Quality Performance Category Scoring Methodology for "The APM Scoring Standard"

Updated for the 2020 Performance Year (2022 MIPS Payment Year)

Updated 12/10/2020

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Section 1: Introduction

The Centers for Medicare & Medicaid Services (CMS) Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians. It rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) or through Qualifying APM Participant (QP) status, attained through participation in Advanced Alternative Payment Models (Advanced APMs).[1] As prescribed by MACRA, MIPS has four performance categories: (1) ***quality—***including a set of evidence-based measures; (2) ***cost***; (3) practice-based ***improvement activities***; and (4) ***promoting interoperability***—use of certified electronic health record technology (CEHRT) to support interoperability and advanced quality objectives—in a single, cohesive program that avoids redundancies.[2] Performance in these categories is scored and weighted, and a final MIPS score is calculated for determining payment adjustment two years later.[3] The general MIPS scoring standard is described elsewhere.[4]

An APM is a CMS payment approach that gives added incentives to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. There are different categories of APMs under the Quality Payment Program[5]:

- **APMs**: An APM is a model under section 1115 of the Social Security Act ("the Act") (other than a health care innovation award); the Shared Savings Program under section 1899 of the Act; a demonstration under section 1866C of the Act; or a demonstration required by Federal law 42 Code of Federal Regulations (CFR) 414.1305.
- **MIPS APMs**: A MIPS APM is a type of APM that meets the criteria in 42 CFR 414.1370(b), including basing payment on quality measures and cost/utilization.
- **Advanced APMs**: An Advanced APM is a type of APM that meets the criteria in 42 CFR 414.1415, including CEHRT use, payment based on MIPS-comparable quality measures, and financial risk or being a medical home model.
- **Other Payer Advanced APM**: An Other-Payer Advanced APM is a payment arrangement offered by other payers (Medicaid, Medicare Health Plans including Medicare Advantage plans, or commercial plans) that meets the CEHRT, quality, and financial risk criteria in 42 CFR 414.1420.

[1] https://www.federalregister.gov/d/2016-25240/p-112

[2] https://www.federalregister.gov/d/2018-24170/p-6194

[3] https://www.federalregister.gov/d/2018-24170/p-6090

[4] https://www.federalregister.gov/d/2018-24170/p-6194

[5] https://qpp.cms.gov/apms/overview

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An APM can be a MIPS APM, an Advanced APM, both, or neither. MIPS eligible clinicians participating in MIPS APMs are subject to MIPS reporting requirements but receive special MIPS scoring under the "APM Scoring Standard" under 42 CFR 414.1370. Eligible clinicians who meet threshold levels of participation in an Advanced APM in a performance year become Qualifying APM Participants (QPs), excluding them from MIPS reporting, scoring, and payment adjustments and potentially earning them eligibility for an APM incentive payment (for payment years 2019 through 2024). If the Advanced APM also is a MIPS APM and an eligible clinician does not meet the threshold of having sufficient payments or patients through the Advanced APM to become a QP, the eligible clinician will be scored under MIPS according to the APM Scoring Standard.

The weights assigned to the MIPS performance categories under the APM Scoring Standard may be different from the regular MIPS performance category weights. As described above, the APM Scoring Standard also does not apply to a QP for the performance year because that clinician is excluded from the MIPS reporting requirements and payment adjustment for that year. A clinician who is a Partial QP can choose whether to participate in MIPS.[6]

1.1 MIPS APMs

Based on the MIPS APM criteria, the following APMs will satisfy the requirements to be MIPS APMs for the 2020 performance year:[7]

- Medicare Shared Savings Program (all tracks)
- Next Generation Accountable Care Organization (ACO) Model
- Comprehensive Primary Care Plus Model (all tracks)
- Oncology Care Model (all tracks)
- Comprehensive End-Stage Renal Disease (ESRD) Care Model (all tracks)
- Independence at Home Demonstration
- Bundled Payments for Care Improvement Advanced
- Maryland Primary Care Program (under the Maryland Total Cost of Care Model)
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative)

[6] https://www.federalregister.gov/d/2018-24170/p-6056

[7] Final CMS determinations of MIPS APMs for the 2020 MIPS performance year will be announced via the Quality Payment Program website at https://qpp.cms.gov/.

1.2 Purpose of this Document

The purpose of this document is to describe the APM Scoring Standard for the ***quality performance category*** for MIPS APMs. The quality performance category is the first of four categories used for the Quality Payment Program performance assessment. Here, we aim to: (1) present the regulatory guidance for performance year 2020 APM scoring; and (2) provide a standardized APM scoring methodology for MIPS APMs that reflects the updated procedures for performance year 2020. The scoring methodologies for the other APM categories can be found in 42 CFR 414.1370.

Note: For performance year 2020 (payment year 2022), CMS is implementing significant changes to the APM Scoring Standing for MIPS APMs, especially in the Quality performance category. Details are described in Section 4 of this document.

1.3 Organization of this Document

Section 2 describes the overall APM Scoring Standard. Section 3 describes each MIPS APM for performance year 2020 (MIPS payment year 2022). Section 4 describes the revised 2020 scoring methodology for the Quality performance category.

Section 2: Overview of the APM Scoring Standard

Section 414.1370 of Title 42 of the CFR provides the regulatory standards for the APM Scoring Standard, discussed in the 2017 Quality Payment Program Final Rule[8] and updated in the 2018 Quality Payment Program Final Rule,[9] the 2019 Quality Payment Program Final Rule,[10] and the 2020 Quality Payment Program Final Rule.[11] The APM Scoring Standard is the MIPS scoring methodology applicable to MIPS eligible clinicians identified on the Participation List for the performance period of an APM Entity participating in a MIPS APM.[12]

2.1 Performance Period for the APM Scoring Standard

The MIPS performance period applies for the APM Scoring Standard. For the 2020 performance year, which corresponds to the 2022 payment year, the APM Scoring Standard performance period for the quality and cost performance categories is calendar year (CY) 2020 (January 1, 2020, through December 31, 2020). For the Promoting Interoperability and Improvement

[8] https://www.federalregister.gov/d/2016-25240

[9] https://www.federalregister.gov/d/2017-24067

[10] https://www.federalregister.gov/d/2018-24170

[11] https://www.federalregister.gov/d/2019-24086

[12] https://www.federalregister.gov/d/2016-25240/p-6561; MIPS eligible clinicians on the Participant Lists are identified in each of the determination periods, or snapshots, during the performance period.

Activities performance categories, the 2020 performance period is a minimum of a continuous 90-day period within CY 2020, up to and including the full CY 2020.[13]

2.2 APM Participant Identifier and MIPS APM Determination

The APM participant identifier for an eligible clinician is the combination of four identifiers: (1) APM identifier (established for the APM by CMS); (2) APM Entity identifier (established for the APM Entity by CMS); (3) Medicare-enrolled billing tax identification number (TIN); and (4) eligible clinician national provider identifier (NPI).

MIPS APMs are those in which:

- APM Entities participate in the APM under an agreement with CMS or through a law or regulation;
- The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List;
- The APM bases payment on quality measures and cost/utilization; and
- The APM is not either of the following:
    - *Beginning after first day of performance period:* An APM for which the first performance year begins after the first day of the MIPS performance period for the year.
    - An APM in its *final year of operation for which the APM Scoring Standard is impracticable:* An APM in the final year of operation for which CMS determines, within 60 days after the beginning of the MIPS performance period for the year, that it is impracticable for APM Entities to report to MIPS using the APM Scoring Standard.[14]

2.3 APM Scoring Standard

For the APM Scoring Standard, eligible clinicians are assessed through their collective participation in an APM Entity that is participating in a MIPS APM. The MIPS final score calculated for the APM Entity is applied to each MIPS eligible clinician in the APM Entity. The MIPS payment adjustment is applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity.

[13] https://www.federalregister.gov/d/2018-24170/p-6096

[14] https://www.federalregister.gov/d/2016-25240/p-6566

2.4 APM Performance Categories and Weights

The performance category weights used to calculate the MIPS final score for an APM Entity for the performance year 2020 APM Scoring Standard are:[15]

If CMS reweights the Promoting Interoperability performance category to 0 percent, then CMS will reassign its weight such that:[16]

1. Quality: reweighted to 80 percent; and
2. Improvement Activities: remains at 20 percent.

If CMS reweights the Quality performance category to 0 percent—such as in extreme and uncontrollable circumstances, for example—then CMS will reassign weights such that:[17]

1. Promoting Interoperability: reweighted to 75 percent; and
2. Improvement Activities: reweighted to 25 percent.

2.5 Total APM Entity Score (Final MIPS Score)

CMS scores each performance category and then multiplies each score by the applicable performance category weight. CMS then calculates the sum of each weighted performance category score and then applies all applicable adjustments. Each MIPS eligible clinician receives a final score of zero to 100 points for a performance period for a MIPS payment year. If a MIPS eligible clinician is scored on fewer than two performance categories, he or she receives a final score equal to the performance threshold.

APM Entities will receive MIPS bonuses applied to the final score, just as eligible clinicians do under the MIPS scoring standard. For the 2020 performance year (2022 MIPS payment year), one such bonus is available:[18]

> *Complex patient bonus*. If the APM Entity submits data for at least one MIPS performance category during the 2020 MIPS performance period, a complex

[15] https://www.federalregister.gov/d/2017-24067/p-4369

[16] https://www.federalregister.gov/d/2017-24067/p-4385

[17] https://www.federalregister.gov/d/2018-24170/p-6185

[18] https://www.federalregister.gov/d/2018-24170/p-6319

patient bonus will be added to APM Entities' final score for the 2022 MIPS payment year, based on the beneficiary weighted average Hierarchical Condition Category risk score for all MIPS eligible clinicians and the average dual-eligible ratio for all MIPS eligible clinicians. The bonus does not exceed 5.0.

Thus, the MIPS final score is calculated as the sum of each performance category percent score multiplied by its weight, multiplied by 100, in addition to the complex patient bonus if applicable, all not to exceed 100 points:

Final score =	[(quality performance category percent score × quality performance category weight) + (cost performance category percent score × cost performance category weight, which is zero for MIPS APMs) + (improvement activities performance category score × improvement activities performance category weight) + (Promoting Interoperability performance category score × Promoting Interoperability performance category weight)] × 100 + the complex patient bonus, not to exceed 100 points.

2.6 Flow of Data

For MIPS performance year 2020 (corresponding to payment year 2022), the MIPS system will calculate the Quality performance category score using the quality measure information submitted by each MIPS APM participant where applicable. As in the past, CMS Web Interface submissions will be scored in the MIPS system automatically for MIPS APM Entities; new for this performance year, all MIPS APM participants under the APM Scoring Standard will submit quality measure performance data via a MIPS submission mechanism, and their APM Entities will have the option of submitting these quality measures to MIPS on their behalf. The MIPS system will be responsible for aggregating the results from the Quality performance category as well as from the improvement activities category and the Promoting Interoperability category and generating a weighted final MIPS score with any applicable bonus points as specified above for each APM Entity group.

Section 3: MIPS APMs in 2020

In 2017, the Shared Savings Program and Next Generation ACO Model were the only APMs for which the Quality performance category was scored under the APM Scoring Standard, as their quality measures were submitted via the CMS Web Interface used for MIPS scoring. Beginning in 2018, additional MIPS APMs were scored in the Quality performance category under the APM Scoring Standard. Unlike ACOs, these additional APMs did not report through the CMS Web Interface; they included participants in:

- The Oncology Care Model (OCM);
- The Comprehensive Primary Care Plus (CPC+) Model; and
- The Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model.

For the 2019 performance period, the list of other MIPS APMs also included:

- The Independence at Home (IAH) Demonstration;
- The Bundled Payments for Care Improvement (BPCI) Advanced Model;
- The Maryland Primary Care Program; and
- The Vermont All-Payer ACO Model.

These models remain as MIPS APM in the MIPS performance year 2020, and there are no additional eligible MIPS APMs for this performance year. The following sections describe each 2020 MIPS APM.

3.1 Medicare Shared Savings Program

The Medicare Shared Savings Program is a voluntary program that encourages clinicians, hospitals, and other health care providers to work together through an ACO to provide coordinated, high-quality care to their Medicare patients. An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. Since 2012, the Shared Savings Program has offered different participation options (tracks) that allow ACOs to assume various levels of risk, and these tracks were updated in 2019 under the CMS "Pathways to Success" (**Table 1**).[19]

Table 1. Description of Each Track of the Shared Savings Program

Track	Financial Risk Arrangement	Description
BASIC Track, Level A & Level B	One-sided	Level A & Level B ACOs do not assume downside risk (shared losses).
BASIC Track, Level C	Two-sided	Level C ACOs may share in savings or repay Medicare losses depending on performance. Level C ACOs may share in a greater portion of savings than Level A & Level B ACOs and must assume limited downside risk (less than Level D & Level E).
BASIC Track, Level D	Two-sided	Level D ACOs may share in savings or repay Medicare losses depending on performance, with a higher cap on shared losses than Level C.
BASIC Track, Level E	Two-sided	Level E ACOs may share in savings or repay Medicare losses depending on performance, with losses capped at the revenue-based nominal amount standard under the Quality Payment Program.
ENHANCED Track (previously Track 3)	Two-sided	ENHANCED Track ACOs may share in savings or repay Medicare losses depending on performance; these ACOs take on the greatest amount of risk but may share in the greatest portion of savings if successful.

[19] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html

Participating ACOs must meet the quality performance standard, which includes completely and accurately reporting quality data to CMS after the close of every performance year, to be eligible to share in any savings. Quality measures span four domains: (1) patient/caregiver experience; (2) care coordination/patient safety; (3) preventive health; and (4) at-risk populations.[20] Although claims-based and administrative-data measures must be reported for purposes of assessing the quality of care under the Shared Savings Program, only the ACO quality measures submitted via the CMS Web Interface and the patient experience Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey will be used for APM Quality performance category scoring.

For the Shared Savings Program, the Quality performance category under the APM Scoring Standard will include the same measures as that for the Next Generation ACO Model. In performance year 2020, there are 10 ACO quality measures that are submitted via the CMS Web Interface and one collected by the CAHPS patient survey. See **Table 2** in Section 4 for more information on these quality measures.

3.2 Next Generation ACO (NGACO) Model

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program, the NGACO Model is another opportunity to participate in accountable care—one that sets predictable financial targets, enables health care providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care. The NGACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients and allows participating ACOs to assume higher levels of financial risk and reward than under the Pioneer ACO Model and the Shared Savings Program. The goal of the NGACO Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare FFS beneficiaries.[21]

As noted above, for the NGACO Model in the 2020 performance year, the Quality performance category under the APM Scoring Standard will follow the same measures and methodology used under the Shared Savings Program. Both the Shared Savings Program and the NGACO Model use the CMS Web Interface – a MIPS submission mechanism – for quality reporting.

3.3 Comprehensive Primary Care Plus (CPC+) Model

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks (CPC+ Track 1 and Track 2) with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. This Model seeks to improve quality, access, and efficiency of primary care. Practices in both tracks are required to make changes in the way they deliver

[20] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications.html

[21] https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

care, centered on key comprehensive primary care functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health.[22]

3.4 Oncology Care Model (OCM)

OCM aims to provide higher-quality, more coordinated oncology care at the same or lower cost to Medicare. Under OCM, physician practices have the opportunity to receive performance-based payments for episodes of care surrounding chemotherapy administration to cancer patients. One-sided risk and two-sided risk arrangements are available in the Model. The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries such as documenting a care plan, providing the core functions of patient navigation, and adhering to national treatment guidelines for treatment with therapies.[23]

3.5 Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. The Model aims to test accountable care concepts for ESRD beneficiaries. In the CEC Model, dialysis clinics, nephrologists, and other providers and suppliers join together to create an ESRD Seamless Care Organization (ESCO) to coordinate care for aligned beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes.[24]

The CEC Model includes separate financial arrangements for large and small dialysis organizations. Large Dialysis Organizations (LDOs), which own 200 or more dialysis facilities, are eligible to receive shared savings payments. These LDOs also are be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts. Non-LDOs include chains that own fewer than 200 dialysis facilities and include independent dialysis facilities and hospital-based dialysis facilities. Non-LDOs have the option of participating either in a one-sided risk track where they are able to receive shared savings payments but are not be liable for payment of shared losses, or in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of non-LDOs more limited resources.[25]

3.6 Independence at Home (IAH) Demonstration

The IAH Demonstration tests whether delivering comprehensive primary care services at home results in improved care for Medicare beneficiaries with multiple chronic conditions and reduces Medicare expenditures. Additionally, participating practices that meet financial and quality performance thresholds have the opportunity to receive incentive payments.[26]

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[22] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

[23] https://innovation.cms.gov/initiatives/oncology-care/

[24] https://innovation.cms.gov/initiatives/comprehensive-esrd-care/

[25] https://innovation.cms.gov/initiatives/comprehensive-esrd-care/

[26] https://innovation.cms.gov/initiatives/independence-at-home/

The IAH Demonstration provides chronically ill patients with a complete range of primary care services in the home setting. Medical practices led by physicians or nurse practitioners provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. This MIPS APM tests whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. Initially authorized for a three-year period, the Demonstration has been extended twice, with the most recent two-year extension beginning on January 1, 2019.

3.7 Bundled Payments for Care Improvement (BPCI) Advanced Model

The BPCI Advanced Model tests a new iteration of bundled payments for 32 clinical episodes and aims to align incentives among participating health care providers for reducing expenditures and improving quality of care for Medicare beneficiaries.[27] A bundled payment methodology involves combining the payments for physician, hospital, and other health care provider services into a single payment amount. This amount is calculated based on the expected costs of all items and services furnished to a beneficiary during an episode of care.

BPCI Advanced aims to encourage clinicians to redesign care delivery by adopting best practices, reducing variation from standards of care, and providing a clinically appropriate level of services for patients throughout a clinical episode. The first cohort of participants started participating in the Model on October 1, 2018, and BPCI Advanced is designed to run for ten performance periods through December 31, 2023. Under BPCI Advanced, the "Physician Group Practice Non-Convener" entities, the "Physician Group Practice Convener" entities, and the "Physician Group Practices and Acute Care Hospitals Mixed Convener" entities are MIPS APMs subject to the APM Scoring Standard.

3.8 Maryland Primary Care Program (under the Maryland Total Cost of Care Model)

CMS and the state of Maryland are partnering to test the Maryland Total Cost of Care (TCOC) Model, which sets a per capita limit on Medicare total cost of care in Maryland and holds the state fully at risk for the total cost of care for Medicare beneficiaries.[28] The Maryland TCOC Model sets Maryland on course to achieve fixed amounts of Medicare total cost of care savings during each Model Year between 2019 and 2023. The Maryland TCOC Model includes three programs: (1) the Hospital Payment Program; (2) the Care Redesign Program (CRP); and (3) the Maryland Primary Care Program (MDPCP). Practices participating in the Maryland Primary Care Program, which is an MIPS APM and an Advanced APM, will be evaluated based on quality and patient experience of care**.** The performance period of the Maryland TCOC Model began on January 1, 2019 and concludes on December 31, 2026.

[27] https://innovation.cms.gov/initiatives/bpci-advanced

[28] https://innovation.cms.gov/initiatives/md-tccm/

3.9 Vermont All-Payer Model

The Vermont All-Payer ACO Model is CMS's test of an APM in which the most significant payers throughout the entire State—Medicare, Medicaid, and commercial health care payers—incent health care value and quality. The focus is on health outcomes, under the same payment structure for the majority of providers throughout the State's care delivery system to transform health care for the entire State and its population.[29]

The Vermont All-Payer ACO Model offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the State. Participation by providers and other payers in the Vermont All-Payer ACO Model will be voluntary. In addition to providing $9.5 million in start-up investment to assist Vermont providers with care coordination and bolster their collaboration with community-based providers, CMS also approved a five-year extension of Vermont's section 1115(a) Medicaid demonstration, which enables Medicaid to be a full partner in the Vermont All-Payer ACO Model. Under the Vermont All-Payer ACO Model, the State commits to achieving statewide health outcomes, as well as financial and ACO scale targets across all significant health care payers. CMS and Vermont expect to work closely together to achieve success.

The Vermont All-Payer ACO Model began on January 1, 2017, and will conclude on December 31, 2022. There will be six performance years, each spanning a full calendar year. Beginning in 2019, the Vermont All-Payer ACO Model offered ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the State, the Vermont Medicare ACO Initiative.

Section 4: New APM Scoring Standard for the Quality Performance Category

In performance year 2020, there are substantive changes to the APM Scoring Standard for MIPS APMs, particularly for APMs that do not require their participants to submit data through a MIPS system.

Rationale for Change

For the past few years, CMS had in place a policy to reweight the Quality performance category to zero percent in cases where an APM has no measures available to score for the Quality performance category for a MIPS performance period, for example, if none of the APM's measures would be reported on in time to be available for calculating a Quality performance category score by the close of the MIPS submission period. After several years of implementation of the APM Scoring Standard, CMS found that for participants in certain MIPS APMs, it often is not operationally possible to collect and score performance data on APM quality measures for purposes of MIPS because these APMs run on episodic or yearly timelines that do not align with the MIPS performance periods and deadlines for data submission, scoring, and performance feedback.[30] In fact, for the past two performance years, OCM was the only

[29] https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/

[30] https://www.federalregister.gov/d/2019-24086/p-4122

MIPS APM besides the Medicare Shared Savings Program and Next Generation ACO Model able to be scored under the APM Scoring Standard; the Quality performance category for all other MIPS APMs was reweighted to zero. Although CMS anticipated different scenarios for which quality would need to be reweighted, the Quality performance category was not intended to be reweighted regularly or for a significant number of APMs.

4.1 Performance Year 2020 APM Scoring Standard for the Quality Performance Category

To achieve the aims of the APM Scoring Standard, CMS is implementing for performance year 2020 a new approach to Quality performance category scoring for these APMs. The new APM Scoring Standard Methodology for the Quality performance category has three components:[31]

- Requiring MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures;
- Allowing reporting on quality measure performance through MIPS at the APM Entity level; and
- Providing an APM Quality Reporting Credit.

Under this new scoring standard, MIPS APMs are defined into two categories:[32]

1. MIPS APMs that require APM Entities to submit quality data through a MIPS submission mechanism (such as the Web Interface); and
2. MIPS APMs that do not require APM Entities to submit quality data through a MIPS submission mechanism.

4.1.1 MIPS APMs that Require APM Entities to Submit Quality Data through a MIPS Submission Mechanism

For APM Entities which are required under the terms of their APM participation agreement to report quality measures performance data through a MIPS submission mechanism, CMS will use that quality data to calculate an APM Entity level score for the Quality performance category. There are six submission mechanisms, or collection types, for quality measures:

- CMS Web Interface Measures (for groups with 25 or more clinicians);
- Electronic Clinical Quality Measures (eCQMs);
- MIPS CQMs (formerly "Registry measures");
- Qualified Clinical Data Registry (QCDR) Measures;
- Medicare Part B claims measures; and
- The CAHPS for MIPS survey (for groups with 25 or more clinicians).[33]

[31] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/594/2020%20QPP%20Proposed%20Rule%20Fact%20Sheet.pdf

[32] https://www.federalregister.gov/d/2019-24086/p-5986

[33] https://www.federalregister.gov/d/2018-24170/p-6107

In Performance Year 2020, only Medicare Shared Savings Program entities, and Next Generation ACO entities, fit into this category, as their MIPS APMs require them to submit data through the CMS Web Interface.

4.1.2 MIPS APMs that Do Not Require APM Entities to Submit Quality Data through a MIPS Submission Mechanism

For MIPS APMs that do not require reporting through any of the above MIPS submission mechanisms as part of their participation agreement, CMS will require MIPS eligible clinicians or APM Entities to separately report on MIPS quality measures through one of the submission mechanisms above. In addition, they will be eligible for a 50 percent APM Quality Reporting Credit.[34] APM Entities, or MIPS eligible clinicians reporting in a group TIN or as individual NPIs can submit to the MIPS Quality performance category, using the following types of quality measures to assess performance in the Quality performance category:[35]

1. Measures included in the MIPS final list of quality measures established by CMS through rulemaking;
2. QCDR measures approved by CMS under 42 CFR 414.1400; and
3. Facility-based measures described in 42 CFR 414.1380.

All MIPS measures are detailed in the Quality Payment Program Resource Library. The current list of 268 measures can be filtered by measure type, specialty, and submission/collection mechanism.[36] For groups with 25 or more clinicians, they can choose to submit the CAHPS for MIPS survey measure.[37] Likewise, groups with 25 or more clinicians may choose to report quality data through the CMS Web Interface for a sample of their beneficiaries, but they must report on all ten measures under this submission mechanism for performance year 2020.

For 2020, the Quality performance category is the full calendar year (January 1 through December 31). Participants must collect measure data for the 12-month performance period (January 1 - December 31, 2019). For all submission types except the CMS Web Interface and the CAHPS for MIPS survey, participants will need to submit collected data for at least six measures or a complete specialty measure set; one of these measures must be an outcome measure (except that if no outcome measures are applicable, then another high priority measure can be submitted instead). An individual or group can submit any combination of measures across these collection types to fulfill the six-measure requirement. If an entity, a group, or an individual submit more than the required six measures, then the Quality performance category score will be calculated using the six highest measure scores. In addition, for practices of 16 or more clinicians who meet the case minimum of 200, the administrative

[34] https://www.federalregister.gov/d/2019-24086/p-5988

[35] https://www.federalregister.gov/d/2018-24170/p-6114

[36] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures

[37] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/mips

claims-based all-cause readmission measure will be automatically scored as a seventh measure.[38]

4.2 Quality Performance Category Scoring

For all MIPS APMs, quality scoring based on the performance of submitted data is composed of five scoring concepts:

1. Quality benchmarks;
2. Quality measures achievement points;
3. Quality measures bonus points;
4. Quality improvement score, if applicable; and
5. Quality reporting credit, if applicable.

4.2.1 Benchmarks

Under the APM Scoring Standard, CMS will use performance benchmarks, where available, to evaluate quality measure performance.[39] In particular, for MIPS APMs reporting via the CMS Web Interface, CMS will use the benchmarks from the corresponding reporting year as calculated by the Shared Savings Program.[40] For MIPS APMs that submit quality data via other MIPS mechanisms, CMS will use MIPS benchmarks.

Quality measure benchmarks are defined as decile breakpoints in the performance rating distribution for a given measure, performance year, and by submission mechanism. Thus, a given set of benchmarks will be distinct to the measure, performance year, and submission mechanism.

4.2.2 Achievement Points

MIPS eligible clinicians receive between 3 and 10 measure achievement points (including partial points) for each measure submitted that has a benchmark, meets the case minimum requirement[41], and meets the data completeness requirement. The exceptions follow:

1. Each submitted CMS Web Interface-based measure that meets the data completeness requirement but that does not have a benchmark, fails to meet the case minimum requirement, or is redesignated as pay-for-reporting for all Shared Savings Program ACOs by the Shared Savings Program, will be excluded from a MIPS eligible clinician's total measure achievement points and total available measure achievement points.[42] MIPS eligible clinicians will receive zero measure

[38] https://www.federalregister.gov/d/2017-24067/p-1766

[39] https://www.federalregister.gov/d/2019-24086/p-5996

[40] https://www.federalregister.gov/d/2018-24170/p-6213

[41] Except for the all-cause hospital readmission measure, the minimum case requirement is 20 cases. For the all-cause hospital readmission measure, the minimum case requirement is 200 cases.

[42] https://www.federalregister.gov/d/2018-24170/p-6204

achievement points for each submitted CMS Web Interface-based measure that does not meet the data completeness requirement, described below.[43]

2. Each administrative claims-based measure that does not have a benchmark or meet the case minimum requirement will be excluded from a MIPS eligible clinician's total measure achievement points and total available measure achievement points.[44]
3. MIPS eligible clinicians other than those in small practices (15 or fewer MIPS eligible clinicians) receive zero measure achievement points if they do not meet the data completeness requirement. Small practices will continue to receive three measure achievement points in these circumstances.[45]

The minimum number of required measures to be reported is either at least six measures or the number of measures required to complete CMS Web Interface reporting. The number of measure achievement points received is determined based on the applicable benchmark decile category and the percentile distribution. Measures that fall within the 10th decile earn the maximum 10.0 points with no partial points. Measures that do not meet the data completeness requirement or measures for which performance was not reported at the entity, TIN, or individual level will receive a score of zero.[46]

Note that data completeness is described as follows:

1. MIPS eligible clinicians and groups submitting quality measures data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least 70 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer, for the MIPS performance year 2020 (MIPS payment year 2022).[47]
2. MIPS eligible clinicians and groups submitting quality measure data on Medicare Part B claims measures must submit data on at least 70 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for the MIPS performance year 2020 (MIPS payment year 2022).[48]

[43] https://www.federalregister.gov/d/2018-24170/p-6210

[44] https://www.federalregister.gov/d/2018-24170/p-6205

[45] https://www.federalregister.gov/d/2018-24170/p-6209

[46] https://www.federalregister.gov/d/2018-24170/p-6210

[47] https://www.federalregister.gov/d/2019-24086/p-5965

[48] https://www.federalregister.gov/d/2019-24086/p-5967

3. Groups submitting quality measures data on CMS Web Interface measures or the CAHPS for MIPS survey must submit data on the sample of the Medicare Part B patients CMS provides, as applicable. For CMS Web Interface measures, the group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module. If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries.[49]

4.2.3 Bonus Points in the Quality Performance Category

Measure bonus points are available in the Quality performance category in three ways:

1. High-priority measures. A high-priority measure is defined as an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. Outcome measures include intermediate-outcome and patient-reported outcome measures. Measure bonus points are not available for the first reported outcome measure, which is required to be reported. Outcome and patient experience measures receive two measure bonus points. Other high-priority measures receive one measure bonus point. Note that if no outcome measures are available, then one high-priority measure is required, and thus one bonus point will be awarded for each additional high-priority measure reported beyond the first required high-priority measure.

   To qualify for measure bonus points, each measure must:
   - Meet the required case minimum;
   - Meet the data completeness criteria; and
   - Have a performance rate that is greater than zero.[50,51]

   Measure bonus points may be included in the calculation of the Quality performance category percent score regardless of whether the measure is included in the calculation of the total measure achievement point. However, measure bonus points for high-priority measures cannot exceed 10 percent of the total available measure achievement points for performance year 2020 (2022 MIPS payment year).
   Note that MIPS eligible clinicians do not receive high-priority bonus points for CMS Web Interface measures.[52] Also, MIPS eligible clinicians who collect data on a single measure via multiple collection types receive measure bonus points only once.[53]

[49] https://www.federalregister.gov/d/2018-24170/p-6133

[50] https://www.federalregister.gov/d/2019-24086/p-6001

[51] For any high-priority measures that are inverse measures, the requirement becomes “not have a 100 percent performance rate.”

[52] https://www.federalregister.gov/d/2018-24170/p-6219

[53] https://www.federalregister.gov/d/2018-24170/p-6222

2. CEHRT end-to-end electronic reporting. One measure bonus point is also available for each measure submitted with end-to-end electronic reporting for a quality measure under certain criteria determined by the Secretary.[54] CEHRT bonus points cannot exceed 10 percent of the total available measure achievement points for the 2020 performance year (2022 MIPS payment year). If the same measure is submitted via two or more submission mechanisms, the measure will receive measure bonus points only once.
3. Small practices. A small practice is defined as a group consisting of 15 or fewer MIPS eligible clinicians during the MIPS determination period. As they did in the 2019 performance year, in the 2020 performance year (2022 MIPS payment year), MIPS eligible clinicians in small practices will receive six measure bonus points if they submit data to MIPS on at least one quality measure.[55]APM Entity

Any bonus points earned by an APM Entity that reports more than the minimum number of measures required will be awarded even if the measure is be scored for achievement points. Bonus points will be accrued only at the level at which the quality measure performance is reported: if quality measure performance is reported by an individual or TIN, then bonus points will be considered at that level before calculating the APM Entity's Quality performance category score. Alternately, if quality measure performance is reported at the APM Entity level, then CMS would continue to apply any bonuses or adjustments that are available to MIPS groups for the measures reported by the APM Entity and to calculate the applicability of these adjustments at the APM Entity level.

4.2.4 Quality Improvement Score

CMS began to calculate a quality improvement score for the APM Entity beginning in 2018.[56] The improvement score is assessed at the entity level for the Quality performance category.[57] To be eligible for the quality improvement score, data must be comparable to meet the requirement of data sufficiency, which means that:

- The Quality performance category achievement percent score is available for the current performance period and the previous performance period and Quality performance category achievement percent scores can be compared.
- The Quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods.

[54] https://www.federalregister.gov/d/2018-24170/p-6223

[55] https://www.federalregister.gov/d/2018-24170/p-6226

[56] https://www.federalregister.gov/d/2018-24170/p-6227

[57] https://www.federalregister.gov/d/2018-24170/p-6234

If the identifier is not the same for two consecutive performance periods for an APM Entity, the comparable Quality performance category achievement percent score is the average of the Quality performance category achievement percent scores associated with the final score from the prior performance period that was used for payment for each of the individuals in the APM Entity.

The improvement score is awarded based on the rate of increase in the Quality performance category achievement percent score, which does not include measure bonus points, from the previous performance period to the current performance period. In particular, this score is calculated by dividing the increase in the Quality performance category achievement percent score from the prior performance period to the current performance period by the prior performance period Quality performance category achievement percent score multiplied by 10 percent. The improvement score may not total more than 10 percentage points and cannot be lower than zero percentage points.

For the 2020 performance year (2022 MIPS payment year), if an APM Entity has a previous year Quality performance category achievement percent score less than or equal to 30 percent, then the 2020 performance will be compared to an assumed 2019 Quality performance category achievement percent score of 30 percent.[58]

4.2.5 The APM Quality Reporting Credit

As stated above, for MIPS APMs that do not require their APM Entities to submit quality data through a MIPS submission mechanism, CMS will apply a score of 50 percent, also called an "APM Quality Reporting Credit," under the MIPS Quality performance category. Beginning with performance year 2020 (MIPS payment year 2022), CMS is implementing a policy where APM Entities participating in certain MIPS APMs receive a minimum score of one-half of the highest potential score for the Quality performance category.[59] As such, beginning with the 2020 MIPS performance period, APM Entities participating in certain MIPS APMs will receive a minimum score of one-half of the highest potential score (half of 100 percent = 50 percent) for the Quality performance category.

CMS would not apply the APM Quality Reporting Credit to the APM Entity's Quality performance category score for those APM Entities reporting only through a MIPS quality reporting mechanism according to the requirements of their APM. This is the case even if the APM Entity (*e.g.,* Shared Savings Program ACO) failed to report on the required quality measures in the CMS Web Interface, and the individual eligible clinicians and TINs that make up that APM Entity reported quality measures to MIPS for purposes of calculating a MIPS Quality performance category score. In these cases, because no burden of duplicative reporting would exist, they would remain ineligible for the APM Quality Reporting Credit.[60]

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[58] https://www.federalregister.gov/d/2019-24086/p-amd-85

[59] Finalized in https://www.federalregister.gov/d/2019-24086/p-4139

[60] https://www.federalregister.gov/d/2019-24086/p-4152

4.2.6 Total Quality Performance Category Score

The total Quality performance category percent score is calculated differently for MIPS APMs reporting at the APM Entity level and MIPS APMs reporting at the TIN or NPI level.

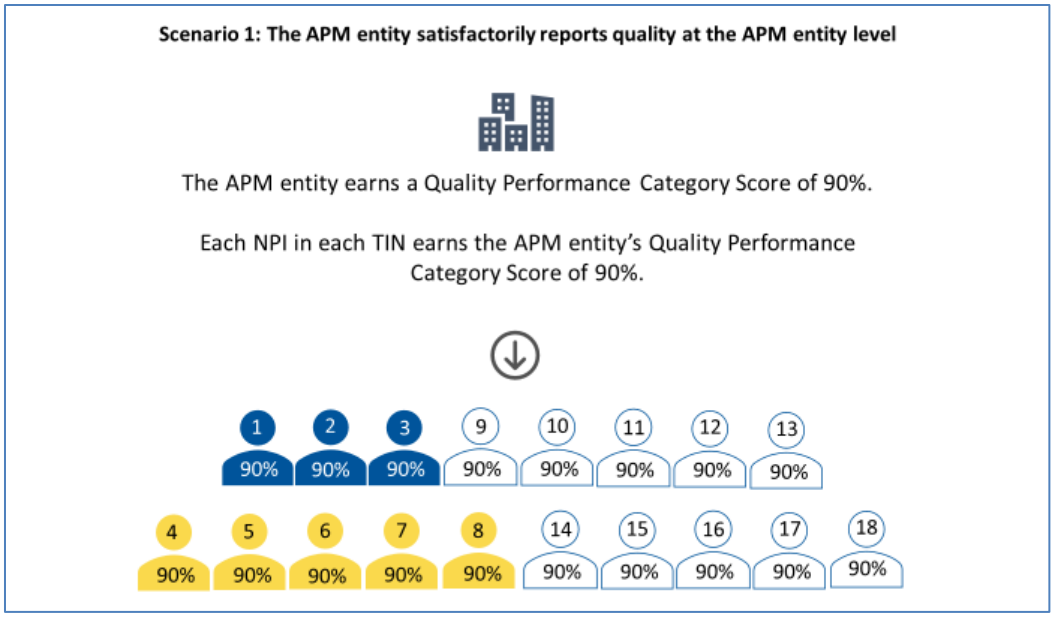
4.2.6.1 Total Quality Performance Category Score for MIPS APMs Reporting at the APM Entity Level

For MIPS APMs reporting quality at the APM Entity level, the total Quality performance category percent score is generated by first summing achievement points and any applicable bonus points earned by the entity. This sum is then divided by the total number of available achievement points, multiplied by 100 percent, and added to the quality improvement score. MIPS APMs that do not require reporting through MIPS submission mechanisms are eligible for the quality reporting credit, which adds 50 percent to the total sum. The total Quality performance category score is capped at 100 percent.

> *Quality performance category percent score = [(total measure achievement points + measure bonus points)/total available measure achievement points x 100%] + quality improvement score + 50% quality reporting credit (if applicable)*

Figure 1 provides an example of this scenario, assuming the APM Entity earned a quality achievement score of 40 percent, and was eligible to receive the 50 percent quality reporting credit, for a Quality Performance Category Score of 90 percent.

Figure 1. Quality Performance Category Scoring for MIPS APM Reporting at the APM Entity Level



4.2.6.2 Total Quality Performance Category Score for MIPS APMs reporting at the TIN or NPI level

Similar to the approach for the Promoting Interoperability performance category, MIPS eligible clinicians in MIPS APMs can receive a score for the Quality performance category either through individual NPI or TIN-level reporting. Under this approach (where the APM Entity does not satisfactorily report quality at the APM Entity level), CMS will attribute one quality score to each MIPS eligible clinician in an APM Entity by looking at both individual NPI- and TIN-level data submitted for the eligible clinician and then using the higher score.[61] The APM Entity score is then calculated as the average of the scores for each MIPS eligible clinician in the APM Entity. Note that CMS will use only scores reported by an individual MIPS eligible clinician or a TIN reporting as a group, and will not accept virtual group level reporting.[62]

Regardless of whether quality measure performance is reported at the TIN or NPI level, the number of available achievement points is the number of measures required by the submission type that meet the criteria for scoring, multiplied by 10. Bonus points for CEHRT reporting and bonus points for reporting high priority measures are each capped at 10 percent of the total available measure achievement points; the quality improvement score is capped at 10 percent of the total Quality performance category percent score. MIPS APMs that do not require reporting through MIPS submission mechanisms are eligible for the quality reporting credit, which adds 50 percent to the total score. The total Quality performance category score is capped at 100 percent.

Quality performance category percent score = ∑ [(total measure achievement points + measure bonus points) / total available measure achievement points x 100%] / number of attributed ECs + quality improvement score + 50% quality reporting credit (if applicable)

Figures 2a through 2e provide an example of how Quality performance category scores are rolled up from NPIs or TINs to the APM Entity level when an APM Entity does not report at the APM Entity level. For illustration purpose, these are the Quality performance category scores before the 50 percent eligible APM reporting is applied to the entire APM Entity.

[61] https://www.federalregister.gov/d/2019-24086/p-5989

[62] https://www.federalregister.gov/d/2019-24086/p-5984

Figure 2a shows an APM Entity comprised of three TINs, with TIN A comprising of three MIPS eligible clinicians identified as NPI 1, 2, and 3; TIN B comprising of five MIPS eligible clinicians identified as NPI 4 through 8; and TIN C comprising of 10 MIPS eligible clinicians identified as NPI 9 through 18.

Figure 2a. The APM Entity is Comprised of TINs and NPIs within Each TIN

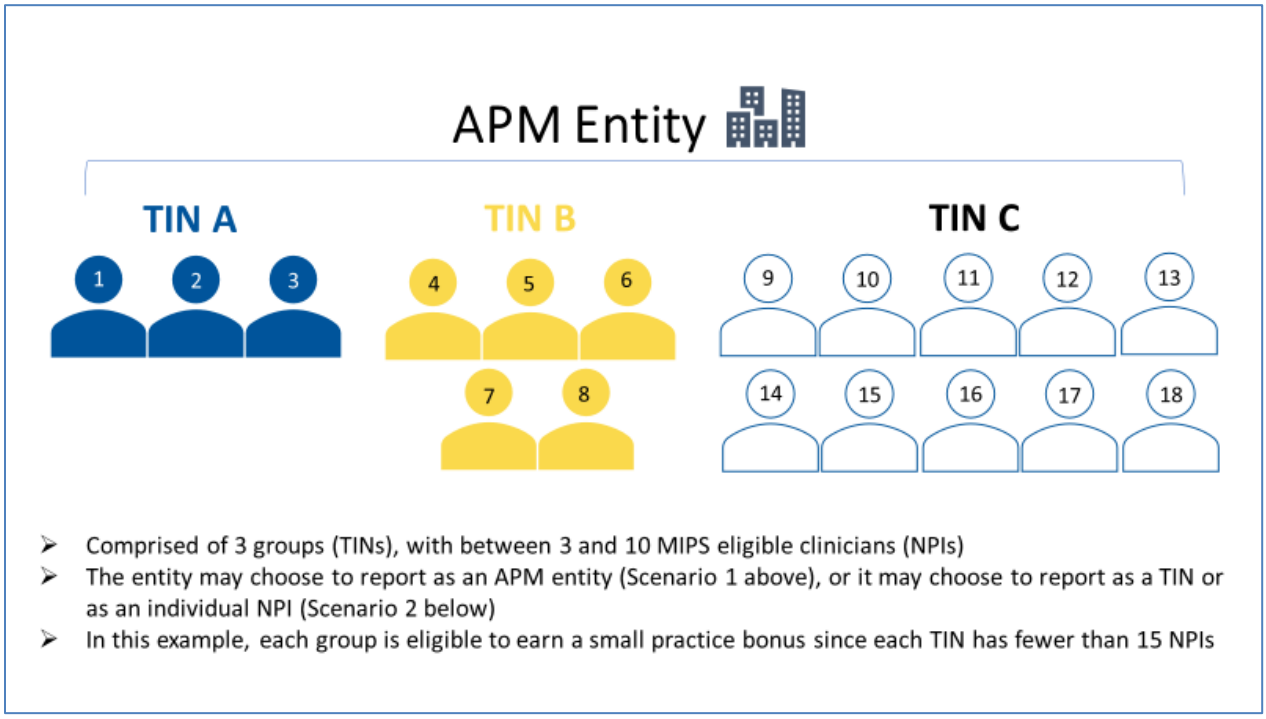


Figure 2b shows the quality performance for each NPI under TIN A. Here, we assume that TIN A reported as a TIN, and earned 76 percent for each of its three NPIs after accounting for achievement and bonus points. Therefore, NPIs 1, 2, and 3 each will contribute 76 percent to the entity score.

Figure 2b. Performance Scoring for NPIs within TIN A

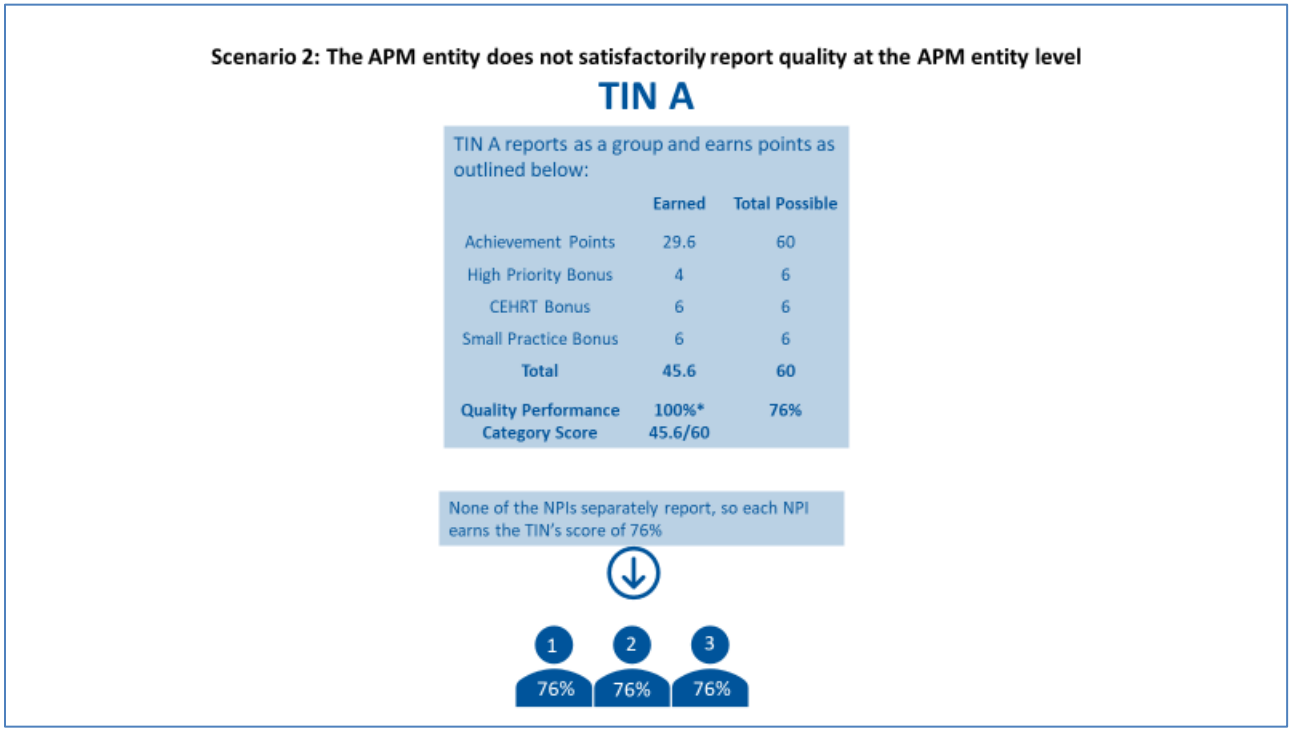


Figure 2c shows the quality performance for each NPI under TIN B. TIN B also reported as a group and earned 70 percent as a group after accounting for achievement and bonus points. However, NPI 7 within TIN B also reported individually, and earned a higher performance score of 88 percent compared to their colleagues. NPIs 4, 5, 6, and 8 will contribute their 70 percent to the entity score while NPI 7 will contribute their earned 88 percent to the entity score.

Figure 2c. Performance Scoring for NPIs within TIN B

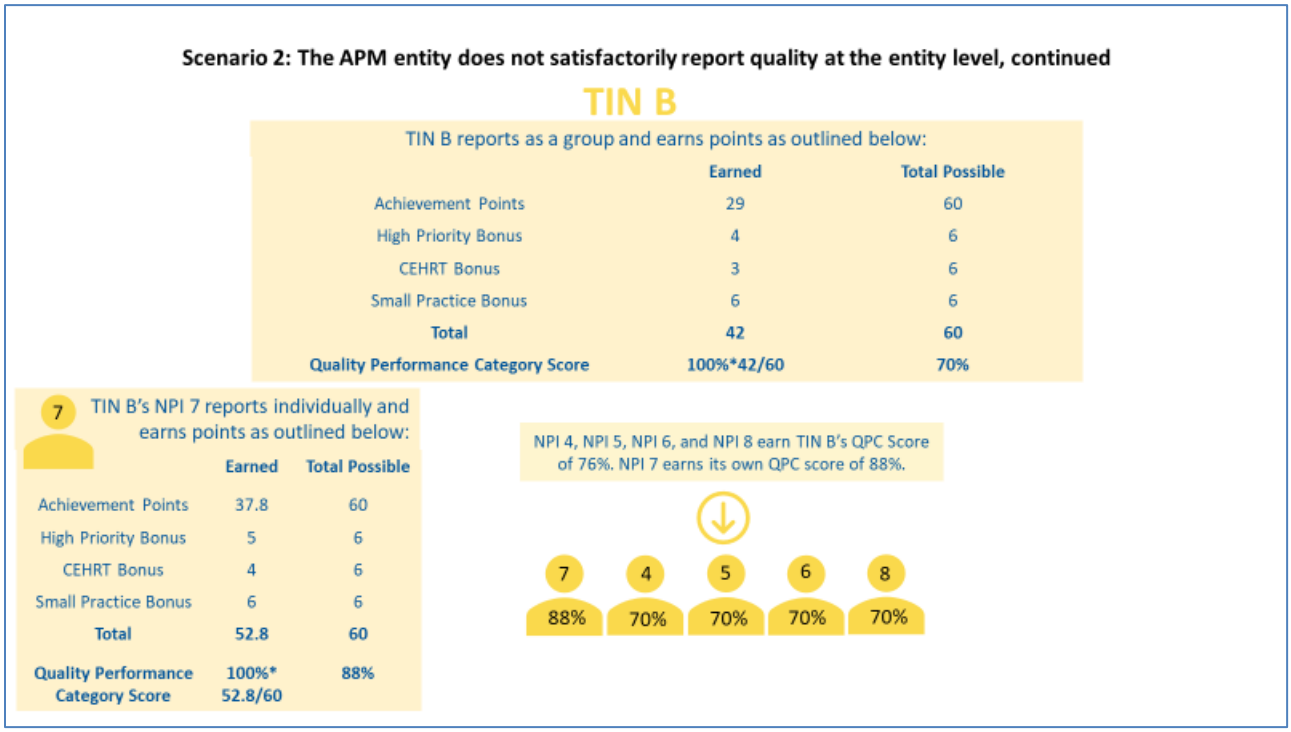
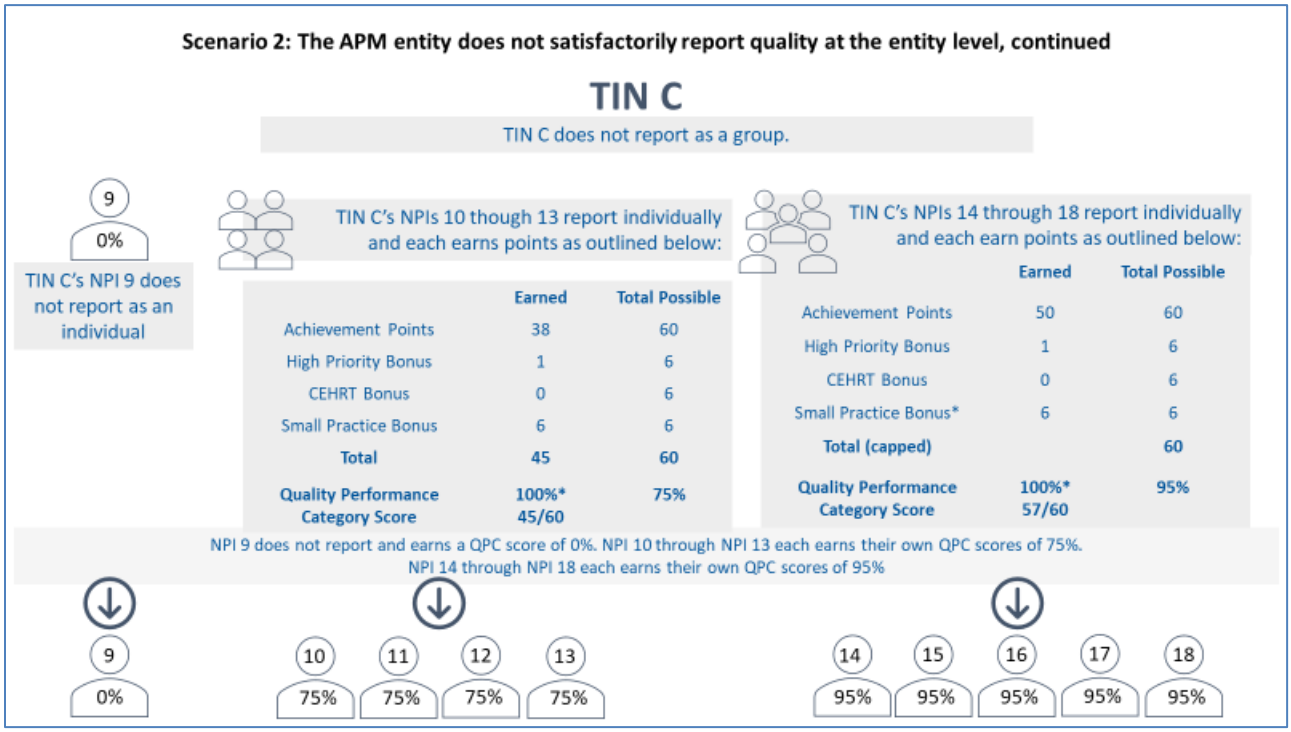


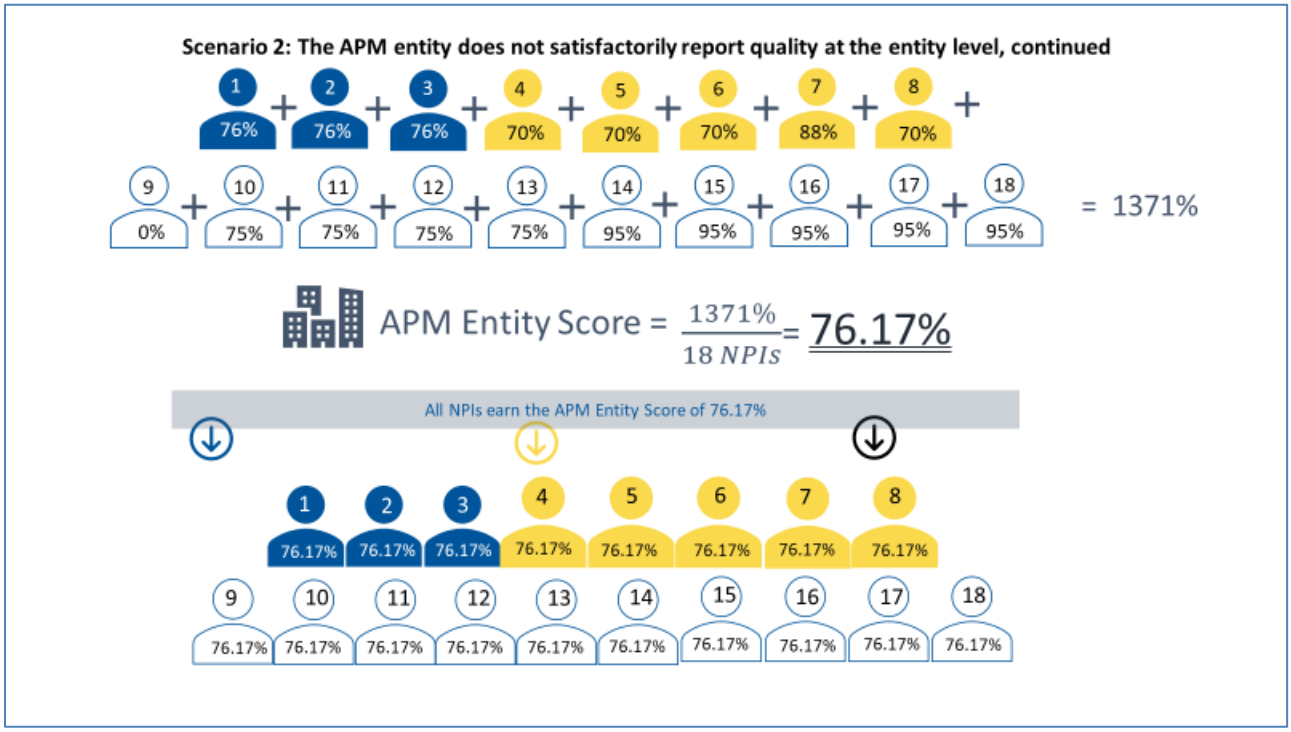
Figure 2d shows the quality performance for each NPI under TIN C. TIN C chose not to report as a group TIN, and each of its ten eligible clinicians, except one, reported individually to MIPS and earned achievement and bonus points accordingly. In this example, NPI 9 did not report to MIPS and earned zero percent. NPIs 10 through 13 reported individually and each earned 75 percent. NPIs 14 through 18 performed even better and each earned 95 percent. Each of these NPIs will contribute their individual score to the roll up to the APM Entity level.

Figure 2d. Performance Scoring for NPIs within TIN C



As with Promoting Interoperability performance category scoring, each MIPS eligible clinician in the APM Entity would receive one score, weighted equally with that of the other MIPS eligible clinicians in the APM Entity, and CMS would calculate one Quality performance category score for the entire APM Entity. In this example **(Figure 2e),** this APM Entity's score is 76.17 percent, which is the average performance rate across the 18 NPIs in the three TINs it contains. Note that this is the Quality performance category score before any applicable quality improvement score or quality reporting bonus are applied and capped at 100 percent. Note that if a MIPS eligible clinician has no Quality performance category score—if the individual's TIN did not report and the individual did not report—that MIPS eligible clinician would contribute a score of zero to the aggregate APM Entity score, as in the case of NPI 9 above.

Figure 2e. The Quality Scores are Summed and Averaged Across all NPIs to Generate the APM Entity Score



4.3 Quality Performance Category Reporting and Scoring

4.3.1 Mandatory Quality Reporting via the CMS Web Interface

- Medicare Shared Savings Program and Next Generation ACO entities must report through the CMS Web Interface.
- ACO entities must also report on the CAHPS for ACO survey.
- For all entities submitting through the CMS Web Interface, the maximum number of points for each measure submitted, assuming complete reporting, is 10 points. The eight Web Interface measures designated as pay-for-performance all have benchmarks in 2020 (which allows the measures to be scored), the total number of possible points for CMS Web Interface reporters under the APM Scoring Standard is 80 points for this category (*i.e.,* this is the "denominator" from which the 10 percent cap for bonus points is calculated).
    - Because the CAHPS for ACO measure is required by Medicare Shared Savings Program and Next Generation ACO, the total number of possible points for entities participating in these programs is 90.
    - For entities that have 16 or more clinicians and meet the minimum case size of 200, CMS will also calculate their readmission measure performance rate, thus the total number of possible points will increase by another 10 points to be 100.
- High-priority bonus points:
    - There are no high-priority bonus points for CMS Web Interface measures. However, Medicare Shared Savings Program and Next Generation ACO APM Entities will be eligible to receive two high-priority patient experience bonus points for reporting the CAHPS for ACO measure.
- CEHRT bonus points:
    - Submitters will need to demonstrate end-to-end reporting via CEHRT to earn one bonus point for each measure.
- Small practice bonus points:
    - If a group qualifies as a small practice (15 or fewer MIPS eligible clinicians), then MIPS eligible clinicians in these small practices will receive six measure bonus points if they submit data to MIPS on at least one quality measure.[63]

[63] https://www.federalregister.gov/d/2018-24170/p-6226

Table 2 shows the set of quality measures accepted for submission via the CMS Web Interface in performance year 2020.[64] This is the set of measures from which the Quality performance category score will be calculated for MIPS APM Entities reporting quality performance through the CMS Web Interface.

Table 2. CMS Web Interface Quality Measures for APM Scoring

Quality ID	Measure Title	Measure Description	Submission Mechanism
318 (CARE-2)	Falls: Screening for Future Falls	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	CMS Web Interface
110 (PREV-7)	Preventive Care and Screening: Influenza Immunization	**Preventive Care and Screening:** **Influenza Immunization:** Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	CMS Web Interface
226 (PREV-10)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**Preventive Care and Screening:** **Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	CMS Web Interface
134 (PREV-12)	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	CMS Web Interface
113 (PREV-6)	Colorectal Cancer Screening	**Colorectal Cancer Screening:** Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	CMS Web Interface

[64] https://www.federalregister.gov/d/2019-24086/p-3064

Updated 12/10/2020

Table 2. CMS Web Interface Quality Measures for APM Scoring *(continued)*

Quality ID	Measure Title	Measure Description	Submission Mechanism
112 (PREV-5)	Breast Cancer Screening	**Breast Cancer Screening:** Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	CMS Web Interface
1 (DM-2)	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18–75 years of age with diabetes who had HbA1c >9.0% during the measurement period.	CMS Web Interface
236 (HTN-2)	Hypertension: Controlling High Blood Pressure	**Controlling High Blood Pressure:** Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period.	CMS Web Interface
370 (MH-1)	Depression Remission at 12 Months	**Depression Remission at 12 Months:** Patients aged 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at 12 months (+/− 30 days after an index visit) defined as a PHQ-9 score lower than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	CMS Web Interface
438 (PREV-13)	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients— all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥190 mg/dL; OR Adults aged 40–75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL	CMS Web Interface

4.3.2 Optional Quality Reporting via the CMS Web Interface

- Though the Web Interface is used to measure primary care, all MIPS APM Entities with 25 or more MIPS eligible clinicians have the option to use the CMS Web Interface for Quality performance category reporting.
- MIPS APM Entities with 25 or more eligible clinicians have the option to submit the CAHPS for MIPS survey, but it is not required.
- For all APM Entities and groups submitting through the CMS Web Interface, the maximum number points for each measure submitted, assuming complete reporting, is 10 points. The eight Web Interface measures designated as pay-for-performance all have benchmarks in 2020 (which allows the measures to be scored), the total number of possible points for CMS Web Interface reporters under the APM Scoring Standard is 80 points for this category (i.e., this is the "denominator" from which the 10 percent cap for bonus points is calculated).
    - For entities and groups that also submit the CAHPS for MIPS measure, the total number of possible points for these entities is 90.
    - For entities and groups that have 16 or more clinicians and meet the minimum case size of 200, CMS will also calculate their readmission measure performance rate, thus the total number of possible points will increase by another 10 points to be 100.
- High-priority bonus points:
    - There are no high-priority bonus points for CMS Web Interface measures. However, APM Entities and groups will be eligible to receive two high priority patient experience bonus points for reporting the CAHPS for MIPS measure, if applicable.
- CEHRT bonus points:
    - Submitters will need to demonstrate end-to-end reporting via CEHRT to earn one bonus point for each measure.
- Small practice bonus points:
    - Because small practice is defined as a group consisting of 15 or fewer MIPS eligible clinicians during the MIPS determination period, and the CMS Web Interface can be used only for practices with at least 25 such clinicians, any TIN or APM Entity that would be eligible to submit to the CMS Web Interface would not qualify as a small practice.

4.3.3 Quality Measure Performance Reporting via Other Submission Mechanisms

- MIPS APM Entities and groups have a plethora of quality metrics from which to select the six required measures. CMS provides details and specifications for these quality metrics in the QPP Resource Library and specifies the submission mechanism(s) for each metric.
- The maximum number points for each measure submitted, assuming complete reporting, is 10 points. Given that there are six required measures under APM Scoring Standard (if the CMS Web Interface is not selected), the total number of possible points is 60 points for this category (*i.e.*, this is the "denominator" from which the 10 percent cap for bonus points is calculated).
    - The CAHPS for MIPS measure, if submitted, will be considered as one of the six required measures, and the total number of possible points for these entities remains at 60.
    - For entities and groups that have 16 or more clinicians and meet the minimum case size of 200, CMS will also calculate their readmission measure performance rate; the readmission measure will be considered an automatic seventh measure, and the total number of possible points will increase by another 10 points to be 70.
- High-priority bonus points:
    - High-priority designations, if applicable, are listed along with the measure details on the QPP Resource Library website.
- CEHRT bonus points:
    - Submitters will need to demonstrate end-to-end reporting via CEHRT to earn one bonus point for each measure.
- Small practice bonus points:
    - As implemented in the 2019 performance year, for the 2020 performance year (MIPS payment year 2022), APM Entities, groups, or MIPS eligible clinicians designated as small practices receive six measure bonus points if they submit data to MIPS on at least one quality measure.[65] The small practice designation is based on the total size of the APM Entity. A small practice is defined as a group consisting of 15 or fewer eligible clinicians during the MIPS determination period.

[65] https://www.federalregister.gov/d/2018-24170/p-6226

4.3.4 Example Performance Category Score Calculations and Scenarios

Examples of these APM Quality performance category scoring calculations for MIPS APMs are shown below. Each table displays possible achievement points for each measure, under both a maximum points scenario and a more realistic "real-world" performance scoring scenario for the purpose of illustration. The calculations of the Quality performance category score are then shown by rolling up the achievement points with any bonus points, quality improvement score, and quality reporting credit, and weighting the final score by the weight of the category (50 percent).

- **Table 3** and **Table 4** provide detailed examples of the Quality performance category score calculation under the APM Scoring Standard for MIPS APMs that report quality at the APM Entity level through the CMS Web Interface.
    - **Table 3** reflects the scoring standard for entities that are required by their MIPS APM to submit through the CMS Web Interface (*e.g.*, ACOs), and
    - **Table 4** reflects the scoring standard for APM Entities that are not required by their MIPS APM to submit through the CMS Web Interface but that choose todo so.
- **Table 5** displays different possible scoring scenarios based on a set of MIPS measures selected when quality measure performance is reported at the entity level through a submission mechanism other than the Web Interface. It provides the maximum points possible, a hypothetical more realistic "real-world" performance scoring scenario, and a minimum points scenario for illustration purpose.

Table 3. MIPS APM Quality Performance Category Percentage Score Calculation for Entities that Must Submit Through the CMS Web Interface (Medicare Shared Savings Program and NGACO)

Quality ID	Measure Title	High Priority Measure? (# bonus points)	Eligible for end to end CEHRT Bonus?	Benchmark Available?	MIPS APM Web Interface Reporting Max. Points Scenario		MIPS APM Web Interface Reporting Hypothetical Scenario*	
					Scored?	Achievement Points Earned	Scored?	Achievement Points Earned
318	Falls: Screening for Future Falls	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
110	Preventive Care and Screening: Influenza Immunization	No	Yes	Yes	Yes	10.0	Yes	5.4
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	No	Yes	Yes	Yes	10.0	Yes	5.4
113	Colorectal Cancer Screening	No	Yes	Yes	Yes	10.0	Yes	5.4
112	Breast Cancer Screening	No	Yes	Yes	Yes	10.0	Yes	5.4
1	Hemoglobin A1c (HbA1c) Poor Control (>9%)	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
236	Hypertension: Controlling High Blood Pressure	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
370	Depression Remission at 12 Months	Yes (0 points**)	Yes	No	No	N/A	No	N/A
438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	No	Yes	No	No	N/A	No	N/A
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	No	Yes	No	No	N/A	No	N/A
Composite	CAHPS for ACO	Yes (2 points; patient experience)	No	Yes	Yes	10.0	Yes	5.4

N/A = not applicable

* For ease of illustration, we assume that this CMS Web Interface submitting APM entity receives 5.4 out of 10 achievement points for each eligible measure in this hypothetical but more realistic scenario.

** Per regulations, "beginning with the 2021 MIPS payment year, MIPS eligible clinicians do not receive such [high priority] measure bonus points for CMS Web Interface measures"; CAHPS for ACO measure is eligible for 2 high priority bonus points.

Updated 12/10/2020

Table 3. MIPS APM Quality Performance Category Percentage Score Calculation for Entities that Must Submit Through the CMS Web Interface (Medicare Shared Savings Program and NGACO) *(continued)*

	MIPS APM Web Interface Reporting Max. Points Scenario		MIPS APM Web Interface Reporting Hypothetical Scenario*	
		Achievement Points Earned		Achievement Points Earned
(A) Total Possible Measure Achievement Points[a]		80		80
(B) Earned Measure Achievement Points[b]		**80.0**		**43.2**
(C) Earned High Priority Bonus Points		2		2
(D) Earned CEHRT Bonus Points[c,d]		8		8
(E) Total Bonus Points[e] = [(C)+(D)]		**10**		**10**
Total Earned Quality Performance Category points = [(B)+(E)]		90.0		53.2
(F) Quality Performance Category Achievement Score = [[(B)+(E)]/(A)*100%]		112.5000%		66.5000%
(G) Quality Performance Category Improvement Score[f]		10.0000%		10.0000%
(H) APM Quality Reporting Credit[g]		N/A		N/A
(I) Total Quality Performance Category Percent Score[h] = [(F)+(G)+(H)]		**100.0000%**		**76.5000%**
(J) Weight of the Quality Performance Category		0.5		0.5
Total Quality Performance Category Percent Score Toward Final Score = [(J)*(I)]		**50.0000%**		**38.2500%**

N/A = not applicable

* For ease of illustration, we assume that this CMS Web Interface submitting APM Entity receives 5.4 out of 10 achievement points for each eligible measure in this hypothetical but more realistic scenario.

[a] Assumes the 20-case minimum has been met and benchmarks are available.

[b] Assumes data completeness requirements have been met; for the maximum points scenario, assumes a maximum score of 10 on all measures.

[c] CEHRT bonus points are capped at 10% of the Total Possible Measure Achievement Points (A).

[d] Assuming end-to-end CEHRT reporting for all ten eligible measures; CAHPS is not eligible for CEHRT submission.

[e] Small practices may be eligible for an additional six bonus points; assuming not a small practice for this example.

[f] Assumes the maximum Quality Performance Category Improvement Score of 10%.

[g] NGACO, VT ACO and MSSP entities are required to report quality measure performance through a MIPS submission mechanism as part of APM participation and are thus ineligible for the APM reporting credit.

[h] Total Quality Performance Category Percent Score is capped at 100 percent. These values are expressed to the fourth decimal place.

Updated 12/10/2020

Table 4. MIPS APM Quality Performance Category Percentage Score Calculation for Entities that Choose to Submit Through the CMS Web Interface

Quality ID	Measure Title	High Priority Measure? (# bonus points)	Eligible for end to end CEHRT Bonus?	Benchmark Available?	MIPS APM Web Interface Reporting Max. Points Scenario		MIPS APM Web Interface Reporting Hypothetical Scenario*	
					Scored?	Achievement Points Earned	Scored?	Achievement Points Earned
318	Falls: Screening for Future Falls	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
110	Preventive Care and Screening: Influenza Immunization	No	Yes	Yes	Yes	10.0	Yes	5.4
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	No	Yes	Yes	Yes	10.0	Yes	5.4
113	Colorectal Cancer Screening	No	Yes	Yes	Yes	10.0	Yes	5.4
112	Breast Cancer Screening	No	Yes	Yes	Yes	10.0	Yes	5.4
1	Hemoglobin A1c (HbA1c) Poor Control (>9%)	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
236	Hypertension: Controlling High Blood Pressure	Yes (0 points**)	Yes	Yes	Yes	10.0	Yes	5.4
370	Depression Remission at 12 Months	Yes (0 points**)	Yes	No	No	N/A	No	N/A
438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	No	Yes	No	No	N/A	No	N/A
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	No	Yes	No	No	N/A	No	N/A
321	CAHPS for MIPS	Yes (2 points; patient experience)	No	Yes	Yes	10.0	No***	N/A

N/A = not applicable

* For ease of illustration, we assume that this CMS Web Interface submitting APM Entity receives 5.4 out of 10 achievement points for each eligible measure in this hypothetical but more realistic scenario.

** Web Interface measures are ineligible for high priority bonus points.

*** Under the hypothetical scenario, we assume the APM Entity did not choose to participate in the CAHPS for MIPS measure.

**** To be eligible to submit through the CMS Web Interface, the MIPS APM Entity must have at least 25 providers, which means it will surpass the minimum 16 providers required for the readmission measure to be automatically calculated, and this measure will be included assuming it meets the case minimum of 200.

Updated 12/10/2020

Table 4. MIPS APM Quality Performance Category Percentage Score Calculation for Entities that Choose to Submit Through the CMS Web Interface *(continued)*

	MIPS APM Web Interface Reporting Max. Points Scenario		MIPS APM Web Interface Reporting Hypothetical Scenario*	
		Achievement Points Earned		Achievement Points Earned
(A) Total Possible Measure Achievement Points[a]		80		70
(B) Earned Measure Achievement Points[b]		**80.0**		**37.8**
(C) Earned High Priority Bonus Points		2		N/A
(D) Earned CEHRT Bonus Points[c,d]		8		7
(E) Total Bonus Points[e] = [(C)+(D)]		**10**		**7**
Total Earned Quality Performance Category points = [(B)+(E)]		90.0		44.8
(F) Quality Performance Category Achievement Score = [[(B)+(E)]/(A)*100%]		112.5000%		64.0000%
(G) Quality Performance Category Improvement Score[f]		10.0000%		10.0000%
(H) APM Quality Reporting Credit[g]		50%		50%
(I) Total Quality Performance Category Percent Score[h] = [(F)+(G)+(H)]		**100.0000%**		**100.0000%**
(J) Weight of the Quality Performance Category		0.5		0.5
Total Quality Performance Category Percent Score Toward Final Score = [(J)*(I)]		**50.0000%**		**50.0000%**

N/A = not applicable

[a] Assumes the 20-case minimum has been met and benchmarks are available.

[b] Assumes data completeness requirements have been met; for the maximum points scenario, assumes a maximum score of 10 on all measures.

[c] Web Interface measures are ineligible for high priority bonus points through MIPS.

[d] CEHRT bonus points are capped at 10% of the Total Possible Measure Achievement Points (A). Assuming end-to-end CEHRT reporting for all ten eligible measures; CAHPS is not eligible for CEHRT submission.

[e] Small practices may be eligible for an additional six bonus points; assuming not a small practice for this example.

[f] Assumes the maximum Quality Performance Category Improvement Score of 10 percent.

[g] Assumes entity not required to report quality measure performance through a MIPS submission mechanism as part of APM participation.

[h] Total Quality Performance Category Percent Score is capped at 100 percent. These values are expressed to the fourth decimal place.

Updated 12/10/2020

Table 5. MIPS APM Quality Performance Category Percentage Score Calculation for Quality Data Submitted Through Other MIPS Mechanisms

Measure Title (Example measures selected for illustration purpose only)	High Priority Measure? (# bonus points)	Eligible for end to end CEHRT Bonus? (collection type)	Benchmark Available?	MIPS APM Max. Points Scenario		MIPS APM Hypothetical Points Scenario		MIPS APM Minimum Points Scenario	
				Scored?	Potential Achievement Points	Scored?	Potential Achievement Points	Scored?	Potential Achievement Points
Depression Remission at 12 Months	Yes (0 pt; first reported outcome)	Yes (eCQM)	Yes	Yes	10	Yes	3.5	Did not submit	0
CAHPS for MIPS	Yes (2 pt; patient experience)	No (CAHPS for MIPS)	Yes	Yes	10	Yes	4	Did not submit	0
Advance Care Plan	Yes (1 pt; care coordination)	No (Medicare Part B claims)	Yes	Yes	10	Yes	3 pt-floor	Did not submit	0
Use of High-Risk Medications in the Elderly	Yes (1 pt; patient safety)	Yes (eCQM)	Yes	Yes	10	Yes	4	Did not submit	0
Controlling High Blood Pressure	Yes (2 pt; outcome)	Yes (QCDR)	Yes	Yes	10	Did not submit	0	Did not submit	0
Breast Cancer Screening	No	No, (Medicare Part B claims)	Yes	Yes	10	Not needed (lowest score)	3 pt-floor	Did not submit	0
HIV screening	No	Yes (eCQM)	Yes	Not needed*	0	Yes	4.4	Did not submit	0
Pneumococcal Vaccination Status for Older Adults	No	No (Medicare Part B claims)	Yes	Not needed*	0	Yes	3.5	Did not submit	0
All-cause readmission**	No (calculated by CMS)	No	Yes	Yes	10	No	N/A	No	N/A

(continued)

*The minimum requirement of six submitted measures already met.
**For the maximum points scenario, we assume the entity has 16 or more clinicians and meet the case minimum of 200, so this claims-based all-cause readmission measure will be automatically scored as a seventh measure; for the hypothetical and minimum points scenario, we assume the entity does not meet the provider or case size minimums and this measure is removed from calculations.

Updated 12/10/2020

Table 5. MIPS APM Quality Performance Category Percentage Score Calculation for Quality Data Submitted Through Other MIPS Mechanisms *(continued)*

	MIPS APM Max. Points Scenario		MIPS APM Hypothetical Points Scenario		MIPS APM Minimum Points Scenario	
		Achievement Points Earned		Achievement Points Earned		Achievement Points Earned
(A) Total Possible Measure Achievement Points[a]		70		60		60
(B) Earned Measure Achievement Points[b]		**70.0**		**22.4**		**0**
(C) Earned High Priority Bonus Points[c]		6		4		0
(D) Earned CEHRT Bonus Points[c,d]		4		3		0
(E) Total Bonus Points[e] = [(C)+(D)]		**10**		**7**		**0**
(F) Total Earned MIPS Measure Points = [(B)+(E)]		80.0		29.4		0
(G) Quality Performance Category Achievement Score = [[(B)+(E)]/(A)*100%]		114.2857%		49.0000%		0.0000%
(H) Quality Performance Category Improvement Score[f]		10.0000%		0.0000%		-
(I) APM Quality Reporting Credit[g]		50.0000%		50.0000%		50.0000%
(J) Total Quality Performance Category Percent Score[h] = [(G)+(H)+(I)]		**100.0000%**		**99.0000%**		**50.0000%**
(K) Weight of the Quality Performance Category in Performance Year 2020		0.50		0.50		0.50
Total Quality Performance Category Points Toward Final MIPS Score = [(J)*(K)]		**50.0000%**		**49.5000%**		**25.0000%**

[a] Assumes the 20-case minimum has been met and benchmarks are available.
[b] Assumes data completeness requirements have been met; for the maximum points scenario, assumes a maximum score of 10 on all measures; only the best six measure achievement scores are used in the calculation.
[c] High priority and CEHRT bonus points are separately capped at 10 percent of the Total Possible Measure Achievement Points (A).
[d] Assumes successful end-to-end CEHRT reporting for all eligible measures submitted by APM Entities.
[e] Small practices may be eligible for an additional six bonus points; assuming not a small practice for this example.
[f] Assumes the maximum Quality Performance Category Improvement Score of 10 percent for the maximum scenario and 0 percent for the hypothetical scenario; the Improvement Score does not apply in the last scenario where no MIPS measures were submitted.
[g] Assumes entity not required to report quality measure performance through a MIPS submission mechanism as part of APM participation.
[h] Total Quality Performance Category Percent Score is capped at 100 percent. These values are expressed to the fourth decimal place.

Updated 12/10/2020

Version History

Date	Change Description
12/10/2020	Removed Vermont all-payer ACO Model entities under section 4.1.1 - MIPS APMs that Require APM Entities to Submit Quality Data through a MIPS Submission Mechanism.
10/6/2020	Updated Tables 3 and 4 to reflect change in measure 134: Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan. This measure is pay-for-reporting and, therefore, does not have a benchmark. For purposes of MIPS, this measure is excluded from scoring for the 2020 performance year as long as data completeness requirements are met.
5/18/2020	Original posting

Updated 12/10/2020