.74	6.5	1
2. <b>Measure 130</b>	eCQM	96.74	5.9	1
3. <b>Measure 239</b>	eCQM	32.56	5.4	1
4. <b>Measure 119</b>	eCQM	77.19	4.1	1
5. <b>Measure 436</b>	Medicare Part B Claims	97.25	3.3	0
6. <b>Measure 111</b>	Medicare Part B Claims	70.56	3.2	0

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

**The following measures don't contribute achievement points but DO contribute bonus points toward the quality performance category score.**

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points	Comment
<b>Measure 111</b>	eCQM	22.12	N/A	1	Not one of the top 6 scored measures
<b>Measure 110</b>	eCQM	0.09	N/A	1	Not one of the top 6 scored measures

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

**The following measure don't contribute achievement points or bonus points toward the quality performance category score.**

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points	Comment
<b>Measure 113</b>	eCQM	36.32	3.0	1	<ul style="list-style-type: none"> <li>Not one of the top 6 scored measures</li> <li>Group has already reached the 10% cap on the end-to-end bonus points.</li> </ul>

# Appendices

## Appendix B: Reweighting the Performance Categories

### Performance Category Weight Redistribution

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

Performance Category Redistribution for the 2021 Performance Year/2023 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
No Reweighting Needed				
General weighting for all 4 performance categories	40%	20%	15%	25%
Reweighting 1 Performance Category				
No Cost: Cost → Quality and PI	55%	0%	15%	30%
No Promoting Interoperability: PI → Quality	65%	20%	15%	0%
No Quality: Quality → PI	0%	20%	15%	65%
No Improvement Activities: IA → Quality	55%	20%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability Cost and PI → Quality	85%	0%	15%	0%
No Cost and No Quality Cost and Quality → PI	0%	0%	15%	85%
No Cost and No Improvement Activities Cost and IA → Quality and PI	70%	0%	0%	30%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities PI and IA → Quality	80%	20%	0%	0%
No Quality and No Improvement Activities Quality and IA → PI	0%	20%	0%	80%

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

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

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

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

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

If you are reporting a mixture of eQCMs and MIPS CQMs using the QPP JSON format, you must submit these types as separate [measurement sets](#):

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

Please refer to the Submission API documentation in the [Developer Tools](#) section of the QPP website for the most current information.

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

### When an Exclusion is Claimed

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

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed...
e-Prescribing	e-Prescribing		Yes	...the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: <ul style="list-style-type: none"> <li>Option 1 <ul style="list-style-type: none"> <li>5 points to the Support Electronic Referral Loops by Sending Health Information measure</li> <li>5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure</li> </ul> </li> <li>Option 2 <ul style="list-style-type: none"> <li>10 points to the HIE Bi-Directional Exchange measure</li> </ul> </li> </ul>
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		N/A	N/A
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	...the 20 points are redistributed to the Provide Patients Electronic Access to the Health Information
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	...the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	<b>NEW:</b> HIE Bi-Directional Exchange	No	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		No	N/A
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> <li>Immunization Registry Reporting</li> <li>Electronic Case Reporting</li> <li>Public Health Registry Reporting</li> <li>Clinical Data Registry Reporting</li> <li>Syndromic Surveillance Reporting</li> </ul>		Yes	...the 10 points are still available in this objective if you <b>claim one exclusion</b> and submit a 'yes' attestation for one of the 5 measures in the objective.  ...the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you <b>claim two exclusions</b> .

## Appendix E: Quality Measures with MIPS Scoring Changes

This table identifies measures affected by coding issues, clinical guideline changes during the 2021 performance period, or specifications determined during or after the performance period to have substantive changes. This list will be updated if additional measures are identified for suppression or truncation in the 2021 performance period.

Quality Measure ID/ Title	Collection Type	Reason for Scoring Change	Result	Impact to scoring, submission and feedback expectations
<b>Measure 001/</b> 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 were not activated during the annual Current Procedural Terminology (CPT) Category II update process.	Suppressed	Excluded from scoring (denominator reduced by 10 points) if claims are submitted with active CPT codes for this measure.
<b>Measure 111/</b> Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims  MIPS 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 have not 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 have not received a pneumococcal vaccine.  Due to the updated guidelines allowing the use of 15 – or 20-valent pneumococcal conjugate vaccine, this measure will likely produce misleading results for the last quarter of the performance period.	Truncated (MIPS CQM and Medicare Part B claims collection types only – see next slide for eCQM impact)	Truncated performance period – those reporting this measure as a MIPS CQM should only include data from the first 9 months of the performance period (January 1 – September 30, 2021) in their submission. CMS will truncate the performance period automatically for Medicare Part B claims reporting.

## Appendix E: Quality Measures with MIPS Scoring Changes

This table identifies measures affected by coding issues, clinical guideline changes during the 2021 performance period, or specifications determined during or after the performance period to have substantive changes. This list will be updated if additional measures are identified for suppression or truncation in the 2021 performance period.

Quality Measure ID/ Title	Collection Type	Reason for Scoring Change	Result	Impact to scoring, submission and feedback expectations
<b>Measure 111/ CMS127v9</b> Pneumococcal Vaccination Status for Older Adults	eCQM	<p>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 have not 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 have not received a pneumococcal vaccine.</p> <p>Due to the updated guidelines allowing the use of 15 – or 20-valent pneumococcal conjugate vaccine, this measure could produce misleading results for the last quarter of the performance period. The current measure specifies that only PCV13 or PPSV23 vaccine (or both) will meet the quality action. CMS determined that the burden for electronic health record (EHR) developers would be prohibitive to truncating the data for the performance period and it is not feasible to collect nine consecutive months of data.</p>	Suppressed (eCQM collection type only)	Excluded from scoring (denominator reduced by 10 points) if measure is submitted.

## Appendix E: Quality Measures with MIPS Scoring Changes (continued)

This table identifies measures affected by coding issues, clinical guideline changes during the 2021 performance period, or specifications determined during or after the performance period to have substantive changes. This list will be updated if additional measures are identified for suppression or truncation in the 2021 performance period.

Quality Measure ID/ Title	Collection Type	Reason for Scoring Change	Result	Impact to scoring, submission and feedback expectations
<b>Measure 117/</b> Diabetes: Eye Exam	Medicare Part B Claims	The 2021 Medicare Part B Claims measure specification includes quality data codes (2023F, 2025F, and 2033F) that were not activated during the annual Current Procedural Terminology (CPT) Category II update process.	Suppressed	Excluded from scoring (denominator reduced by 10 points) if claims are submitted with active CPT codes for this measure.
<b>Measure 128/</b> Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	eCQM	<p>During the 2021 performance period, a misalignment was identified between the numerator header in the measure narrative and the numerator logic. Due to a change in the CQL, the timing for documenting the quality action changed and, according to the CQL definition, may in some circumstances extend beyond the end of the measurement period. Clinicians, groups, and/or virtual groups may submit data per the defined time except when the quality action takes place beyond the end of the performance period.</p> <p>Due to the inability to accurately submit the quality action and the misalignment between the measure narrative and logic, CMS determined that this measure has undergone a significant change that may result in misleading results.</p>	Suppressed	Excluded from scoring (denominator reduced by 10 points) if measure is submitted.



## Appendix E: Quality Measures with MIPS Scoring Changes (continued)

This table identifies measures affected by coding issues, clinical guideline changes during the 2021 performance period, or specifications determined during or after the performance period to have substantive changes. This list will be updated if additional measures are identified for suppression or truncation in the 2021 performance period.

Quality Measure ID/ Title	Collection Type	Reason for Scoring Change	Result	Impact to scoring, submission and feedback expectations
<b>Measure 134/</b> Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS Web Interface	<p>CMS determined that coding changes made to the 2021 PREV-12 were substantive changes to the measure. The modifications removed the Systematized Nomenclature of Medicine (SNOMED) codes that recognized the rescreening of a patient using an additional standardized depression screening tool as a means of meeting the performance criteria for implementing an appropriate follow-up plan specific to a patient with a positive depression screening.</p> <p>The coding changes no longer allow clinicians to meet the performance criteria of implementing a follow-up plan without providing an appropriate follow-up plan to the patient (patient would not be eligible for the measure numerator).</p>	Suppressed	Excluded from scoring (denominator reduced by 10 points) if data completeness is met.

## Appendix F

### Subject: CMS Reweighting 2021 MIPS Cost Performance Category

The following message was distributed through the Quality Payment Program listserv on 4/25/2022.

The Centers for Medicare & Medicaid Services (CMS) recognizes the impact that the COVID-19 pandemic public health emergency (PHE) continued to have on clinicians and the services they provided in the 2021 performance period.

Due to COVID-19's impact on cost measures, we're reweighting the cost performance category from 20% to 0% for the 2021 performance period. The 20% cost performance category weight will be redistributed to other performance categories in accordance with [§ 414.1380\(c\)\(2\)\(ii\)\(E\)](#). Please see the table below for reweighting scenarios.

### Why CMS is Reweighting the MIPS Cost Performance Category for 2021

Cost was already reweighted to 0% for all individual MIPS eligible clinicians, even if data were submitted for other performance categories, due to the automatic extreme and uncontrollable circumstances (EUC) policies under [§ 414.1380\(c\)\(2\)\(i\)\(A\)\(6\)](#) and [§ 414.1380\(c\)\(2\)\(i\)\(C\)](#). Our analysis of the underlying data for the 2021 performance period shows similar results at the group- and individual-level across measures. As a result, we believe that reweighting shouldn't depend on whether you choose to report as a group or individual.

Given these circumstances and in accordance with [§ 414.1380\(c\)\(2\)](#), we'll assign a weight of 0% to the cost performance category for the 2021 performance period and redistribute the prescribed weight of 20% to another performance category or categories.

Specifically, we don't believe we can reliably calculate scores for some of the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians based on the following reasons, as shown by our analysis of the cost performance category data for the 2021 performance period:

- Most measures have higher observed and risk-adjusted costs at the episode-level. This indicates that risk adjustment at the episode-level doesn't entirely account for differences in resource use, particularly for broader measures or measures that are clinically proximate to respiratory disease and COVID-19.
- There's less of an effect at the provider-level for most measures where testing shows that scores don't appear to be adversely impacted by higher case-loads of episodes with a recent or concurrent COVID-19 diagnosis. However, there are a small number of measures where scores may be adversely affected by the volume of episodes with a COVID-19 diagnosis.

## Appendix F (Continued)

### Subject: CMS Reweighting 2021 MIPS Cost Performance Category (Continued)

Please note that starting with the 2022 performance period, instead of reweighting the entire cost performance category, individual cost measures can be suppressed if the data used to calculate the score was impacted by significant changes during the performance period, such that calculating the cost measure would lead to misleading or inaccurate results. This provision allowing greater flexibility was finalized in the [CY 2022 Physician Fee Schedule Final Rule](#).

Clinicians **don't need to take any action as a result of this decision** because the cost performance category relies on administrative claims data.

### MIPS Performance Category Weight Redistribution Policies Finalized for the 2021 Performance Period

The table below illustrates the MIPS performance category weights and reweighting policies that apply to MIPS eligible clinicians, groups and virtual groups in the 2021 performance period.

MIPS Performance Category Reweighting Scenario	Quality Performance Category Weight	Cost Performance Category Weight	Improvement Activities Performance Category Weight	Promoting Interoperability Performance Category Weight
<b>Reweight the Cost Performance Category</b>				
<b>No Additional Reweighting Applies</b>	55%	0%	15%	30%
<b>Reweight 2 Performance Categories</b>				
<b>No Promoting Interoperability, No Cost</b>	85%	0%	15%	0%
<b>No Quality, No Cost</b>	0%	0%	15%	85%
<b>No Improvement Activities, No Cost</b>	70%	0%	0%	30%

\*This table can be found at [§ 414.1380\(c\)\(2\)\(ii\)\(E\)](#).

This reweighting of the cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policies under [§ 414.1380\(c\)\(2\)\(i\)\(A\)\(6\)](#) and [§ 414.1380\(c\)\(2\)\(i\)\(C\)](#).

- Cost was already reweighted to 0% for all individual MIPS eligible clinicians, even if data were submitted for other performance categories, due to the automatic EUC policy.
- Cost will now be reweighted to 0% for all groups and virtual groups, even if they didn't request reweighting through an EUC exception application.

## Appendix F (Continued)

### Subject: CMS Reweighting 2021 MIPS Cost Performance Category (Continued)

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.

### Cost Data in Performance Feedback for 2021

We recognize that this is the second year that we've had to reweight the cost performance category due to COVID-19, and that clinicians need more insight into and familiarity with their performance in this category. To support this need, we'll provide patient-level reports on the 2021 cost measures for which clinicians, groups and virtual groups met the case minimum. Patient-level reports will be available as part of the final performance feedback in August 2022.

Please note that we won't include measure-level scoring information in performance feedback. As previously mentioned, we don't believe we can reliably calculate scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians.

### Questions?

Please contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov). To receive assistance more quickly, 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.