Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Alternative Payment Model (APM) Performance Pathway (APP) Scoring Guide for the 2022 Performance Year

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

How to Use This Guide

How to Use This Guide

Please Note: This guide provides a general summary about scoring for the Alternative Payment Model (APM) Performance Pathway (APP). It is for informational purposes only and does not intend to grant rights, impose obligations, or take the place of either the statute or regulations. We urge you to review the specific statutes, regulations, and other relevant materials for their complete and accurate contents. **This guide does not review reporting requirements or scoring policies for traditional Merit-based Incentive Payment System (MIPS).**

In this guide, we often use the term "individual" to refer to a MIPS eligible clinician participating in the program as an individual.

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Overview

Medicare Shared Savings Program Quality Extreme and Uncontrollable Circumstances Policy

The Shared Savings Program Quality Extreme and Uncontrollable Circumstances (EUC) policy for determining shared savings and losses applies to all Shared Savings Program ACOs for performance year 2022.

CMS considers all ACOs to be affected by the COVID-19 PHE and the Shared Savings Program EUC policy applies for performance year 2022. ACOs that are able to report quality data via the APM Performance Pathway (APP) and meet MIPS data completeness and case minimum requirements will receive the higher of their ACO quality score or the 30th percentile MIPS quality performance category score. ACOs that are unable to report quality data via the APP and meet the MIPS quality data completeness and case minimum requirements, will have their quality score set equal to the 30th percentile MIPS quality performance category score.

Please note that Shared Savings Program Quality EUC policy doesn't affect MIPS payment adjustments or reporting requirements for MIPS eligible clinicians in the ACO. However, ACO officials can submit a MIPS EUC application for performance year 2022 through March 3, 2023, on behalf of the MIPS eligible clinicians in the ACO.

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides 2 participation tracks:

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

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

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

What is the Alternative Payment Model (APM) Performance Pathway (APP)?

The APP is a MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs. To view the list of MIPS APMs, please go to the 2021 and 2022 Comprehensive List of APMs (PDF).

- Please note that all Shared Savings Program Accountable Care Organizations (ACOs) are required to report their quality data via the APP.

The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. Performance is measured across 3 areas and accounts for the following percentages of the MIPS final score for MIPS APM participants reporting through the APP: quality (50%), improvement activities (20%), and Promoting Interoperability (30%).

- All MIPS APM participants who report through the APP in 2022 will automatically receive 100% for the improvement activities performance category score.

- In addition, under the APP, the cost performance category is weighted at 0% of the MIPS final score, because all MIPS APM participants are already responsible for costs under their APMs.

With the exception of Shared Savings Program ACOs, the APP is an optional MIPS reporting and scoring pathway for MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the 4 snapshot dates (March 31, June 30, August 31, and December 31) during a performance period.

Who Can Report via the APP?

The APP can be reported by MIPS eligible individuals or groups that participate in MIPS APMs, or by APM Entities on behalf of their MIPS eligible clinicians. Virtual groups aren't eligible to report via the APP.

Accountable Care Organizations (ACOs) participating in the Shared Savings Program are required to report via the APP for the purpose of assessing their quality performance for that program.

- If an ACO reports via the APP, then the ACO participants don't have to report quality separately to MIPS.
- If an ACO fails to report via the APP, or if a MIPS eligible clinician or group finds it is in their best interest to report separately, MIPS eligible clinicians in the ACO could report outside the ACO via the APP or a different MIPS reporting option, at the group or individual eligible clinician level. An ACO that fails to report via the APP wouldn't meet the Shared Savings Program quality performance standard.[1]

Your final score determines whether you will receive a positive, neutral, or negative MIPS payment adjustment. The Centers for Medicare & Medicaid Services (CMS) will award the highest available score. For example, if your APM Entity reports via the APP and your group reports under traditional MIPS, you'll receive whichever of the 2 scores is higher.[2]

[1] Starting in 2021, the APP will be required for all Shared Savings Program ACOs. All quality data reported via the APP will be used to calculate the ACOs' MIPS Quality performance category scores, and quality measure scores between MIPS and Shared Savings Program will be identical.

[2] If you participate in a virtual group, you will receive a final score based on the performance of the virtual group, even if you have a higher score through another means of participation.

Getting Started: Reviewing MIPS Terms

Collection Type*

- **Collection Type** refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data. The following collection types apply to APP reporting:
  - Electronic clinical quality measures (eCQMs).
  - MIPS clinical quality measures (MIPS CQMs).
  - Medicare Part B Claims measures (available only to individuals, groups and APM Entities with the small practices designation).
  - CMS Web Interface measures (available only to Shared Savings Program ACOs).
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (required for groups and APM Entities with 2 or more clinicians).
- Appendix D explains each of these collection types in further detail.

* The term "Collection Type" is unique to the Quality performance category and doesn't apply to the other performance categories.

Getting Started: Reviewing MIPS Terms (Continued)

Submitter Type

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

Submission Type

- **Submission Type** is the mechanism by which the submitter type submits data to CMS:
  - Direct (transmitting data through a computer-to-computer interaction, such as an Application Programming Interface, or API).
  - Sign in and upload (attaching a file).
  - Sign in and attest (manually entering data).
  - Medicare Part B Claims.
  - CMS Web Interface.

APP: Quality Performance Category

APP: Quality Performance Category

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What Are the Quality Performance Category Data Submission Requirements Under the APP?

Individual MIPS eligible clinicians, groups, and APM entities reporting the APP must submit 3 specific quality measures (as eCQMs, MIPS CQMs, or Medicare Part B claims measures) and groups and APM Entities are required to administer the CAHPS for MIPS Survey. In addition, there are 2 administrative claims measures that we'll automatically calculate for you.

Quality

50% of MIPS Score

Option 1: Quality Measures Set

Quality ID: 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Quality ID: 134** Preventive Care and Screening: Screening for Depression and Follow-up Plan	Quality ID: 236** Controlling High Blood Pressure	Quality ID: 321 CAHPS for MIPS (Groups and APM entities only)	Measure #479 Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Measure #484 Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
Collection Type: • eCQM • MIPS CQM • Medicare Part B Claims*	**Collection Type:** • eCQM • MIPS CQM • Medicare Part B Claims*	**Collection Type:** • eCQM • MIPS CQM • Medicare Part B Claims*	**Collection Type:** • CAHPS for MIPS Survey	**Collection Type:** • Administrative Claims	**Collection Type:** • Administrative Claims
Submitter Type: • MIPS EC • Representative of a Practice • APM Entity • Third Party Intermediary	**Submitter Type:** • MIPS EC • Representative of a Practice • APM Entity • Third Party Intermediary	**Submitter Type:** • MIPS EC • Representative of a Practice • APM Entity • Third Party Intermediary	**Submitter Type:** • Third Party Intermediary (CMS-Approved Survey Vendor)	**Submitter Type:** • N/A	**Submitter Type:** • N/A

*Medicare Part B claims measures can only be reported by individuals, groups or APM Entities with a small practice designation.

** Please see slide 14 for additional information

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UPDATE: 01/25/2023

We recently announced via QPP listserv a number of quality measures significantly impacted by International Classification of Diseases, Tenth Revision (ICD-10) updates mid-performance period. ICD-10 code updates are effective annually on October 1, but quality measure specifications can't be updated until the next MIPS program year. (Download this fact sheet to learn more.)

If a MIPS quality measure is impacted by 10% or more ICD-10 code changes, the measure will be truncated to the first 9 months of the 12-month performance period. However, we determined that the burden for electronic health record (EHR) developers would be prohibitive to truncating the data for the 2022 performance period and it wouldn't be feasible to collect 9 consecutive months of data for electronic clinical quality measures (eCQMs); therefore, impacted eCQMs will be suppressed instead of truncated.

Two of the APP quality measures were significantly impacted when reporting as a MIPS CQM, Medicare Part B claims measure and/or eCQM. **These measures are unaffected if reported by a Shared Savings Program ACO through the CMS Web Interface.**

Quality ID: 134
Preventive Care and Screening: Screening for Depression and Follow-up Plan

- When reporting this measure as a **MIPS CQM**, your submission should only reflect measure data from January 1, 2022 to September 30, 2022. The measure will be scored against its benchmark provided the measure meets data completeness and case minimum requirements.
- When reporting this measure as an **eCQM**, you must still meet data completeness and case minimum requirements. The measure will be excluded from scoring, and your quality denominator will be reduced by 10 points. **Please note you must submit the measure to receive the denominator reduction.**
- **Small practices reporting this measure through Medicare Part B claims:** we'll truncate the measure data for you.

Quality ID: 236
Controlling High Blood Pressure

- When reporting this measure as an **eCQM**, you must still meet data completeness and case minimum requirements. The measure will be excluded from scoring, and your quality denominator will be reduced by 10 points. **Please note you must submit the measure to receive the denominator reduction.**

The **MIPS CQM and Medicare Part B claims measure** specifications for this measure didn't meet the 10% impact threshold above and should be reported for the full 12-month performance period. The measure will be scored against its benchmark provided that the measure meets data completeness and case minimum requirements.

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What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures instead of the 3 eCQMs/MIPS CQMs. Shared Savings Program ACOs that choose to report the CMS Web Interface measures must also administer the CAHPS for MIPS Survey and will be evaluated on 2 administrative claims measures. This alternative measure set is available only to Shared Savings Program ACOs.

Note: As part of the CY 2022 PFS Final Rule, CMS finalized a longer transition for eCQM/CQM measure reporting for Shared Savings Program ACOs, extending the CMS Web Interface as an option through the 2024 performance year.

Option 2: Quality Measures Set (Shared Savings Program ACOs only)

Quality ID: 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (DM-2)	Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan (PREV-12)	Quality ID: 236 Controlling High Blood Pressure (HTN-2)	Quality ID: 318 Falls: Screening for Future Fall Risk (CARE-2)	Quality ID: 110 Preventive Care and Screening: Influenza Immunization (PREV-7)	Quality ID: 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (PREV-10)
Collection Type: • CMS Web Interface	**Collection Type:** • CMS Web Interface	**Collection Type:** • CMS Web Interface	**Collection Type:** • CMS Web Interface	**Collection Type:** • CMS Web Interface	**Collection Type:** • CMS Web Interface
Submitter Type: • APM Entity (ACO) • Third Party Intermediary	**Submitter Type:** • APM Entity (ACO) • Third Party Intermediary	**Submitter Type:** • APM Entity (ACO) • Third Party Intermediary	**Submitter Type:** • APM Entity (ACO) • Third Party Intermediary	**Submitter Type:** • APM Entity (ACO) • Third Party Intermediary	**Submitter Type:** • APM Entity (ACO) • Third Party Intermediary

APP: Quality Performance Category

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What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

Option 2: Quality Measures Set (Shared Savings Program ACOs only) [continued]

Quality ID: 113
Colorectal Cancer Screening (PREV-6)

Collection Type:
- CMS Web Interface

Submitter Type:
- APM Entity (ACO)
- Third Party Intermediary

Quality ID: 112
Breast Cancer Screening (PREV-5)

Collection Type:
- CMS Web Interface

Submitter Type:
- APM Entity (ACO)
- Third Party Intermediary

Quality ID: 438
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (PREV-13)

Collection Type:
- CMS Web Interface

Submitter Type:
- APM Entity (ACO)
- Third Party Intermediary

Quality ID: 370
Depression Remission at Twelve Months (MH-1)

Collection Type:
- CMS Web Interface

Submitter Type:
- APM Entity (ACO)
- Third Party Intermediary

Quality ID: 321
CAHPS for MIPS

Collection Type:
- CAHPS for MIPS Survey

Submitter Type:
- Third Party Intermediary (CMS-approved survey vendor)

Measure #479
Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Collection Type:
- Administrative Claims

Submitter Type:
- N/A

Measure #484
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Collection Type:
- Administrative Claims

Submitter Type:
- N/A

APP: Quality Performance Category

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

What Are the Quality Measure Reporting Requirements for eCQMs, MIPS CQMs, and Medicare Part B Claims Measures?

Quality measures have a 12-month performance period (January 1, 2022 – December 31, 2022). (Exception: Truncated measures have a 9-month performance period. See updated list of truncated measures on slide 14.)

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

To meet **data completeness** requirements, you must identify all of the measure's denominator eligible encounters **and** report performance data for at least 70% of these encounters.

- When reporting eCQMs and MIPS CQMs, your denominator eligible encounters **include your entire patient population**, not just your Medicare patient population.
- Medicare Part B Claims measures can only be reported by individuals, groups, and APM Entities with the small practice designation and are limited to Medicare patients.

Did you know? You can use multiple collection types when reporting Measures 001, 134, and 236. For example, you could report Measure 001 as an eCQM and Measures 134 and 236 as MIPS CQMs.

What Does "Data Completeness" Mean?

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

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

Submitting APP Measures as Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

How are eCQMs, MIPS CQMs, and Medicare Part B Claims Measures Assessed in the Quality Performance Category for the 2022 Performance Year?

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

Benchmarks are differentiated by collection type. Because the 3 APP measures (Quality IDs 001, 134, and 236) can be reported through multiple collection types, different benchmarks will be used for scoring based on whether you report these measures as eCQMs, MIPS CQMs, or Medicare Part B Claims measures (available to small practices only). Are you reporting CMS Web Interface measures? Click here.

Whenever possible, we use historical data to establish benchmarks. Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years before the applicable performance period. The historical benchmarks for the 2022 MIPS performance period were established from quality data submitted for the 2020 MIPS performance period.

Did you know? If you submit eCQMs, you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eCQM data. The CEHRT used to collect the data must meet the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

For more information about the 2022 quality benchmarks, please review the 2022 Quality Benchmarks (ZIP).

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

How Are Measures Scored?

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

- A benchmark is available.
- The volume of cases that you've submitted is sufficient (≥20 cases for most measures).
- You've met data completeness requirements (identified all denominator eligible encounters and submitted performance data for at least 70% of the denominator eligible encounters).

Did you know? In 2020, we established an alternate (flat) benchmarking methodology for scoring the following quality measures when we determine that their historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient:

- Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%); and
- Measure 236, Controlling High Blood Pressure.

- We'll use **flat benchmarks*** to score all collection types for Measure 001, and the Medicare Part B Claims and MIPS CQM collection types for Measure 236.

- As noted on slide 14, we're **suppressing** the eCQM collection type for Measure 236; this measure will be excluded from scoring if submitted.

The 2022 Quality Benchmarks (ZIP) reflect these flat benchmarks.

*In flat percentage benchmarks, any performance rate at or above 90% would be in the top decile, any performance rate between 80% and 89.99% would be in the second highest decile, and so on. (For inverse measures, this would be reversed – any performance rate at or below 10% would be in the top decile, any performance rate between 10.01% and 20% would be in the second highest decile, and so on.)

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Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

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

Measure Achievement Points When Reporting the APP

3-10 points

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

3 points (small practices only)

You'll receive 3 points for measures that don't meet data completeness requirements.

0 (0 out of 10 points)

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

0 (0 out of 10 points)

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

N/A (0 out of 0 points)

You won't be scored on measures without a benchmark or on measures that don't meet the case minimum for scoring, as long as you meet data completeness requirements.

Suppressed measures will also be excluded from scoring when submitted.

APP: Quality Performance Category

01/25/2023: As noted on slide 14, the eCQM collection type for measure 236 has been suppressed for the 2022 performance period and will be excluded from scoring. We've updated this example.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Example: Assigning Measure Achievement Points

You submit Measure 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 1. Find the benchmark based on collection type for the measure.

- Achievement points are determined by mapping the performance rate to the benchmark (ZIP) for the measure, specific to collection type.
- Remember that Measure 236 is scored according to the flat benchmark methodology for Medicare Part B Claims and MIPS CQM, which is reflected in the 2022 Quality Benchmarks (ZIP).

The following extract from the 2022 Quality Benchmarks (ZIP) shows the range of performance rates associated with each decile for each collection type for Measure 236.

Measure Name	Measure ID #	Collection Type	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	Medicare Part B Claims	Intermediate Outcome	Y	20.00 - 29.99	30.00 - 39.99	40.00 - 49.99	50.00 - 59.99	60.00 - 69.99	70.00 - 79.99	80.00 - 89.99	≥ 90.00
Controlling High Blood Pressure	236	MIPS CQM	Intermediate Outcome	Y	20.00 - 29.99	30.00 - 39.99	40.00 - 49.99	50.00 - 59.99	**60.00 - 69.99**	70.00 - 79.99	80.00 - 89.99	≥ 90.00
Controlling High Blood Pressure	236	eCQM	Intermediate Outcome	Y	This measure has been suppressed for PY 2022 and won't be scored against a benchmark.							

APP: Quality Performance Category

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Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Step 2. Calculate achievement points in a decile.

- Determine the decile that the performance rate falls in
- In this case, the measure performance rate is 66.74, which corresponds to Decile 7 (eligible for 7.0 – 7.9 points)

Measure Name	Controlling High Blood Pressure
Measure ID#	236
Collection Type	MIPS CQM
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 3	20.00 – 29.99
Decile 4	30.00 – 39.99
Decile 5	40.00 – 49.99
Decile 6	50.00 – 59.99
Decile 7	**60.00 – 69.99**
Decile 8	70.00 – 79.99
Decile 9	80.00 – 89.99
Decile 10	≥90.00

APP: Quality Performance Category

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Step 3. Apply the following formula based on the measure performance and decile range:

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

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

$$\text{decile \#}\ 7 + \frac{[\,66.74 - 60.00\,]}{[\,70.00 - 60.00\,]} = 0.674\ldots = 7.7$$

...which is rounded to 0.7

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Data Aggregation and Multiple Submissions

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

Let's look at an example:

- You uploaded a file with the 3 eCQMs in January. In February, your electronic health record (EHR) vendor contacts you about a measure calculation issue that they just fixed so you upload a new file with the 3 eCQMs.
- The eCQMs you uploaded in February overwrote the ones you submitted in January.

If you submit the same measure through **multiple collection types** (that is, as a MIPS CQM and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points for 2 collection types for the same measure.

Let's look at an example:

- You're working with a qualified registry to report the 3 APP measures as MIPS CQMs because your certified EHR technology is only coded for Measure 001. Your registry uploads a file of all 3 measures submitted as MIPS CQMs, and you upload a file with Measure 001 submitted as an eCQM.
- When scoring Measure 001, we'll use either the MIPS CQM or eCQM collection type — whichever results in more achievement points based on comparison to its benchmark.

APP: Quality Performance Category

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Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

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

Maximum Points by Reporting Level	
Individuals	• 30 POINTS – For the 3 required quality measures: ○ The CAHPS for MIPS Survey can't be administered for individual clinicians. ○ The Hospital-wide, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure doesn't apply to individual clinicians. ○ Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure doesn't apply to individual clinicians.
Groups and APM Entities	• 60 POINTS – For the 3 required quality measures + CAHPS for MIPS Survey measure + HWR measure + MCC measure
ACOs Reporting eCQMs/MIPS CQMs	• 60 POINTS – For the 3 required quality measures + CAHPS for MIPS Survey measure + HWR measure + MCC measure

Did you know?

- The maximum number of measure points available is different from the quality performance category weight
- The category weight identifies the number of points that the quality performance category can contribute to your MIPS final score.
- The total number of points for the quality performance category will be calculated as a percentage (for example, 55 out of 60 points would be 91.6%) and then multiplied by the category weight of 50% to determine the category's contribution to the final score.
- If you don't submit at least one required APP measure, you will receive zero points in this performance category unless you qualify for the performance category to be reweighted.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Can the Denominator (Maximum Number of Points) Be Lower Than the Maximum Points Available?

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

IF…	THEN…
There's no historical benchmark for one of the required APP measures and we can't calculate one based on data submitted for the performance period…	…we'll lower the denominator by 10 points for each measure without a benchmark.
You don't meet the case minimum for one or more measures…	…we'll lower the denominator by 10 points for each measure for which you don't meet the case minimum but do meet data completeness criteria.
Your group or APM Entity doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey…	…we'll lower the denominator by 10 points to account for your inability to administer the CAHPS for MIPS Survey measure.
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available… **01/25/2023:** See slides 27 - 29 for examples related to measures that were suppressed for the 2022 performance year.	…we'll lower the denominator by 10 points for each impacted measure. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Suppressed and Truncated Measures: Submission and Scoring Examples.

Example 1.

You've collected data for Quality IDs 001, 134 and 236 as eCQMs.

You submit data for Quality ID 001 but don't submit Quality IDs 134 and 236 because they're suppressed.

- **Quality ID 001:** Scored according to the benchmark (provided that data completeness and case minimum requirements are met).
- **Quality IDs 134 and 236:** Receive 0 out of 10 points each because they weren't submitted.
- **Quality denominator:** Not reduced because no suppressed measures were submitted. (i.e., Your denominator would be remain 60 points if you could be scored on the 2 administrative claims measures and met the CAHPS for MIPS Survey patient sampling requirements.)

Example 2.

You submit data for Quality IDs 001, 134 and 236 as eCQMs.

- **Quality ID 001:** Scored according to the benchmark (provided that data completeness and case minimum requirements are met).
- **Quality IDs 134 and 236:** Excluded from scoring because you submitted them as eCQMs.
- **Quality denominator:** Reduced by 20 points. (i.e., Your denominator would be reduced to 40 points if you could be scored on the 2 administrative claims measures and met the CAHPS for MIPS Survey patient sampling requirements.)

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Suppressed and Truncated Measures: Submission and Scoring Examples.

Example 3.

You're working with a qualified registry to report Quality IDs 001, 134 and 236 as MIPS CQMs because your certified EHR technology is only coded for Quality ID 134.

Your registry truncates the performance data, prior to submission, for Quality ID 134 (MIPS CQM) to reflect 9 months of data. (Quality IDs 001 and 236 aren't truncated when reported as MIPS CQMs.)

Your registry submits all 3 measures as MIPS CQMs.

You submit Quality ID 134 as an eCQM.

- **Quality ID 001:** Scored against benchmark (provided that data completeness and case minimum requirements are met).
- **Quality ID 134:** Excluded from scoring. Because you submitted it as an eCQM, you won't be scored on measure 134, even though it was also submitted as a MIPS CQM.
- **Quality ID 236:** Scored against benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Reduced by 10 points. (i.e., Your denominator would be reduced to 50 points if you could be scored on the 2 administrative claims measures and met the CAHPS for MIPS Survey patient sampling requirements.)

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Suppressed and Truncated Measures: Submission and Scoring Examples.

Example 4.

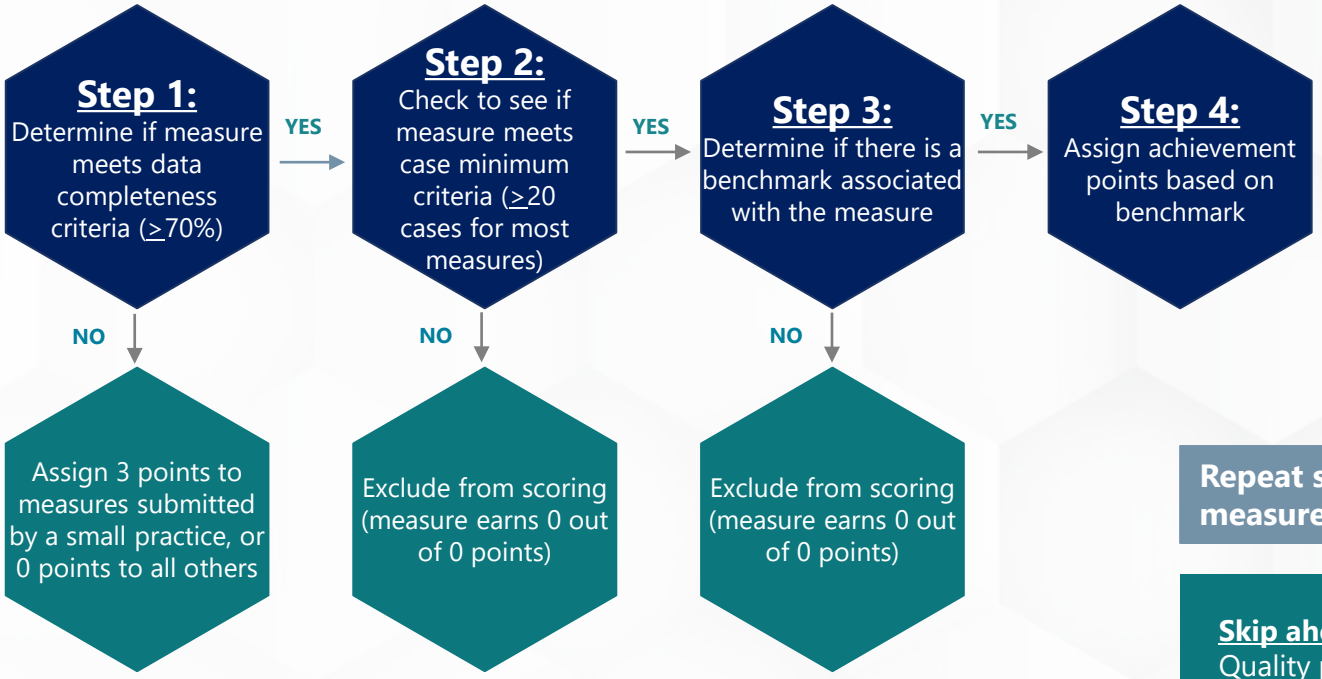
You're working with a qualified registry to report Quality IDs 001, 134 and 236 as MIPS CQMs.

Your registry truncates the performance data, prior to submission, for Quality ID 134 (MIPS CQM) to reflect 9 months of data. (Quality IDs 001 and 236 aren't truncated when reported as MIPS CQMs.)

- **Quality IDs 001, 134, and 236:** Scored according to the benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Not reduced. Submitting a truncated measure doesn't reduce your denominator. (i.e., Your denominator would be remain 60 points if you could be scored on the 2 administrative claims measures and met the CAHPS for MIPS Survey patient sampling requirements.)

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

What Are the Steps for Scoring Medicare Part B Claims measures, eCQMs, and/or MIPS CQMs?



Repeat steps 1-4 for each measure.

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

Submitting CMS Web Interface Measures (Shared Savings Program ACOs only)

How are the CMS Web Interface Measures Assessed in the Quality Performance Category When Reporting via the APP for the 2022 Performance Year?

For the 2022 performance year, only Shared Savings Program ACOs may report CMS Web Interface measures. When you submit data for the 10 required measures through the CMS Web Interface, your performance on each scored measure is assessed against a benchmark to see how many points you earn for the measure. ACOs submitting their quality measures through the CMS Web Interface will be assessed against benchmarks established under the Shared Savings Program. The benchmarks used for the CMS Web Interface are identified in the Performance Year 2022 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs (PDF).

REMINDER: This guide focuses on scoring for the APP and doesn't address scoring policies for traditional MIPS.

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

CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet reporting requirements for such measures.

The following CMS Web Interface measures don't have a benchmark for the 2022 performance year:

- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438)
- Depression Remission at Twelve Months (Quality ID# 370)

A total of 8 CMS Web Interface measures will be scored against a benchmark. In the CY 2023 Medicare Physician Fee Schedule Final Rule, we finalized retroactively setting flat percentage benchmarks to score the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) measure and the Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) measure for the 2022 performance year using our authority under § 1871(e)(1)(A) of the Social Security Act.

Reminder: As part of the 2022 PFS Final Rule, CMS finalized a longer transition for eCQM/CQM measure reporting for Shared Savings Program ACOs by extending the CMS Web Interface as an option through the 2024 performance year.

REMINDER: CMS Web Interface measures aren't affected by the suppression and truncation referenced earlier in this document; only the eCQM and MIPS CQM collection types are affected.

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

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

Please note: The tables below reflect scoring information based on recently finalized policy. The Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule established flat benchmarks for PREV-10 and PREV-12 for the 2022 performance period.

Measure-Level Scoring for CARE-2, HTN-2, PREV-5, PREV-6, PREV-7, PREV-10 and PREV-12.		
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 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

APP: Quality Performance Category

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

Measure achievement points are based on your performance for a measure in comparison to a benchmark, not including bonus points.

Measure Achievement Points

3-10 points

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

0 (0 out of 10 points)

You'll continue to receive 0 points (0 out of 10) for measures that don't meet data completeness requirements. If you don't report a measure without a benchmark, you'll receive a score of zero points and the denominator used to calculate their quality performance category score will increase by 10 points.

N/A (0 out of 0 points)

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

N/A (0 out of 0 points)

You won't be scored on measures without a benchmark as long as you meet data completeness 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**:

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

Submitting CMS Web Interface Measures (Continued)

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

- 80 Points for the 8 scored CMS Web Interface measures + 10 Points for Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure + 10 Points for CAHPS for MIPS Survey measure + 10 Points for HWR Rate for MIPS Eligible Clinician Groups measure for a **total of 110 measure points.**
  - If the ACO doesn't report on a measure without a benchmark (Quality ID #438 or Quality ID #370), the ACO will receive a score of zero points and will result in a denominator increase of 10 points per each unreported measure toward the quality performance category score.
    - Example: The ACO reports the 8 CMS Web Interface measures with a benchmark, earning 10 out of 10 points on each of those measures. The ACO doesn't report the 2 measures without a benchmark, so those measures earn 0 out of 10 points. The ACO also receives 10 out of 10 points for the 2 administrative claims measures and the CAHPS for MIPS Survey measure. The ACO will earn 110 out of 130 measure points.

Did you know?

- The maximum number of measure points available is different from the quality performance category weight
- The category weight is the number of points that the quality performance category can contribute to your MIPS final score.
- The total number of points for the quality performance category will be calculated as a percentage (for example, 99 out of 110 points would be 90%) and then multiplied by the category weight of 50% to determine how many quality points contribute to the final score. Continuing the example, 90% x the 50% performance category weight would result in 45 out of 50 points towards the ACO's final score.

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

Submitting CMS Web Interface Measures (Continued)

Can the Denominator (Maximum Number of Achievement Points) Be Lower or Higher Than 110 Points?

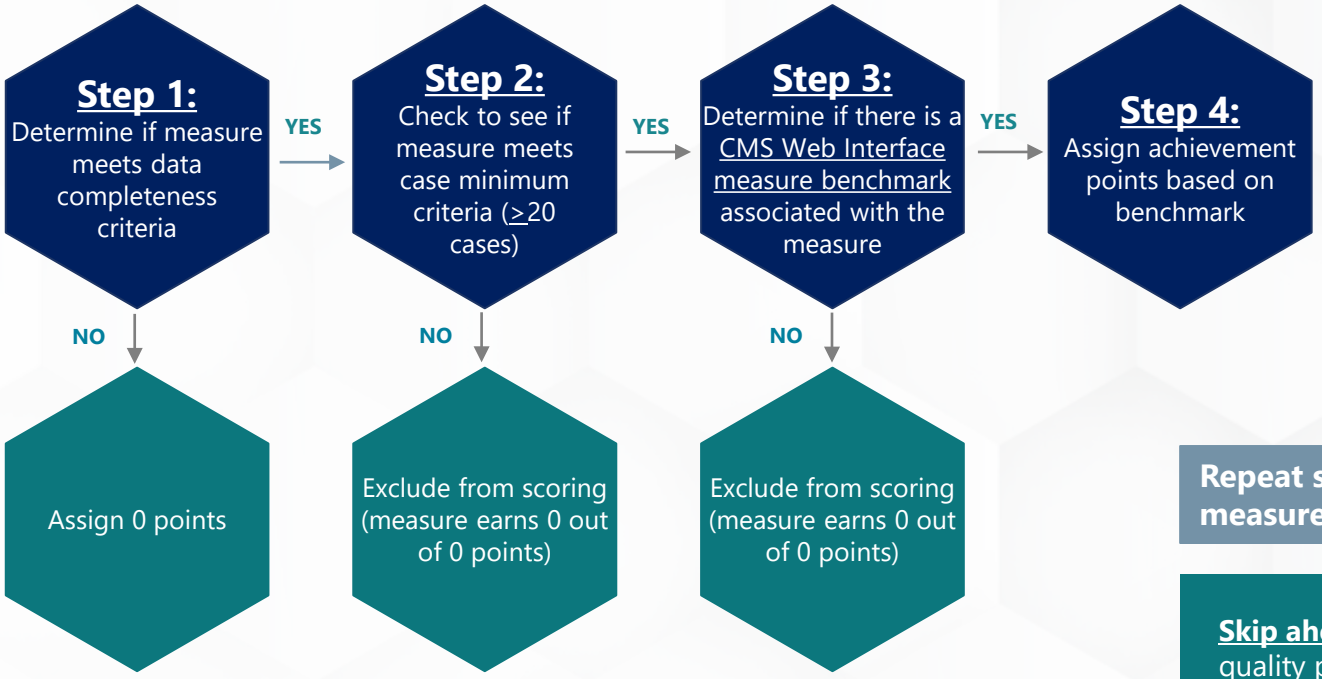
Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower or higher.

IF…	THEN…
The ACO doesn't report a measure without a benchmark…	…we'll increase the denominator by 10 points for each measure without a benchmark that the ACO didn't report.
The ACO doesn't meet the case minimum for one or more measures…	…we'll lower the denominator by 10 points for each measure for which the ACO doesn't meet the case minimum but does meet data completeness criteria.
The ACO doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey…	…we'll lower the denominator by 10 points to account for the ACO's inability to administer the CAHPS for MIPS Survey measure.
A CMS Web Interface measure is determined to be significantly affected by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results, and 9 months of consecutive, reliable data isn't available… **NOTE:** To the extent feasible, we will identify suppressed measures by the beginning of the submission period.	…we'll lower the denominator by 10 points for each affected measure. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.

Quality Payment PROGRAM

Submitting CMS Web Interface Measures (Continued)

What Are the Steps for Scoring CMS Web Interface Measures?



Repeat steps 1-4 for each measure.

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

APP: Quality Performance Category

CAHPS for MIPS Survey

Groups and APM Entities reporting the APP are required to administer the CAHPS for MIPS Survey. Because they're required to report the APP, Shared Savings Program ACOs are automatically registered but groups and non-ACO APM Entities who choose to report the APP must register.

CAHPS for MIPS Survey Measure Scoring and Benchmarks

We established a benchmark for individual summary survey measures (SSMs) in the CAHPS for MIPS Survey measure. These benchmarks were calculated using historical data from the 2019 performance period. Each SSM is awarded 3 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey measure score is calculated by the average number of points across all scored SSMs. Please review the 2022 historical CAHPS for MIPS benchmarks in the 2022 Quality Benchmarks (ZIP).

NOTE: If your group, virtual group, or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements, we'll exclude the measure from scoring.

Administrative Claims Measures

Two of the MIPS quality measures required by the APP will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- Hospital-wide, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure.
  - This measure has a case minimum of 200 cases and will apply to groups and APM Entities with at least 16 clinicians.
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
  - This measure has a case minimum of 18 cases and will apply to groups and APM Entities with at least 16 clinicians.

Administrative Claims Measure Benchmarks

For the Hospital-wide, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure and Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure, we intend to calculate performance period benchmarks for the 2022 performance period.

APP: Quality Performance Category

Quality Payment PROGRAM

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, and APM Entities

We use the following formula to calculate a quality score for individuals, groups, and APM entities that aren't a small practice:

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points / Total Available Measure Achievement Points*) + Improvement Score

A total of 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least one quality measure. (These bonus points are available to small practices through individual, group, and APM Entity participation.)

Your quality performance category score is then multiplied by the 50% quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

We use the following formula to calculate a quality score for individuals, groups, and APM entities with the small practice designation:

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points + Small Practice Bonus (6 points)) / Total Available Measure Achievement Points* + Improvement Score

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

What Happens If a Shared Savings Program ACO Reports CMS Web Interface Measures and eCQMs/MIPS CQMs?

We would calculate scores for each measure set — one score for the 3 eCQMs/MIPS CQMs and one score for the 10 CMS Web Interface measures — and use whichever measure set resulted in the higher score for MIPS scoring.

Calculating the Quality Performance Category Score (Continued)

What Is Improvement Scoring?

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

CMS determines eligibility for these additional percentage points when MIPS eligible clinicians meet the following criteria:

1. **Full participation in the quality category for the current performance period:**
   - Submits a complete set of APP measures.
   - All submitted measures must meet data completeness requirements.
2. **Data sufficiency standard is met — that is, data is available and can be compared:**
   - There is a quality performance category achievement score (the score earned by measures based on performance, excluding bonus points) for the previous performance period (2021 performance period) and the current performance period (2022 performance period).
   - Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did you know?

- Improvement scoring isn't available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately before the current MIPS performance period.
- **Reminder:** Facility-based measurement wasn't available in the 2021 performance period and won't be available in the 2022 performance period.

APP: Quality Performance Category

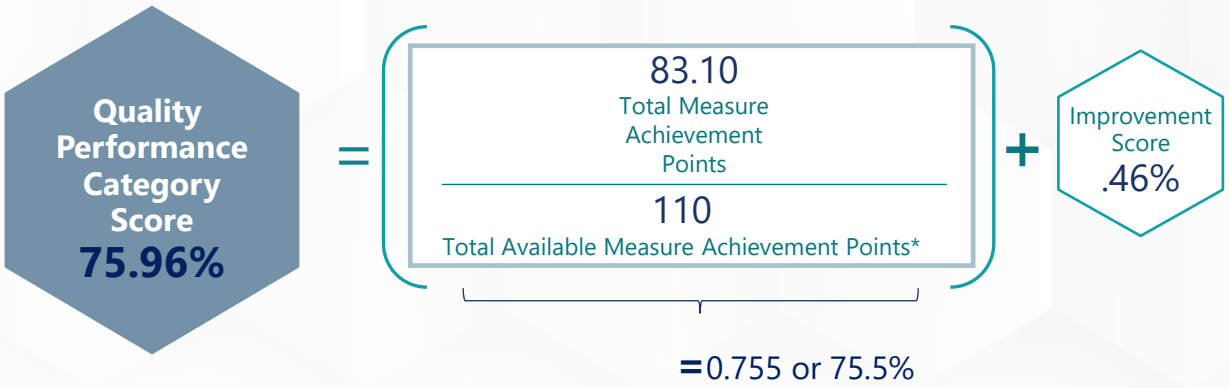
Calculating the Quality Performance Category Score (Continued)

Scoring Example

A Shared Saving Program ACO reported a full set of quality measures through the CMS Web Interface for 2021 and 2022. They earn 83.1 achievement points out of 110 possible points for the 2022 performance period.

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

- Their 2022 achievement score = 83.10/110 = 75.5%.
- Their 2021 achievement score = 72.2% (excludes bonus points).
- The increase in their achievement score = 75.5% - 72.2% = 3.3%.
- Their improvement score = (3.3% ÷ 72.2%) x 10 = .46%.



APP: Quality Performance Category

Quality Payment PROGRAM

How Is My Quality Performance Category Score Calculated?

To determine how many points the quality performance category contributes to your final score, we multiply your quality performance category score by the quality performance category weight. Under the APP, we multiply your quality performance category score by 50% (the quality performance category weight under the APP).

Can the Quality Performance Category Be Reweighted?

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

- We continue to make our extreme and uncontrollable circumstances (EUC) policy available, and you may request performance category reweighting through the EUC application. Please check the Quality Payment Program COVID-19 Response Fact Sheet (PDF), 2022 MIPS Extreme and Uncontrollable Circumstances Exceptions Application User Guide (PDF), or the Exceptions Application webpage for more information.
- In the rare instance that you can't meet the case minimum for any quality measures, you won't be scored on this performance category, and it will be reweighted to 0% of your final score. We anticipate that reweighting of the quality performance category will be rare.

Please see Appendix A for more information on the reweighting of the quality performance category, including the EUC policy.

APP: Improvement Activities Performance Category

APP: Improvement Activities Performance Category

Quality Payment PROGRAM

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

MIPS APM participants reporting via the APP don't need to submit any data for the improvement activities performance category for the 2022 performance period. Each year, we'll assign a score for the improvement activities performance category for each MIPS APM. All MIPS APM participants who report through the APP in 2022 will automatically receive 100% for the improvement activities performance category score (20 out of 20 points towards your MIPS final score).

Improvement Activities

20% **of MIPS Score**

APP: Promoting Interoperability Performance Category

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

There's a single set of measures and objectives you must report for the 2022 performance period, as outlined in the table on slide 46.

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

Promoting Interoperability

30% **of MIPS Score**

IMPORTANT: Promoting Interoperability data is always submitted at the individual or group level. If you're participating as an APM Entity such as a Shared Savings Program ACO, we'll calculate a score for the APM Entity as a weighted average of the scores received from individual and/or group submissions.

2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the 2 are required for participation in this performance category.

NOTE: This performance category only counts toward the MIPS final score and therefore isn't required for Qualifying APM Participants (QPs) and Partial QPs that don't elect to report to MIPS.

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

Objective	Measures		Requirements
e-Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		Optional measure cannot be reported if an exclusion is claimed for the required e-Prescribing measure
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 is reported
		Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 is reported
	Option 2	NEW: HIE Bi-Directional Exchange*	Required (no exclusion available), unless option 1 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required unless an exclusion(s) is claimed
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting		Optional measures (no exclusions available)

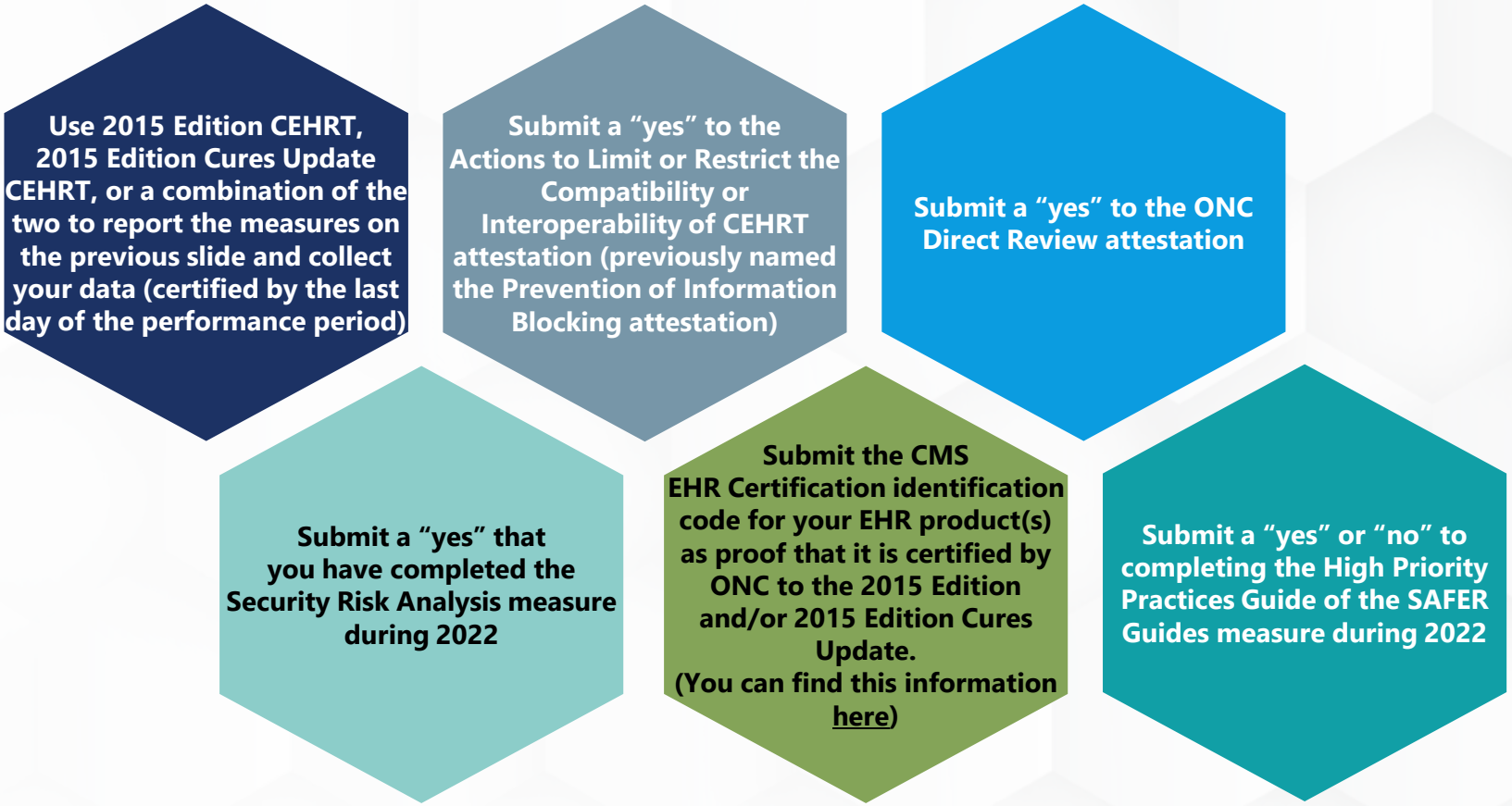
* The HIE Bi-Directional Exchange measure serves as an **alternative** measure to the 2 existing, required HIE objectives. You're expected to report either option 1 (the 2 original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective. **You wouldn't submit both options.**

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

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



If any of these requirements are **not met**, you'll get 0 points in the Promoting Interoperability performance category if you're participating as an individual MIPS eligible clinician or group. If you're participating as an APM Entity, then any clinician or group that fails to meet these criteria would contribute 0 points toward the Entity-level score.

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Submission

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

Any conflicting data submitted for a single measure or required attestation will result in a **score of 0** for individuals and groups in the Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score.

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2022?

For the 2022 performance period, each required measure will be scored based on the performance data you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Query of PDMP measure (optional/bonus measure), Public Health and Clinical Data Exchange objective measures (required and optional/bonus), the optional HIE Bi-Directional Exchange measure, and the Security Risk Analysis and High Priority Practices Guide of the SAFER Guides attestation measure which require a "yes" or "no" submission. Each measure will contribute to your total Promoting Interoperability performance category score.

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

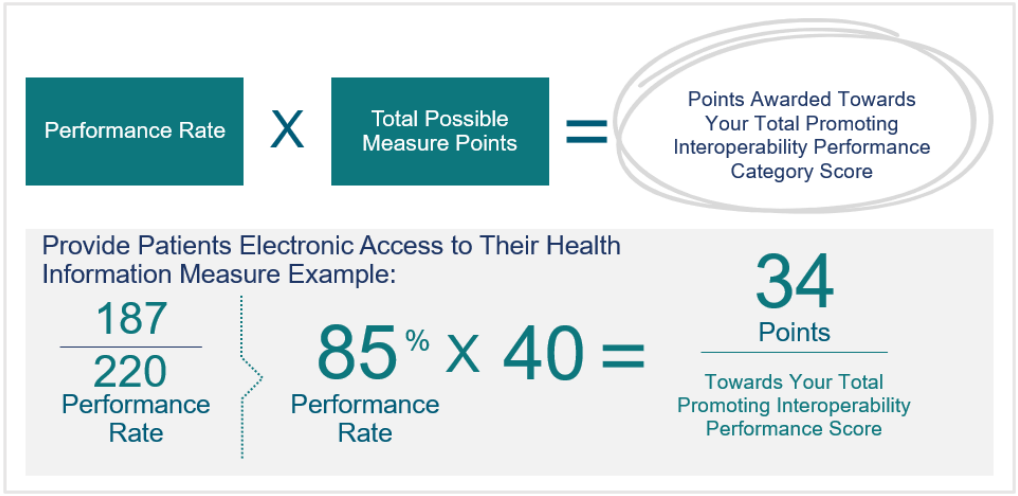
APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2022? (Continued)

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

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



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

Example 1:

Score = 8.53 → Round up to 9

Example 2:

Score = 8.33 → Round down to 8

Note:

- The Query of Prescription Drug Monitoring Program (PDMP) bonus measure in the e-Prescribing objective will earn 10 points if submitted (can only be submitted along with the required e-Prescribing measure).
- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as the numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score.)
- You can earn a maximum of 5 points for submitting 1 (or more) of the optional measures in the Public Health and Clinical Data Exchange objective (you'll earn a maximum of 5 bonus points even if you submit more than 1 measure).

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2022? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		Optional	10 bonus points	YES/NO
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required (unless option 2 is reported)	1 – 20 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 20 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange*	Required* (unless option 1 is reported)	40 points	YES/NO
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required	1 – 40 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required	10 points for the entire objective	YES/NO
	Bonus (Optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		Optional	5 bonus points	YES/NO

* HIE Bi-Directional Exchange measure serves as an **alternative** measure to the 2 existing required HIE objectives. You're expected to report either option 1 (the 2 original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective. You won't submit both options.

APP: Promoting Interoperability Performance Category

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

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

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

You submit a "yes" for the Immunization Registry Reporting measure*.

AND

You submit a "yes" for the Electronic Case Reporting measure*.

* If you submit an exclusion for:

- 1 required measure and "yes" for the other required measure, you'll still earn the full 10 points for the objective.
- Both required measures, the 10 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

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

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

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

While there are 115 total points available, individuals, groups, and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

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

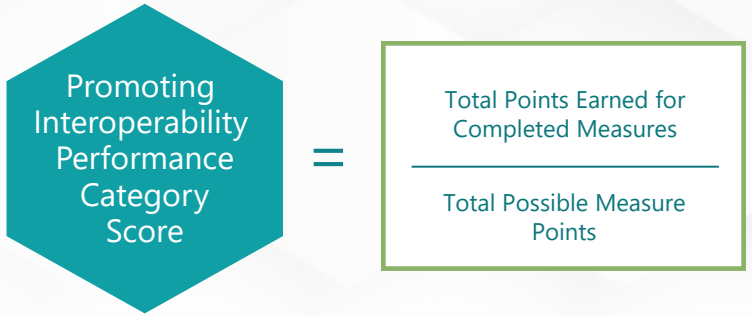
No; you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

- When reporting the APP as an individual or group, we'll add the scores for each of the individual measures (or objectives) and then divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

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



APP: Promoting Interoperability Performance Category

How Is the Promoting Interoperability Performance Category Scored? (Continued)

APM Entity Participation

- When reporting the APP as an APM Entity, the MIPS eligible clinicians in the Entity still report their Promoting Interoperability measures as individuals or as a group. We score the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity.
- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- The APM Entity can also earn the bonus points if at least one individual or group in the APM Entity reports the optional Query of PDMP measure (10 bonus points) or one of the options measures in the Public Health and Clinical Data Exchange objective (5 bonus points), but the Promoting Interoperability performance category score can't exceed 100%.

REMINDER: You'll contribute 0 points toward your APM Entity's Promoting Interoperability performance category score if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).

APM Entity's Promoting Interoperability Score =

$$\frac{\text{Sum of Points Earned by All MIPS Eligible Clinicians for Required Measures}}{\text{Total MIPS Eligible Clinicians in APM Entity} - \text{MIPS Eligible Clinicians Who Receive Performance Category Reweighting}}$$

+ 10 Bonus Points (if at least one clinician reported the optional Query of PDMP measure)

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

Did you know? Only MIPS eligible clinicians are included when calculating the weighted average for the Promoting Interoperability score for an APM Entity.

Promoting Interoperability Performance Category Scoring Example

A Shared Savings Program ACO has 75 participants, but only 10 are MIPS eligible clinicians. The points assigned to each clinician are those earned through either individual or group reporting.

	Points for Required Measures (Excluding Bonus Points)	Optional Query of PDMP Measure Reported?	Optional Measures from Public Health and Clinical Data Exchange Objective Reported?
MIPS Eligible Clinician 1	**87**	Yes	Yes
MIPS Eligible Clinician 2	**87**	No	No
MIPS Eligible Clinician 3	**77**	Yes	No
MIPS Eligible Clinician 4	N/A – qualified for reweighting	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 5	**92**	No	No
MIPS Eligible Clinician 6	**85**	Yes	No
MIPS Eligible Clinician 7	**0** – didn't meet reporting requirements	No	No
MIPS Eligible Clinician 8	N/A – qualified for reweighting	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 9	**49**	No	Yes
MIPS Eligible Clinician 10	**82**	Yes	No

Promoting Interoperability Performance Category Score = $\frac{87 + 87 + 77 + 92 + 85 + 0 + 49 + 82}{10 - 2}$ + 15 = 80.9%

Points from Required Measures

10 Total MIPS ECs in APM Entity

2 MIPS ECs Who Receive Reweighting

15 Bonus Points from PDPM Measure and optional Public Health and Clinical Data Exchange measures

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

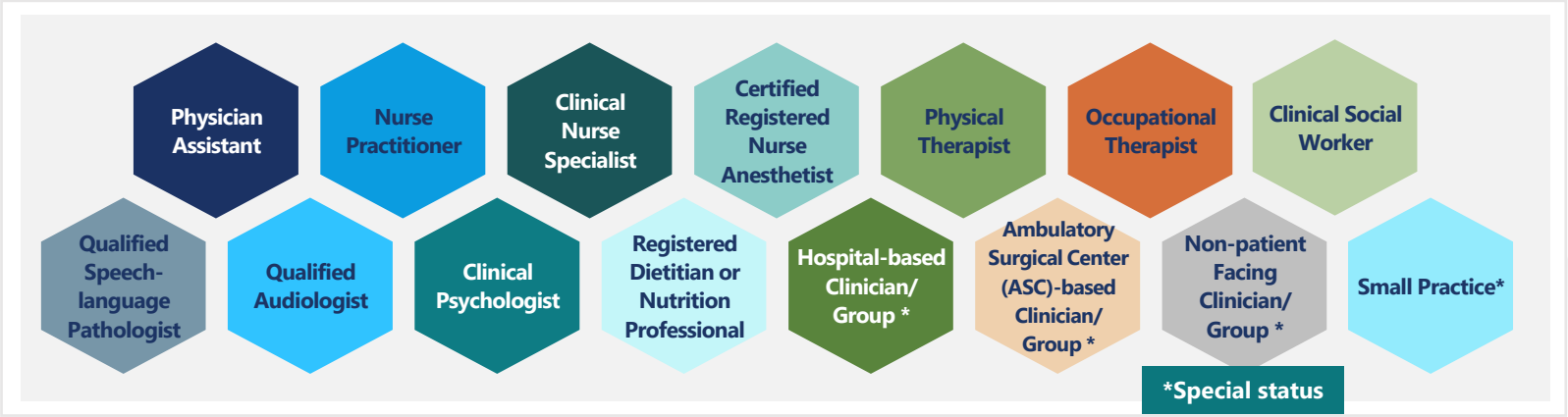
Can the Promoting Interoperability Performance Category be Reweighted?

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

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

1. We continue to make our EUC application available for submitting requests to reweight multiple performance categories. Please check the 2022 MIPS Extreme and Uncontrollable Circumstances Exception Application User Guide (PDF) or the Exceptions Application webpage for more information.
2. An individual or group can submit a Promoting Interoperability Hardship Exception Application (PDF), citing one of the following specified reasons for review and approval:
   - Insufficient internet connectivity
   - Extreme and uncontrollable circumstances
   - Lack of control over the availability of CEHRT
   - Decertified EHR

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



APP: Promoting Interoperability Performance Category

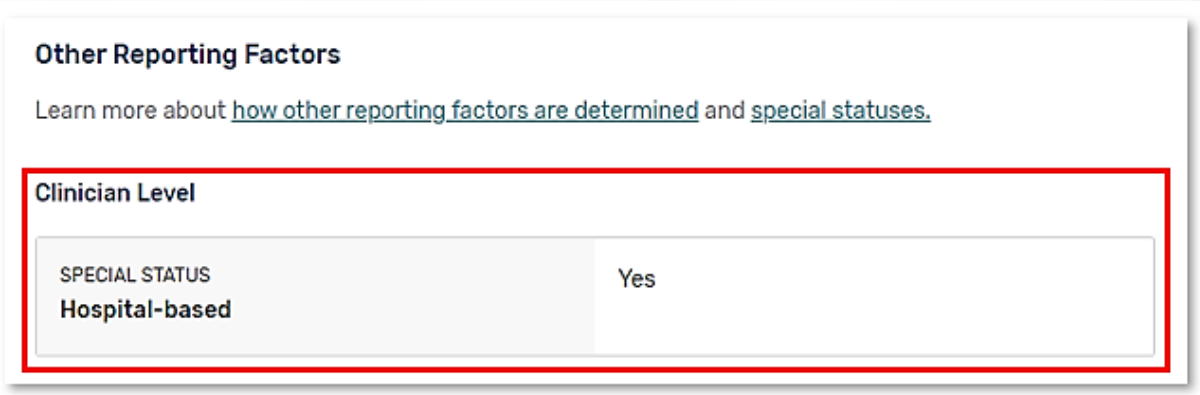
Quality Payment PROGRAM

Can the Promoting Interoperability Performance Category be Reweighted? (Continued)

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

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

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.



NOTE: If you have an approved exception or qualify for automatic reweighting, **we'll reweight the Promoting Interoperability performance category to 0% and redistribute 25% of the weight to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total)** so you can earn up to 100 points in your MIPS final score. However, you can still report Promoting Interoperability data if you want to. If you submit data on any of the measures for the Promoting Interoperability performance category as either an individual or a group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 30% of the final score.

APP: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

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

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

Just as with individual participation, groups who qualify for reweighting but submit data for this performance category will be scored just like any other clinician in MIPS, and their Promoting Interoperability performance category will be weighted at 30% of the final score.

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.

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

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

Individual MIPS eligible clinicians and groups participating as an APM Entity that qualify for automatic reweighting or have an approved Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category. They'll be excluded from the calculation when we determine the APM Entity's score but will still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire APM Entity for the 2022 performance period. This could occur when all of the clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

As with individuals and groups who report via the APP, APM Entities that qualify for reweighting will have the category reweighted to 0%, and CMS will redistribute 25% of the weight to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total).

APP: MIPS Final Score

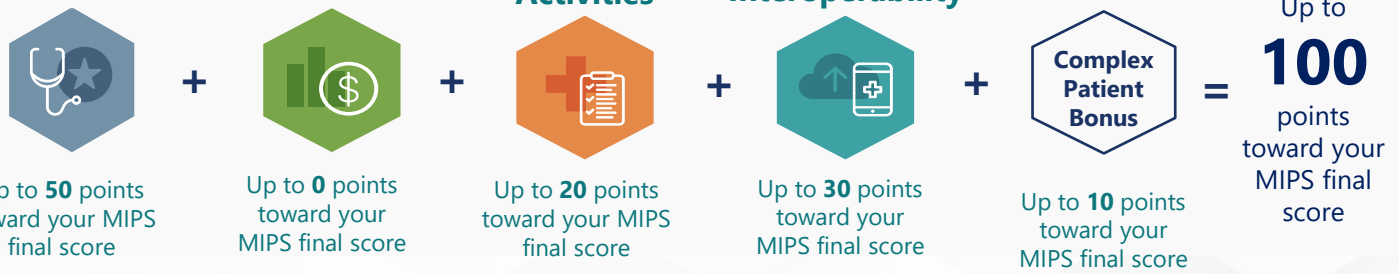
APP: MIPS Final Score

Quality Payment PROGRAM

How Is My Final Score Calculated?

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

APP Performance Category Weights in 2022:

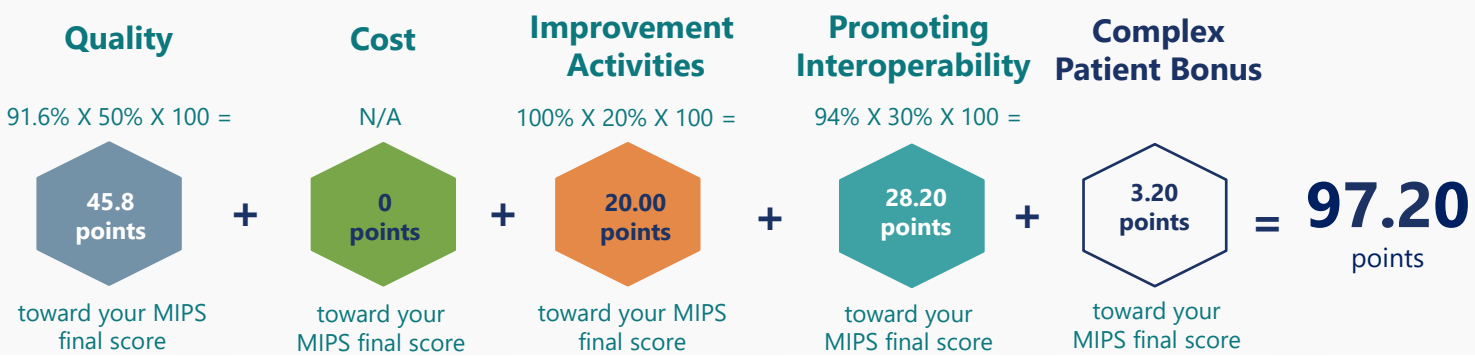


NOTE: The cost performance category is weighted at 0% of the MIPS final score for MIPS APM participants reporting through the APP, because all MIPS APM participants are already responsible for costs under their APMs.

Scoring Example

Below is an example of an APM Entity reporting via the APP. Let's review how the final score is calculated:

APP Performance Category Weights in 2022:



The MIPS final score can't exceed 100 points

APP: MIPS Final Score

What is the Complex Patient Bonus?

The complex patient bonus awards **up to 10 bonus points** based on the medical complexity and social risk of your patients. These bonus points are added to the MIPS final score for qualifying MIPS eligible clinicians, groups, virtual groups and APM Entities.

As finalized in the CY 2022 Physician Fee Schedule Final Rule, we've **updated our complex patient bonus policies** to better target clinicians who have a higher share of medically and/or socially complex patients.

The complex patient bonus is now composed of 2 distinct calculations which are added together:

- The first calculation looks at medical complexity as determined by the average Hierarchical Condition Categories (HCC) risk score of your Medicare patient population.
- The second calculation looks at social risk as determined by the proportion of your Medicare patient population that's dually eligible for both Medicare and Medicaid.

We'll calculate the HCC risk scores and dual eligibility ratio for the unique Medicare patients treated during the second 12-month segment (October 1, 2021 – September 30, 2022) of the MIPS determination period.

The complex patient bonus is now limited to MIPS eligible clinicians, groups, virtual groups and APM Entities with at least one risk indicator (either average HCC risk score or dual eligibility ratio) at or above the median risk indicator calculated for all MIPS eligible clinicians, groups, virtual groups and APM Entities from performance year 2021.

We'll evaluate each MIPS eligible clinician, group, virtual group, or APM Entity for their eligibility to receive the complex patient bonus.

APP: MIPS Final Score

Quality Payment PROGRAM

Eligibility for the Complex Patient Bonus

Step 1

We'll identify the **median HCC risk score** and **median dual eligibility ratio** based on the complex patient bonus included in the final score attributed to each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity) in performance year 2021.

Step 2

We'll calculate the average HCC risk score and dual eligibility ratio for each MIPS eligible clinician, group, virtual group and APM Entity.

- **Average HCC risk score** = sum of HCC risk scores for the unique Medicare patients treated*/number of unique Medicare patients treated*
- **Dual eligibility ratio** = unique Medicare patients treated* who were dually eligible for Medicare and full- or partial-Medicaid benefits/unique Medicare patients treated*

*Medicare patients must have been treated between October 1, 2021 and September 30, 2022 to be included in these calculations.

Step 3

We'll compare your average HCC risk score and dual eligibility ratio (calculated in Step 2) to the median values identified in Step 1.

- **If either (or both) of your risk indicators is at or above the median identified in step 1, you're eligible to receive the complex patient bonus.**

Did you know? A patient's HCC risk score is based on:

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

APP: MIPS Final Score

Quality Payment PROGRAM

Calculating the Complex Patient Bonus

Step 1

We'll identify the **mean HCC risk score** and **mean dual eligibility ratio** based on the complex patient bonus included in the final score attributed to each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity) in performance year 2021. (This is different than the median calculated to determine eligibility.)

Step 2

We'll calculate a **standardized** score for the medical complexity component.

- **Medical component standardized score** = (your average HCC risk score MINUS the 2021 mean HCC risk score from step 1)/ standard deviation for the 2021 mean HCC risk score from step 1.

Step 3

We'll calculate a **standardized** score for the social risk component.

- **Social component standardized score** = (your dual eligibility ratio MINUS the 2021 mean dual eligibility ratio from step 1)/ standard deviation for the 2021 mean dual eligibility ratio from step 1

Step 4

We'll calculate the medical complexity component contribution to your complex patient bonus.

- **Medical complexity complex patient bonus points** = 1.5 + 4*(standardized score from step 2)

Step 5

We'll calculate the social risk component contribution to your complex patient bonus.

- **Social risk complex patient bonus points** = 1.5 + 4*(standardized score from step 3)

Step 6

We'll calculate your total complex patient bonus

- **Complex patient bonus** = Medical complexity points (step 4) + Social risk points (step 5)

If only 1 of the 2 risk indicators – medical complexity or social risk – was at or above the median when we determined your eligibility for the complex patient bonus, then the other will contribute 0 points toward your complex patient bonus.

APP: MIPS Final Score and Payment Adjustment

APP: MIPS Final Score and Payment Adjustment

Quality Payment PROGRAM

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be. **Why?** MIPS is required by law to be a budget-neutral program. Generally, this means that the amount of the payment adjustments will depend on the overall participation and performance of clinicians in the program for a certain year. The table below illustrates how 2022 MIPS final scores will correlate to 2024 MIPS payment adjustments for MIPS eligible clinicians.

Final Score	Payment Adjustment
89.00 – 100.00 points (Additional performance threshold=89.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds) **The 2022 performance year/2024 payment year is the last year for the exceptional performance adjustment.**
75.01 – 88.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
75.00 points (Performance threshold=75.00 points)	• Neutral MIPS payment adjustment (0%)
18.76 – 74.99 points	• Negative MIPS payment adjustment (between -9% and 0%)
0.00 – 18.75 points	• Negative MIPS payment adjustment of -9%

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

The MIPS payment adjustments have two components. The first component applies to all MIPS eligible clinicians. The second is an additional payment adjustment for exceptional performance that applies only to those MIPS eligible clinicians with a final score of 89 points or higher.

1. **MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality. Clinicians with a final score at the performance threshold of 75 points earn a neutral adjustment. Clinicians with a final score above the performance threshold of 75 points earn a positive adjustment (subject to a scaling factor). Clinicians with a final score below the performance threshold of 75 points will be subject to a negative adjustment. The maximum negative adjustment is -9%. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments, and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.
2. **Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 89 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled; it will depend on the scores and the number of clinicians receiving a score of 89 points or higher.

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

FAQs

What happens if your ACO doesn't report quality measures?

If you're a MIPS eligible clinician participating in a Shared Savings Program ACO (or any MIPS APM) and your APM Entity doesn't report quality measures to MIPS on your behalf, you would receive a quality performance category score of 0 points and a final score below the performance threshold of 75 points, resulting in a negative payment adjustment, unless you report as an individual or group via the APP or traditional MIPS. We encourage individuals and groups that participate in the Shared Savings Program to reach out to their ACO during the performance period to determine whether the ACO will report data on their behalf. But regardless of the APM Entity's decision to report on behalf of its participants, individuals or groups of MIPS eligible clinicians who participate in MIPS APMs may choose to report via the APP or traditional MIPS.

Why might a clinician or group choose to report separately from their Entity?

An individual or group of MIPS eligible clinicians may choose to report via the APP or traditional MIPS separately from their APM Entity if they believe they are likely to receive a more favorable MIPS final score from individual or group participation. As noted, CMS will award the higher MIPS final score to clinicians and to groups who report to MIPS at different levels.

Why might an individual or group choose to report via the APP?

An individual or group of MIPS eligible clinicians might choose to report via the APP if:

1. They believe they'll receive a higher score by reporting at the individual or group level than at the APM Entity level;
2. They want to streamline their data collection and reporting; or
3. Their APM Entity has indicated that it won't report to MIPS on their behalf.

We encourage individuals and groups who participate in MIPS APMs to reach out to their APM Entity during the performance period to confirm that the Entity will report data on their behalf.

What if a Shared Savings Program ACO doesn't report via the APP?

For performance year 2022, if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey under the APP, the ACO wouldn't meet the Shared Savings Program quality performance standard.

For ACOs that choose to report via the CMS Web Interface, they are required to completely report all 10 CMS Web Interface measures. If an ACO does not completely report, the ACO will still receive a quality score. However, the ACO will receive zero points for each CMS Web Interface measure not reported. For each CMS Web Interface measure without a benchmark that is not reported, the ACO will receive zero points in the numerator and the denominator used to calculate their quality performance category score will increase by 10 points.

If an ACO is unable to report via the APP and CMS determines that the ACO was affected by extreme and uncontrollable circumstances, then the ACO will have their ACO quality performance score set equal to the 30th percentile MIPS quality performance category score.

Do we need to tell CMS what we're reporting the APP or traditional MIPS in advance of the submission period?

No. MIPS APM participants aren't required to state their intention to report via the APP or traditional MIPS before the data submission period. You'll identify your reporting option (APP or traditional MIPS) when you sign in to qpp.cms.gov to submit your data.

Where can clinicians go for additional information?

Please review the 2022 APM Performance Pathway for MIPS APM Participants Fact Sheet for more information about the quality performance standard, the quality reporting requirements for SSP ACOs, and more.

Resources, Glossary, and Version History

Resources, Glossary, and Version History

Quality Payment PROGRAM

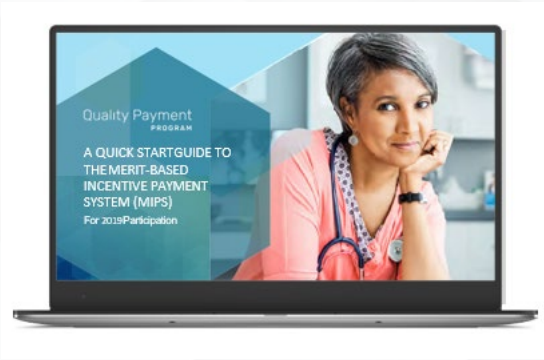
Resources

The following resources are available on the QPP Resource Library:

- **General:**
  - 2022 Group Participation Guide (PDF)
  - 2022 MIPS Eligibility & Participation User Guide (PDF)
  - 2022 Eligibility & Participation Quick Start Guide (PDF)

- **Quality:**
  - 2022 Quality Benchmarks (ZIP)
  - Performance Year 2022 APM Performance Pathway: CMS Proposed Web Interface Measure Benchmarks for ACOs (PDF)
  - 2022 CAHPS for MIPS Overview Fact Sheet (PDF)
  - 2022 Electronic Clinical Quality Measures (eCQMs) Specifications (link to eCQI Resource Center)
  - 2022 Medicare Part B Claims Measure Specifications (ZIP)
  - 2022 MIPS Clinical Quality Measure Specifications (ZIP)
  - 2022 CMS Web Interface Measure Specifications (ZIP)

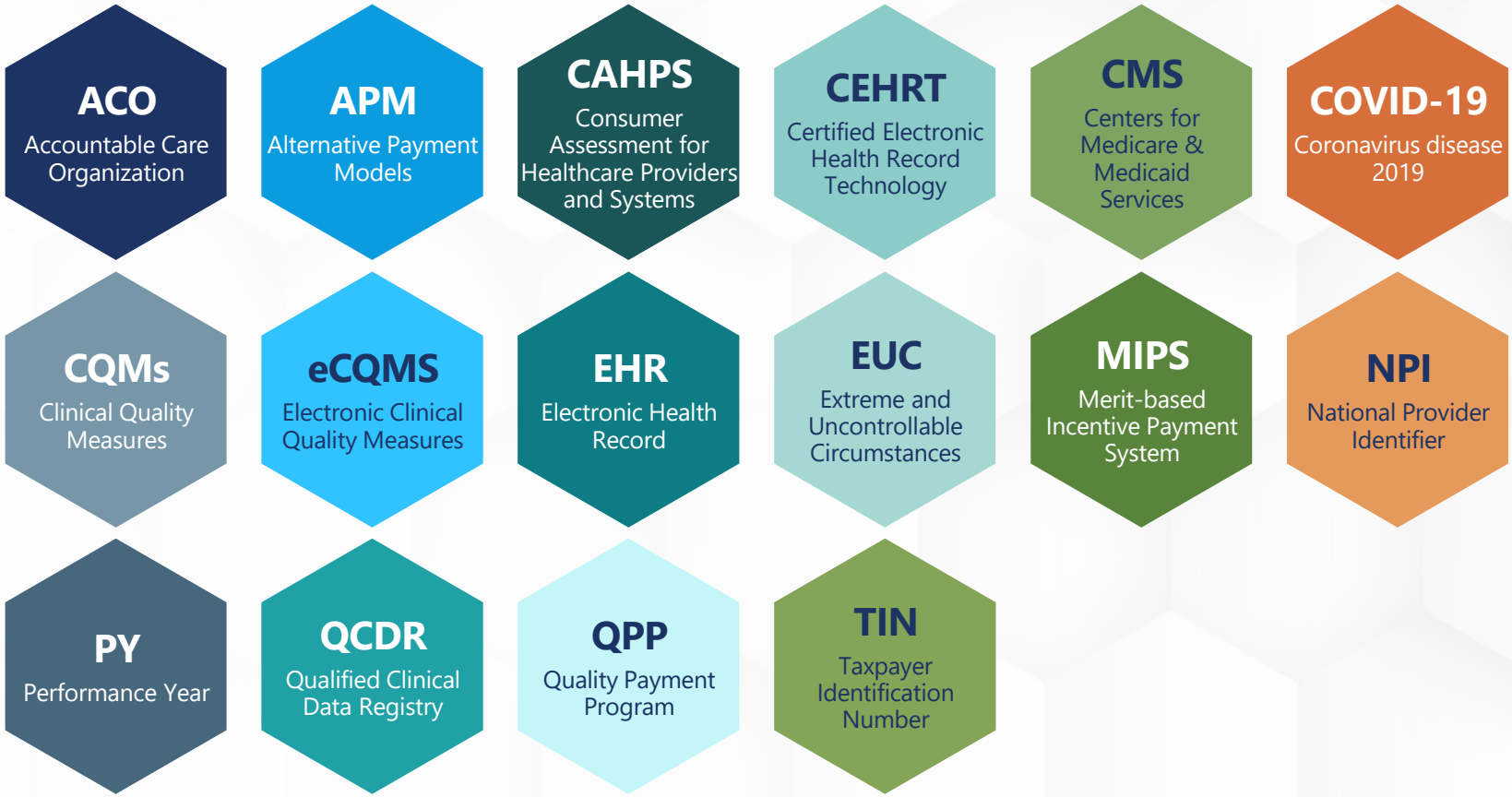
- **Promoting Interoperability:**
  - 2022 MIPS Promoting Interoperability User Guide (PDF)
  - 2022 Promoting Interoperability Quick Start Guide (PDF)
  - 2022 Promoting Interoperability Measure Specifications (ZIP)



Resources, Glossary, and Version History

Quality Payment PROGRAM

Glossary



Version History

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

Date	Description
01/30/2023	Updated to identify APP quality measures affected by ICD-10 coding updates (MIPS CQM, eCQM and Medicare Part B claims measure collection types). Added scoring examples as well.
11/18/2022	Original posting

Appendices

Appendix A: Reweighting the Performance Categories

APP Performance Category Weight Redistribution: Individual, Group, and APM Entity Participation

The table below outlines the performance category weights under the APP for individuals, groups, and APM Entities when performance categories are reweighted to 0% based on any circumstances described throughout this guide.

Performance Category Redistribution for the 2022 Performance Year/2024 MIPS Payment Year				
Reweighting Scenario	**Quality**	**Cost**	**Improvement Activities (IA)**	**Promoting Interoperability (PI)**
Standard Weighting				
General weighting for all performance categories	**50%**	**0%**	**20%**	**30%**
Reweighting 1 Performance Category				
No Promoting Interoperability: *PI → Quality and IA*	75%	0%	25%	0%
No Quality: *Quality → IA and PI*	0%	0%	25%	75%

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

Appendix C: Quality Measure Collection Types

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2022 eCQM Specifications (ZIP) 2022 eCQM Flows (ZIP)	You can report eCQMs if you use technology that meets the 2015 Edition Certified Electronic Health Record Technology (CEHRT) criteria, the 2015 Edition Cures Update criteria, or a combination of both. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B Claims measures, MIPS CQMs, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • APM Entities
MIPS Clinical Quality Measures (MIPS CQMs)	2022 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may choose to work with a Qualified Registry, QCDR, or Health IT vendor to support your data collection and submission. To see the lists of CMS approved Qualified Registries and QCDRs, visit the QPP Resource Library. MIPS CQMs can be reported in combination with Medicare Part B Claims measures, eCQMs, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • APM Entities

Appendix D: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
Medicare Part B Claims Measures	2022 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP) 2022 Part B Claims Reporting Quick Start Guide (PDF)	Medicare Part B Claims measures are always reported with the clinician's individual (rendering) National Provider Identifier (NPI), even when participating as a group, virtual group, or APM Entity. Medicare Part B Claims measures can be reported in combination with eCQMs, MIPS CQMs, and the CAHPS for MIPS Survey measure.	• Individuals [Clinicians in small practices (fewer than 16 clinicians) only] • Groups [Small practices (fewer than 16 clinicians) only] • APM Entities (fewer than 16 clinicians in the APM Entity)
CMS Web Interface	2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)	If you want to report through the CMS Web Interface, groups, virtual groups, and APM Entities must register between April 1, 2022 and June 30, 2022. (Registration not required for Shared Savings Program ACOs.) Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare patients for each measure within the application.	• Groups (registered groups with 25 or more clinicians) • APM Entities (ACOs and registered APM Entities with 25 or more clinicians)

Reminder: As part of the 2022 PFS Final Rule, CMS finalized a longer transition for eCQM/CQM measure reporting for Shared Savings Program ACOs by extending the CMS Web Interface as an option through the 2024 performance year.

Appendix D: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
CAHPS for MIPS Survey Measure	2022 CAHPS for MIPS Survey Overview Fact Sheet (PDF)	Groups, virtual groups and APM Entities can register between April 1, 2022 and June 30, 2022 to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience and care within a group, virtual group or APM Entity. This survey must be administered by a CMS Approved Survey Vendor (PDF).	• Groups (registered groups with 2 or more clinicians) • APM Entities (registered APM Entities with 25 or more clinicians) • Shared Savings Program ACOs don't have to register to administer the CAHPS for MIPS Survey. They're automatically registered.