Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2021 CMS Web Interface Quick Start Guide

Contents

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Purpose: This resource provides information about the CMS Web Interface reporting requirements and the CMS Web Interface measures, with a focus on traditional MIPS. (Traditional MIPS is the original framework for collecting and reporting data since the development and implementation of the Quality Payment Program (QPP), which started with the 2017 performance period). This resource doesn't address quality performance category scoring differences for Shared Savings Program Accountable Care Organizations (ACOs) reporting the CMS Web Interface measures for the APM Performance Pathway (APP).

How to Use This Guide

How to Use This Guide

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

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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 application will be available in the spring 2021 along with additional resources.

Due to the anticipated need for continued COVID-19 clinical trials and data collection, MIPS eligible clinicians, groups, and virtual groups 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 QPP COVID-19 Response webpage.

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the QPP, a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (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 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.
- 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.
- Check your current MIPS participation status using the QPP Participation Status Tool.

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

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under traditional MIPS, participants select from over 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks will be available to MIPS eligible clinicians:

The **APM Performance Pathway (APP)** is a streamlined reporting framework beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.

MIPS Value Pathways (MVPs) are a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority. We didn't propose any MVPs for implementation in 2021 but intend to do so through future rulemaking.

To learn more about the APP:

- Visit the APM Performance Pathway (APP) webpage on the QPP website.
- View the 2021 APM Performance Pathway (APP) for MIPS APM Participants, 2021 APM Performance Pathway (APP) Infographic, 2021 APM Performance Pathway Reporting Scenarios, and 2021 APM Performance Pathway Quick Start Guide.

To learn more about MVPs:

- Visit the MIPS Value Pathways (MVPs) webpage on the QPP website.

What is the CMS Web Interface?

The CMS Web Interface is a secure, internet-based application within qpp.cms.gov that allows you to submit data for a specified set of 10 quality measures. This collection and submission type is available to registered groups, virtual groups and APM Entities with 25 or more eligible clinicians reporting through traditional MIPS. Registration isn't required for Shared Savings Program ACOs reporting on the CMS Web Interface measures as part of the reporting requirements under the APP.

What's New with the CMS Web Interface in 2021?

The CMS Web Interface will **sunset** as a collection and submission type at the end of the 2021 performance period. This will be the last performance period the CMS Web Interface will be available for quality measure reporting. We'll provide additional resources to support the transition to other collection types throughout the year.

Reporting via the CMS Web Interface

Reporting via the CMS Web Interface

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How Does the CMS Web Interface Reporting Work?

There are 4 basic steps to the reporting of CMS Web Interface measures.

1. You register your organization (only applicable to groups, virtual groups, or APM Entities) for the CMS Web Interface between April 1, 2021 and June 30, 2021. **Registration closes at 8 p.m. ET on June 30, 2021.**
2. We use your claims data to identify a sample of your eligible Medicare Part A and B patients that potentially qualify for each CMS Web Interface measure.
3. We pre-populate the CMS Web Interface with the patients sampled for each measure and rank them in numeric order for you to complete.
4. You report each measure for the first 248 consecutively ranked patients identified from the sample (or 100% of the assigned patients if there are fewer than 248 patients assigned to a measure).

When possible, we provide an oversample of patients for each measure (more than 248 patients) in order to account for cases where data may not be able to be reported for certain patients.

> **NOTE:** We'll use the term "organization" throughout this resource to mean a group, virtual group, or APM Entity reporting through the CMS Web Interface.

Reporting via the CMS Web Interface

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Who Can Report through the CMS Web Interface for Traditional MIPS?

Groups, identified by a single Taxpayer Identification Number (TIN), with 25 or more clinicians (including at least one MIPS eligible clinician) that have reassigned their Medicare billing rights to the TIN.

Virtual groups (approved for the 2021 performance year) with 25 or more clinicians.

APM Entities with 25 or more clinicians (including at least one MIPS eligible clinician).

If the CMS Web Interface measures don't apply to your patient population, or if you don't have at least 12 months of data for your Medicare patients, the CMS Web Interface wouldn't be the appropriate collection or submission type to use to meet the quality performance category requirements. We urge your organization to use a different collection and submission type. For more information on other collection and submission types, please refer to resources on the QPP Resource Library.

Reporting via the CMS Web Interface

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How Does Registration Work?

Organizations that are interested in reporting quality data for the 2021 performance period via the CMS Web Interface through traditional MIPS must register on qpp.cms.gov between April 1, 2021 and June 30, 2021 by 8 p.m. ET.

Groups and virtual groups that used the CMS Web Interface to submit quality data for the 2020 performance period are automatically registered for the 2021 performance period. If you don't plan to report quality data through the CMS Web Interface for the 2021 performance period, please cancel your registration by June 30, 2021.

Being registered for the CMS Web Interface doesn't prohibit your organization from reporting quality data using a different collection and submission type if you choose to no longer use the CMS Web Interface for submission.

NOTE: To register, you'll need to have the Security Official role for your organization. Please refer to the QPP Access User Guide for more information.

Shared Savings Program ACOs are automatically registered for the CMS Web Interface for the 2021 performance period. Shared Savings Program ACOs are required to meet reporting requirements under the APP but aren't required to report quality data through the CMS Web Interface. Please review the 2021 APM Performance Pathway Quick Start Guide (PDF) or 2021 APM Performance Pathway (APP) for MIPS APM Participant Fact Sheet (PDF) for more details.

NOTE: Groups that participate in a Shared Savings Program ACO would only register for the CMS Web Interface if they want to report traditional MIPS as a group. The group's participation would be in addition to the ACO's required reporting under the APP.

CMS Web Interface Measures

CMS Web Interface Measures

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What are the 2021 CMS Web Interface Measures?

There are 10 measures required by the CMS Web Interface. The CMS Web Interface measure set for the 2021 performance period is the same as the CMS Web Interface measure set for the 2020 performance period with no substantive changes to the measure specifications. If your organization is interested in submitting quality data through the CMS Web Interface, use the Quality Measure Specifications and supporting documents on the Quality Payment Program Resource Library or the Explore Measures & Activities tool to make sure your organization can collect and submit data on the 10 CMS Web Interface measures outlined below.

CMS Web Interface Measure ID	Measure Name	Quality ID	Measure Type
CARE-2	Falls: Screening for Future Falls	318	Process
DM-2	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	Intermediate Outcome
HTN-2	Hypertension: Controlling High Blood Pressure	236	Intermediate Outcome
MH-1	Depression Remission at Twelve Months (R)	370	Outcome
PREV-5	Breast Cancer Screening	112	Process
PREV-6	Colorectal Cancer Screening	113	Process
PREV-7	Preventive Care and Screening: Influenza Immunization	110	Process
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Process
PREV-12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (R)	134	Process
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (R)	438	Process

Measures without a Benchmark (R): For purposes of MIPS and the APP, such measures are excluded from scoring for the 2021 performance period as long as data completeness requirements are met.

How Does Patient Assignment Work?

Patients are assigned to an organization (group, virtual group, or APM Entity) when the patients were deemed to have the plurality of their Medicare services with that organization (according to claims submitted by the organization in 2021). Patients sampled into the CMS Web Interface had at least 2 primary care services furnished by your organization between January 1, 2021 and October 31, 2021. As a result of your organization being accountable for the care of these patients, it's expected that your organization will obtain the needed information to complete the requirements for each measure in the CMS Web Interface.

The patients assigned to each organization are assessed for measure-specific eligibility, based on the denominator criteria in each measure's specification.

If your organization doesn't have enough patients assigned to each measure, you may have to choose another way to collect and submit your quality measure data. We'll contact any registered organizations that don't meet patient sampling requirements once assignment and sampling has been conducted.

CMS Web Interface Measures

What are the Data Completeness and Case Minimum Requirements?

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.

It's possible an organization may not be able to report performance data on a given patient for a given measure. To account for such cases, an **oversample** is provided when possible, resulting in more than the required 248 consecutively ranked patients in each measure. Any patient ranked above 248 is considered part of the oversample. Your organization isn't required to submit data on patients in the oversample, unless you **skip** a patient within the first **248** (minimum range) consecutively ranked patients. In such case, patients ranked above 248 (the oversample) will move into the minimum range and data will need to be submitted for such patients in order to meet data completeness requirements.

Scoring

How Does Scoring Work?

There are generally 10 points available for each required measure with a benchmark. The table below outlines measure-level scoring information based on the availability of a benchmark, and whether data completeness and case minimum requirements are met.

CMS Web Interface Measure	Points Earned for Each Measure
✓ **Has benchmark** ✓ **Meets data completeness requirement** ✓ **Meets case minimum**	3 – 10 points
✓ **Has benchmark** ✓ **Meets data completeness requirement** ✗ **Doesn't meet case minimum**	N/A – excluded from scoring (denominator reduced) **NOTE:** This differs from scoring for other collection types.
✓ **Meets data completeness requirement** ✗ **Doesn't have benchmark**	N/A – excluded from scoring (denominator reduced) **NOTE:** This differs from scoring for other collection types.
✗ **Doesn't meet data completeness requirement**	You must meet data completeness requirements for **ALL** measures to earn a quality performance category score greater than 0 for CMS Web Interface reporting

How Does Scoring Work? (Continued)

For the quality performance category in traditional MIPS, organizations submitting quality data through the CMS Web Interface can earn a maximum of:

- **70 points** (assuming data completeness requirements are met) for the CMS Web Interface measures alone.
- **80 points** (assuming data completeness requirements are met) for the CMS Web Interface measures **and** the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey **or** the Hospital-Wide All-Cause Unplanned Readmission measure* (**or** the Hip Arthroplasty and Knee Arthroplasty Complication measure**).
- **90 points** (assuming data completeness requirements are met) for the CMS Web Interface measures **and** the CAHPS for MIPS Survey **and** the Hospital-Wide All-Cause Unplanned Readmission measure* **or** the Hip Arthroplasty and Knee Arthroplasty Complication measure**.
- **100 points** (assuming data completeness requirements are met) for the CMS Web Interface measures, the CAHPS for MIPS Survey, the Hospital-Wide All-Cause Unplanned Readmission measure*, **and** the Hip Arthroplasty and Knee Arthroplasty Complication measure**.

* The Hospital-Wide All-Cause Unplanned Readmission measure is eligible for groups, virtual groups, and APM Entities that meet a case minimum of 200 cases. This measure will be automatically evaluated and calculate through administrative claims.

** The Hip Arthroplasty and Knee Arthroplasty Complication measure is eligible for individuals, groups, virtual groups, and APM Entities that meet a case minimum of 25 cases. This measure will be automatically evaluated and calculate through administrative claims.

NOTE: When scoring measures across collection types, the CMS Web Interface measures can't be scored with collection types other than the CMS approved survey vendor measure (the CAHPS for MIPS Survey) and/or the administrative claims measures.

Under MIPS, the CMS Web Interface measures are scored in comparison to quality measure benchmarks established under the Shared Savings Program. To view the 2021 benchmarks for the CMS Web Interface measures, please refer to the Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs.

Mapping of Performance Rates According to the MIPS Benchmark Deciles

CMS Web Interface measures are scored according to the performance rates calculated from the numerator, denominator, and exception data reported for the measure.

Measure-Level Scoring for CARE-2, HTN-2, PREV-5, PREV-6, PREV-7, AND PREV-10		
Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
0.00 - 29.99%	3 - 3.9 points	Decile 3
30.00 - 39.99%	4 - 4.9 points	Decile 4
40.00 - 49.99%	5 - 5.9 points	Decile 5
50.00 - 59.99%	6 - 6.9 points	Decile 6
60.00 - 69.99%	7 - 7.9 points	Decile 7
70.00 - 79.99%	8 - 8.9 points	Decile 8
80.00 - 89.99%	9 - 9.9 points	Decile 9
>= 90.00%	10 points	Decile 10
NOTE: MH-1, PREV-12, and PREV-13 don't have a benchmark and will be excluded from scoring provided data completeness is met.		

Measure-Level Scoring for DM-1 (Inverse Measure, Lower Performance Rate indicates Better Performance)		
Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
100.00 - 70.01%	3 - 3.9 points	Decile 3
70.00 - 60.01%	4 - 4.9 points	Decile 4
60.00 - 50.01%	5 - 5.9 points	Decile 5
50.00 - 40.01%	6 - 6.9 points	Decile 6
40.00 - 30.01%	7 - 7.9 points	Decile 7
30.00 - 20.01%	8 - 8.9 points	Decile 8
20.00 - 10.01%	9 - 9.9 points	Decile 9
<= 10.00%	10 points	Decile 10

Measure Scoring Example

For example, your organization has a performance rate of 67.92% for PREV-5, which means that your organization would earn between 7 and 7.9 achievement points.

We use the following formula to determine the achievement points your organization would receive.

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

$$\text{Achievement points} = X + \frac{(q-a)}{(b-a)}$$

$$\text{Achievement points} = 7 + \frac{(67.92-60.00)}{(70.00-60.00)}$$

$$\textbf{\textit{Achievement points}} = \mathbf{7.8}$$

$\frac{(67.92-60.00)}{(70.00-60.00)} = 0.792$

Which is rounded to 0.8

X = decile #
q = performance rate
a = bottom of decile range
b = bottom of next highest decile range

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.

Scoring Example

In the example below, patient sample counts are designed to illustrate different scoring policies and may not reflect realistic scenarios.

CMS Web Interface Measure ID	# of Patients in Sample (including oversample)	# of Consecutively Ranked Patients Reported	Has a Benchmark	Meets Data Completeness	Meets Case Minimum	Total Points Available	Measure Score	Why?
CARE-2	18	18	Y	Y	N	N/A	N/A	Even though this measure has a benchmark, and the data completeness requirement was met (100% of sample was reported due to fewer than 248 patients included in the sample), it's excluded from scoring because the sample is below case minimum (20).
DM-2	192	192	Y	Y	Y	10	9.0	This measure is scored against its benchmark because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).
HTN-2	302	257	Y	Y	Y	10	8.6	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
MH-1	248	248	N	Y	Y	N/A	N/A	This measure doesn't have a benchmark and is excluded from scoring because the data completeness requirement was met (248 consecutively ranked patients are reported).
PREV-5	300	248	Y	Y	Y	10	7.8	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-6	57	57	Y	Y	Y	10	9.1	This measure is scored against its benchmark because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).

Scoring Example (Continued)

In the example below, patient sample counts are designed to illustrate different scoring policies and may not reflect realistic scenarios.

CMS Web Interface Measure ID	# of Patients in Sample (including oversample)	# of Consecutively Ranked Patients Reported	Has a Benchmark	Meets Data Completeness	Meets Case Minimum	Total Points Available	Measure Score	Why?
PREV-7	300	300	Y	Y	Y	10	8.7	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-10	250	249	Y	Y	Y	10	6.0	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-12	289	248	N	Y	Y	N/A	N/A	This measure doesn't have a benchmark and is excluded from scoring because the data completeness requirement was met (248 consecutively ranked patients are reported).
PREV-13	202	202	N	Y	Y	N/A	N/A	Measure doesn't have a benchmark and is excluded from scoring because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).
Totals						60 Points (max number of point available on the CMS Web Interface measures alone)	49.2 points	The total available points reflects the 6 measures in this example that could be scored against a benchmark. **Note:** If the CARE-2 measure had met the minimum number of patients reported (20), the points available would be 70.

Are Additional or Bonus Points Available?

Yes. In traditional MIPS, your organization can earn 2 additional points for administering the optional CAHPS for MIPS Survey (measuring patient experience) in addition to the CMS Web Interface measures and/or one bonus point per eligible CMS Web Interface measure for end-to-end electronic reporting.

Earn CAHPS for MIPS Survey Additional Points

To administer the CAHPS for MIPS Survey:

- Your organization must register between April 1, 2021 and June 30, 2021. **Registration closes at 8 p.m. ET on June 30, 2021.**
  - To register, you'll need to have the Security Official role for your organization. Please refer to the QPP Access User Guide for more information.
- Your organization will need to hire a CMS approved vendor to administer the survey and pay the associated costs.
- If your organization doesn't plan to administer the CAHPS for MIPS Survey for performance year 2021, we encourage you to cancel your registration by June 30, 2021.

Review the 2021 CAHPS for MIPS Survey Overview Fact Sheet for more information.

Earn End-to-End Electronic Reporting Bonus Points

Your organization can earn one bonus point per CMS Web Interface measure for end-to-end electronic reporting.

- For the CMS Web Interface, end-to-end electronic reporting is the submission of data from the Certified Electronic Health Record Technology (CEHRT) directly to CMS via the CMS Web Interface Application Programming Interface (API) or Excel upload.
- These bonus points are capped at 10% of your denominator.

Data Submission

You can report your quality data on the CMS Web Interface measures for the 2021 performance period between January 3, 2022 and March 31, 2022.

During this time, you can submit quality data through any of the following methods (or a combination) via the CMS Web Interface:

- Manually entering data for each patient.
- Uploading patient data in the CMS-approved (Excel) template.
- Using the CMS Web Interface API.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

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Where Can You Go for Help?

The following resources are available on the QPP Resource Library and other QPP and CMS webpages:

Contact the QPP Service Center at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. ET or by email at: qpp@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

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

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

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

Additional Resources

The QPP Resource Library contains fact sheets, specialty guides, technical and user guides, helpful videos, and more. The table will be updated if more resources become available.

Resource	Description
2021 CMS Web Interface Measure Specifications and Supporting Documents	Provides comprehensive descriptions of the 2021 CMS Web Interface measures.
2021 CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology	This resource can be used as a reference to describe the process for assigning patients to a group or a virtual group participating in MIPS. (This document is coming soon for 2021).
2021 CMS Web Interface User Guide and User Videos	The 2021 CMS Web Interface User Guide and Videos will be available in December 2021. (Please note that the 2020 CMS Web Interface User Guide + User Demo Videos are currently available for informational/reference purposes only.)

Version History

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

Date	Description
4/1/2021	Original Version
4/6/2022	Added slides 21 and 22 to detail measure-level scoring information for the 2021 CMS Web Interface measures.
4/22/2022	Corrected upper value listed for performance rate ranges associated with Deciles 4 – 9 on slide 21 for CARE-2, HTN-2, PREV-5, PREV-6, PREV-7, and PREV-10. (The range of performance rates associated with Decile 3 were previously identified as 30.00 – 30.99, 40 – 40.99 for Decile 4, 50 – 50.00 for Decile 5, etc.) Corrected total points available in the scoring example on slide 24. (Previously indicated 70 points, but CARE-2 didn't meet case minimum in the example and should therefore be excluded from scoring.)