

Merit-based Incentive Payment System (MIPS)

Alternative Payment Model (APM)
Performance Pathway (APP) Scoring
Guide for the 2023 Performance Year



Quality Payment
PROGRAM

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How to Use This Guide



How to Use This Guide



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

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Hyperlinks

Hyperlinks to the [Quality Payment Program website](#) are included throughout the guide to direct the reader to more information and resources.

Overview



What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) advances a forward-looking and coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks.



- Note: If you participate in an Advanced APM and don't achieve Qualifying APM Participant (QP) or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.
- For the CY 2019-2022 performance years, Advanced APM participants who achieved Qualifying APM Participant (QP) status were excluded from MIPS and eligible for a 5% APM Incentive Payment. However, in December 2022, Congress announced it included a value-based care incentive in its year-end spending bill and changed the APM Incentive Payment to 3.5% for the 2023 performance year/2025 payment year. In March 2024, Congress announced another update, and established a 1.88% APM Incentive Payment for QPs for the 2024 performance year/payment year 2026, as well as a 0.75 percent adjustment to the QP conversion factor that will be applied to Medicare payments for covered professional services beginning in 2026. The thresholds for performance year 2024/payment year 2026 were also frozen at 50% for payment amount and 35% for patient count.

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 [2022 and 2023 Comprehensive List of APMs \(PDF, 483KB\)](#).

- 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 the APP: quality (50%), improvement activities (20%), and Promoting Interoperability (30%).

- All MIPS APM participants who report the APP in 2023 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 year.

Who Can Report the APP?

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

ACOs participating in the Shared Savings Program are required to report the APP for the purpose of assessing their quality performance for that program.

- If an ACO reports the APP, then the ACO participants don't have to report quality separately to MIPS but the MIPS eligible clinicians in the ACO will need to report Promoting Interoperability data.
- If an ACO fails to report 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 the APP wouldn't meet the Shared Savings Program quality performance standard.¹

Your MIPS 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 the APP and your group reports under traditional MIPS, you'll receive whichever of the 2 scores is higher for purposes of calculating your MIPS payment adjustment.²

¹ Starting in 2021, the APP is 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.

² If you participate in a virtual group in Traditional MIPS or MIPS Value Pathways (MVPs), you will receive a final score based on the performance of the virtual group for purposes of calculating your MIPS payment adjustment, even if you have a higher score through another means of participation.



Overview

Medicare Shared Savings Program Quality Extreme and Uncontrollable Circumstances (EUC) Policy

The public health emergency (PHE) for coronavirus disease 2019 (COVID-19) was in effect starting in January 2020 and expired on May 11, 2023. All Shared Savings Program ACOs were deemed affected by the PHE for COVID-19 under the program's EUC policy for quality for performance year (PY) 2023. Therefore, for PY 2023, an ACO's minimum quality performance score will be set to the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding Entities/providers eligible for facility-based scoring.

If an ACO reports quality data via the APP and meets MIPS data completeness and case minimum requirements, then CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding Entities/providers eligible for facility-based scoring.

As such, all ACOs that qualify for shared savings for PY 2023 will be eligible to receive the maximum sharing rate for their track (or performance level within a track) and any shared losses determined to be owed to CMS using either a fixed (BASIC Track) or scaled loss rate (ENHANCED Track) will be reduced by a least five-twelfths.



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 for PYs 2023 and 2024).
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (required for groups and APM Entities with 2 or more clinicians reporting the APP).
- [Appendix C](#) 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 Type¹

- 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 (small practices only).
 - CMS Web Interface (Shared Savings Program ACOs only).

¹ While Virtual Groups meet the definition of Submitter type per 42 CFR 414.1305, Virtual Groups are not an applicable submitter type for the APP.

APP: Quality Performance Category



APP: Quality Performance Category

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

MACRA ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:

Option 1: Quality Measures Set

Quality



50% of MIPS Score

Quality ID: 001

Diabetes:
Hemoglobin
A1c (HbA1c)
Poor Control

Collection Type:

- eCQM
- MIPS CQM
- Medicare Part B Claims*

Submitter Type:

- MIPS Eligible Clinicians
- Representative of a Practice
- APM Entity
- Third Party Intermediary

Quality ID: 134**

Preventive Care
and Screening:
Screening for
Depression and
Follow-up Plan

Collection Type:

- eCQM
- MIPS CQM
- Medicare Part B Claims*

Submitter Type:

- MIPS Eligible Clinicians
- Representative of a Practice
- APM Entity
- Third Party Intermediary

Quality ID: 236**

Controlling High
Blood Pressure

Collection Type:

- eCQM
- MIPS CQM
- Medicare Part B Claims*

Submitter Type:

- MIPS Eligible Clinicians
- Representative of a Practice
- APM Entity
- Third Party Intermediary

Quality ID: 321

CAHPS for MIPS

(Groups and
APM Entities
only)

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

*Medicare Part B claims measures can only be reported by individuals, groups or APM Entities with a small practice designation. In PY 2023, no Shared Savings Program ACOs met the small practice criteria at the APM Entity level.

** Please see [slide 14](#) for additional information



APP: Quality Performance Category

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: CMS finalized a longer transition for eCQM/ MIPS CQMs 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)

Collection Type:
• CMS Web Interface

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

Quality ID: 134
Preventive Care and
Screening:
Screening for
Depression and
Follow-up Plan
(PREV-12)

Collection Type:
• CMS Web Interface

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

Quality ID: 236
Controlling High
Blood Pressure
(HTN-2)

Collection Type:
• CMS Web Interface

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

Quality ID: 318
Falls: Screening for
Future Fall Risk
(CARE-2)

Collection Type:
• CMS Web Interface

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

Quality ID: 110
Preventive Care and
Screening:
Influenza
Immunization
(PREV-7)

Collection Type:
• CMS Web Interface

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

Quality ID: 226
Preventive Care and
Screening: Tobacco
Use: Screening and
Cessation
Intervention (PREV-
10)

Collection Type:
• CMS Web Interface

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



APP: Quality Performance Category

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

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, 2023 – December 31, 2023).¹

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 as outlined in the measure’s specification. To meet data completeness criteria, you must include the entire eligible population in the measure denominator, and report performance data for at least 70% of the eligible population.

To illustrate:

$$\text{Data Completeness} = \frac{\text{Number of patients for which performance data is submitted (met, not met, or denominator exception)}^2}{\text{Total number of patients in eligible population}}$$

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

- For Medicare Part B Claims measures, we identify the eligible population (denominator) for you based on the claims you submit.
- When reporting eCQMs and MIPS CQMs, your denominator eligible encounters **include your entire patient population**, not just your Medicare patient population.
- When reporting eCQMs and MIPS CQMs, your numerator consists of the number of patients for which performance data is submitted, in which the performance data must **represent at least 70% of the entire eligible patient population**.
- 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.

¹Measures that are impacted by significant changes or errors prior to the applicable data submission deadline may be based on data for 9 consecutive months of the applicable CY. performance period.

²When numerator data are missing for eCQM measures, the missing data are considered “Performance Not Met” for purposes of scoring. As such, data completeness for eCQM measures is 100

Did you know? 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. No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2023.



APP: Quality Performance Category

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

How is “Data Completeness” Determined for Shared Savings Program ACOs?

To meet **data completeness** requirements, ACOs must also identify their entire eligible population across all participants, and report performance data for at least 70% of their eligible population.

- For Shared Savings Program ACOs, the denominator eligible population will reflect 100% of the matched, deduplicated population across all participant TINs and CMS Certification Numbers (CCNs) in the ACO.
- Data completeness is calculated based on submitted data. Since eCQMs are specified to be calculated using all-payer data and submitted electronically without any manual manipulation, ACOs that submit an eCQM via Certified Electronic Health Record Technology (CEHRT) would generally achieve 100 percent data completeness. The eCQM contains data regarding 100 percent of the eligible clinicians’ matched patient population and its end-to-end electronic reporting ensures no cases are excluded from the submission. In the case of an ACO using multiple CEHRT, eCQM reporting thus requires the aggregation of data across all CEHRT used within the ACO into a single submission to ensure the ACO meets the measure specification by accounting for its complete patient population. ACOs using multiple CEHRT may alternatively consider reporting via MIPS CQMs.
- Since MIPS CQM measure specifications allow for the use of multiple sources of data (e.g., EHRs, paper records, registries, claims data) to compile a measure’s numerator and denominator, an ACO must undertake additional effort to ensure it meets the completeness standard. An ACO reporting via the MIPS CQM collection type must report performance data (“Performance Met,” or “Performance Not Met,” or denominator exceptions) for at least 70 percent of their eligible and matched population denominator.
- For additional information regarding the reporting of eCQMs and MIPS CQMs, the below resources are available:
 - Guidance Document: [Reporting MIPS CQMs and eCQMs in the APP \(PDF, 865KB\)](#)
 - Webinar: [Reporting MIPS CQMs and eCQMs in the APP](#) from December 15, 2022.



APP: Quality Performance Category

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 2023 Performance Year?

Your performance on each quality measure is assessed against a benchmark to see how many points you earn for the measure.¹

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 2023 MIPS performance period were established from quality data submitted for the 2021 MIPS performance period.

Did you know? If you submit eCQMs, you need to use CEHRT to collect the eCQM data. The CEHRT used to collect the data must meet the 2015 Edition Cures Update CEHRT criteria.

For more information about the 2023 quality benchmarks, please review the [2023 Quality Benchmarks \(ZIP, 779KB\)](#).

¹ Some measures may lack a benchmark. For information on how measures without a benchmark is scored, please review the [2023 Quality Benchmarks \(ZIP, 779KB\)](#).



APP: Quality Performance Category

Submitting APP Measures as 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 (MIPS CQM only), and Measure 236 (Medicare Part B Claims and MIPS CQM).

The [2023 Quality Benchmarks \(ZIP, 779KB\)](#) reflect these flat benchmarks.

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.

*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.)



APP: Quality Performance Category

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

**1-10
points**

You'll receive between 1 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. This applies to small practices only.

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 10 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 when data completeness is met.



APP: Quality Performance Category

Submitting Medicare Part B Claims Measure, 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 \(ZIP, 779KB\)](#) 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 [2023 Quality Benchmarks \(ZIP, 779 KB\)](#).

The following extract from the [2023 Quality Benchmarks \(ZIP, 779 KB\)](#) 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 1	Decile 2	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	1.00 – 9.99	10.00 – 19.99	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	1.00 – 9.99	10.00 – 19.99	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	2.74 – 41.95	41.96 – 51.35	51.36 – 56.60	56.61 – 60.70	60.71 – 64.23	64.24 – 67.54	67.55 – 71.09	71.10 – 75.27	75.28 – 81.34	≥ 81.35

APP: Quality Performance Category

Submitting Medicare Part B Claims Measure, 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 1	1.00 – 9.99
Decile 2	10.00 – 19.99
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 Measure, eCQMs, and/or MIPS CQMs (Continued)

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

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

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

$$\begin{array}{|c|} \hline \text{decile \#} \\ \hline 7 \\ \hline \end{array} + \frac{\left[\begin{array}{cc} 66.74 & 60.00 \end{array} \right] - \left[\begin{array}{cc} 70.00 & 60.00 \end{array} \right]}{\left[\begin{array}{cc} 70.00 & 60.00 \end{array} \right] - \left[\begin{array}{cc} 70.00 & 60.00 \end{array} \right]} = 0.674... = 7.7$$

...which is rounded to 0.7

APP: Quality Performance Category

Submitting Medicare Part B Claims Measure, eQMs, 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 eQMs 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 eQMs.
- The eQMs 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 eQM), 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. It is important to note, that when reporting the same measures through multiple collection types, the measure should be completely reported through each collection type; CMS will not aggregate data from multiple collection types to calculate a single measure score.

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 eQM.
- When scoring Measure 001, we'll use either the MIPS CQM or eQM collection type — whichever results in more achievement points based on comparison to its benchmark.



APP: Quality Performance Category

Submitting APP Measures as 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	<ul style="list-style-type: none"> 30 POINTS – For the 3 required quality measures: <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 60 POINTS – For the 3 required quality measures + CAHPS for MIPS measure + HWR measure + MCC measure
ACOs Reporting eCQMs/MIPS CQMs	<ul style="list-style-type: none"> 60 POINTS – For the 3 required quality measures + CAHPS for MIPS 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](#).
- The total measure available achievement points may be less than the maximum points described on this slide when the individual, group, or APM Entity does not meet case minimum requirement or minimum beneficiary sampling requirement.



APP: Quality Performance Category

Submitting Medicare Part B Claims Measure, eQMs, and/or MIPS CQMs (Continued)

Factors Impacting Numerator Points and Available Denominator Points

Under certain circumstances, your numerator points for a measure may be set to 0, and your denominator (10 x the number of measures you're required to report) may be lower than the maximum points available.

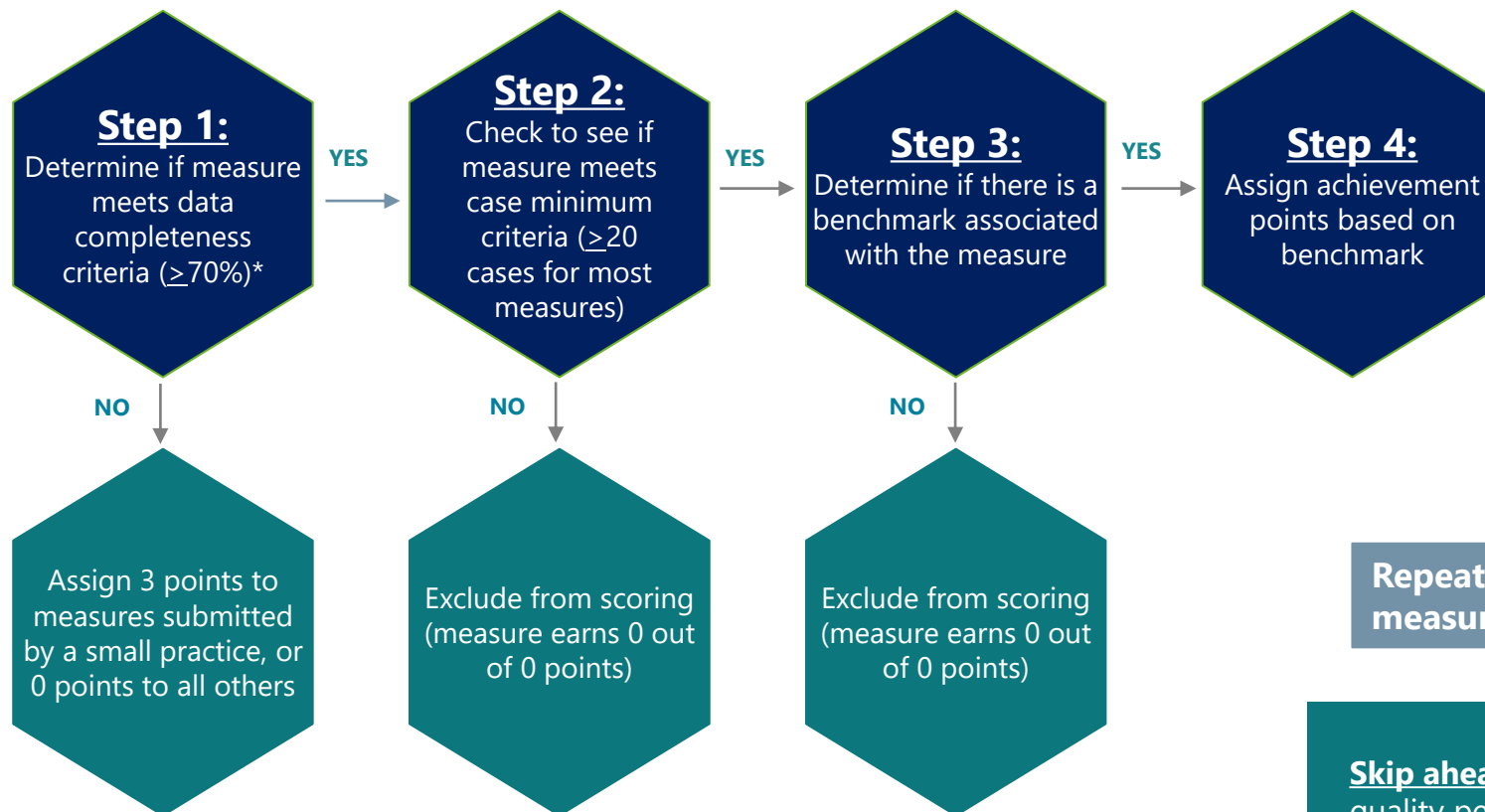
IF...	THEN...
There's no historical benchmark for one of the required APP measures and we can't calculate one based on data submitted for the performance period...	...the measure will receive 0 points.
You don't meet the case minimum for one or more measures...	...the measure will receive 0 points.
Your 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 report the CAHPS for MIPS Survey measure.
<p>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.</p> <p>NOTE: To the extent feasible, we will identify suppressed measures by the beginning of the submission period.</p>	<p>...we'll lower the denominator by 10 points for each impacted measure.</p> <p>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.</p> <p>However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.</p>



APP: Quality Performance Category

Submitting Medicare Part B Claims Measure, 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.

*For Shared Savings Program ACOs, the denominator eligible population will reflect 100% of the matched, deduplicated population across all participant TINs and CCNs in the ACO.



APP: Quality Performance Category

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 the APP for the 2023 Performance Year?

For the 2023 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 2023 APP: CMS Web Interface Measure Specifications and Supporting Documents for ACOs \(ZIP, 6.1MB\)](#).

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 2023 performance year:

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

Reminder: 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.



APP: Quality Performance Category

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.

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 - 9.99 %	1 – 1.9 points	Decile 1
10.00 - 19.99%	2 – 2.9 points	Decile 2
20.00 - 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-2 (Inverse Measure, Lower Performance Rate indicates Better Performance)

Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
100.00 - 90.01%	1 – 1.9 points	Decile 1
90.00 – 80.01%	2 – 2.9 points	Decile 2
80.00 - 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 the CMS Web Interface Measures Scored?

Measure Achievement Points

**1-10
points**

You'll continue to receive between 1 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 your 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.

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

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.



APP: Quality Performance Category

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.

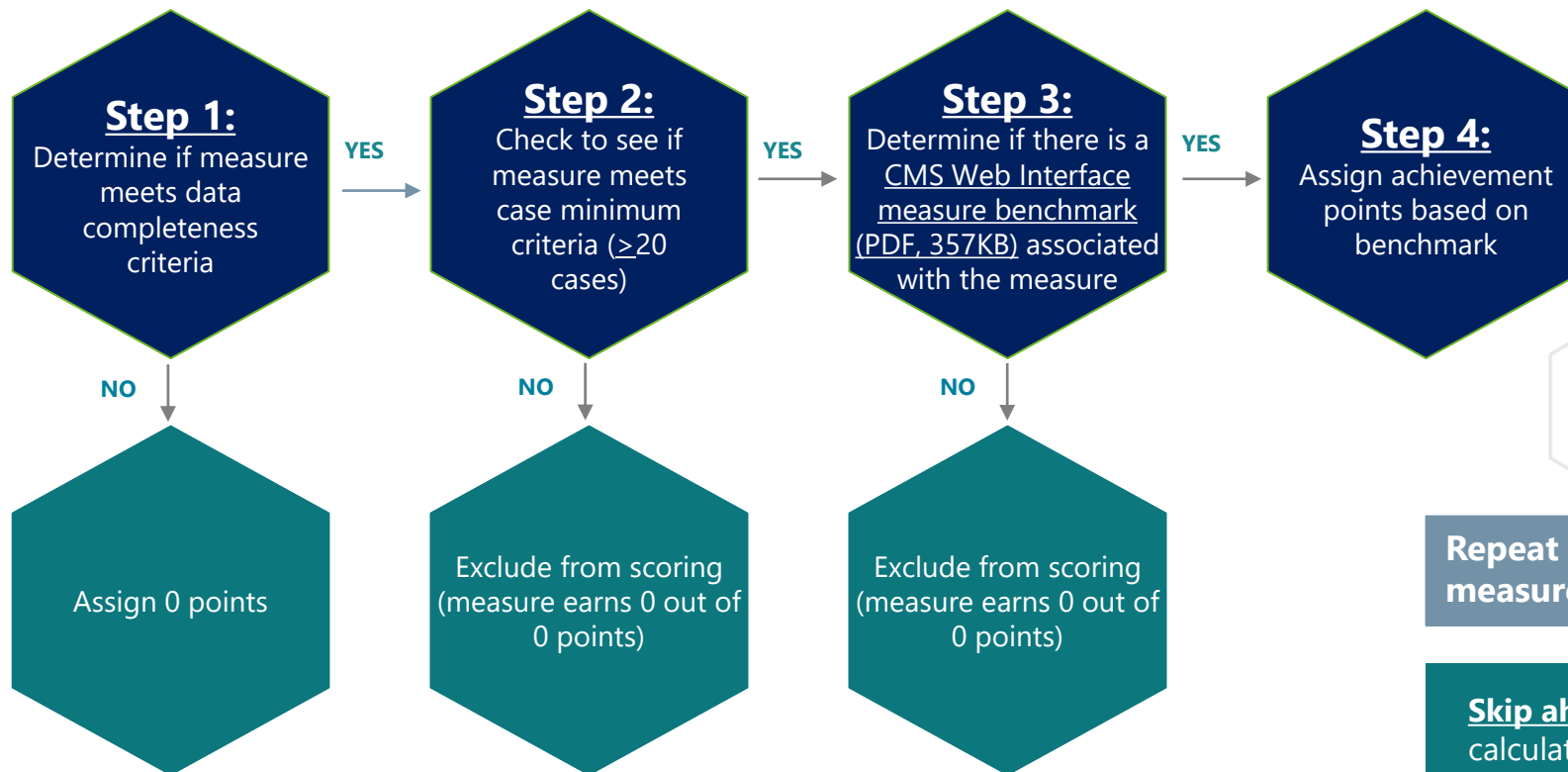
IF...	THEN...
The ACO doesn't report a measure without a benchmark...	...we'll increase the denominator by 10 points for each measure without a benchmark that the ACO didn't report.
The ACO doesn't meet the case minimum for one or more measures...	...we'll lower the denominator by 10 points for each 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.
<p>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...</p> <p>NOTE: To the extent feasible, we will identify suppressed measures by the beginning of the submission period.</p>	<p>...we'll lower the denominator by 10 points for each affected measure.</p> <p>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.</p> <p>However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.</p>



APP: Quality Performance Category

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.

CAHPS for MIPS

What Are the Steps for Scoring CMS Web Interface Measures?

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 Measure Scoring and Benchmarks

We established a benchmark for individual summary survey measures (SSMs) in the CAHPS for MIPS measure. These benchmarks were calculated using historical data from the 2021 performance period. Each SSM is awarded 1 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS measure score is calculated by the average number of points across all scored SSMs. Please review the 2023 historical CAHPS for MIPS benchmarks in the [2023 Quality Benchmarks \(ZIP, 779KB\)](#).

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 2023 performance period.

APP: Quality Performance Category

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 measure + 10 Points for HWR Rate for MIPS Eligible Clinician Groups measure for a total of 110 measure points.¹
 - 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 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.

¹ The total available measure achievement points may be less than the maximum points described in this slide if the individual, group, or APM Entity does not meet case minimum or minimum beneficiary sampling requirement on a measure(s).

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



APP: Quality Performance Category

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, and APM Entities

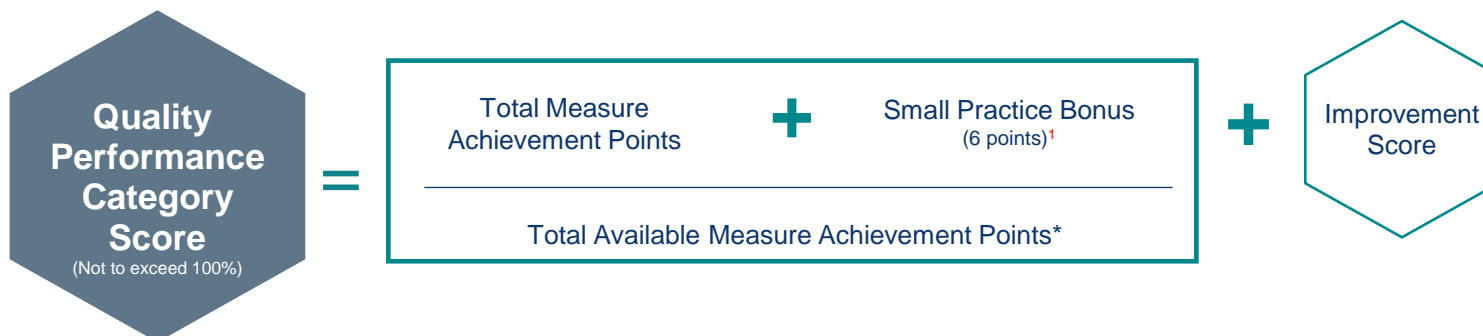
We use the following formula to calculate a quality score for individuals, groups, and APM Entities that aren't a small practice:



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:



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 eCQMs/MIPS CQMs and one score for the CMS Web Interface measures — and use whichever measure set resulted in the higher score for MIPS scoring.

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

¹ No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2023.

APP: Quality Performance Category

Calculating the Quality Performance Category Score (Continued)

What is Improvement Scoring?

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

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 (2022 performance period) and the current performance period (2023 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 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 2022 and 2023. They earn 83.1 achievement points out of 110 possible points for the 2023 performance period.

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

- Their 2023 achievement score = $83.1/110 = 75.5\%$.
- Their 2022 achievement score = 72.2% (excludes bonus points).
- The increase in their achievement score = $75.5\% - 72.2\% = 3.3\%$.
- Their improvement score = $(3.3\% \div 72.2\%) \div 10 = .46\%$.

$$\begin{array}{c} \text{Quality} \\ \text{Performance} \\ \text{Category} \\ \text{Score} \\ \mathbf{75.96\%} \end{array} = \left(\frac{83.1}{110} \right) + \begin{array}{c} \text{Improvement} \\ \text{Score} \\ \mathbf{.46\%} \end{array}$$

$\underbrace{\hspace{10em}}_{=0.755 \text{ or } 75.5\%}$

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). ¹

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 2023 MIPS Extreme and Uncontrollable Circumstances Exceptions Application User Guide \(PDF, 1.24MB\)](#), 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.

For more information, visit the [Quality: APP Requirements](#) webpage.

¹ For Shared Savings Program ACOs, note that only the quality performance score is used by the Shared Savings Program to calculate shared savings and losses, including any relevant adjustments by the Shared Savings Program. The MIPS final score is not utilized by the Shared Savings Program.

APP: Improvement Activities Performance Category



APP: Improvement Activities Performance Category

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

MIPS APM participants reporting the APP don't need to submit any data for the improvement activities performance category for the 2023 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 the APP in 2023 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

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

Objectives	Measures		Requirements
e-Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		Required unless an exclusion is claimed
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	HIE Bi-Directional Exchange	Required (no exclusion available), unless option 1 or option 3 is reported
	Option 3	Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (no exclusion available), unless option 1 or option 2 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 <ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting 		Required unless an exclusion(s) is claimed
	Bonus (Optional): <ul style="list-style-type: none"> Clinical Data Registry Reporting Public Health Registry Reporting Syndromic Surveillance Reporting 		Optional measures (no exclusions available)

There are now 3 options for clinicians to meet the requirements of the Health Information Exchange objective.

You'd choose and report 1 of these 3 options.

New for 2023:

In addition to the required measures in the Public Health and Clinical Data Exchange objective, MIPS eligible clinicians are also required to submit their level of active engagement.



APP: Promoting Interoperability Performance Category

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

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

Use 2015 Edition Cures Update CEHRT to report the measures on the previous slide and collect your data (certified by the last day of the performance period)

Submit a “yes” to the Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation (previously named the Prevention of Information Blocking attestation)

Submit a “yes” to the ONC Direct Review attestation

Submit your level of active engagement for the required Public Health and Clinical Data Exchange measures

Submit a “yes” that you have completed the Security Risk Analysis measure during 2023

Submit the CMS EHR Certification identification code for your EHR product(s) as proof that it is certified by ONC to the 2015 Edition Cures Update.
(You can find this information [here](#))

Submit a “yes” or “no” to completing the High Priority Practices Guide of the SAFER Guides measure during 2023

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.



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 the Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score if reporting Promoting Interoperability at the individual or group level.

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2023?

For the 2023 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, Public Health and Clinical Data Exchange objective measures (required and optional/bonus), the optional HIE Bi-Directional Exchange and TEFCA measures, 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

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2023? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES/NO
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required (unless option 2 is reported)	1 – 15 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 15 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange	Required* (unless option 1 or 3 is reported)	30 points	YES/NO
	Option 3	Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (unless option 1 or 2 is reported)	30 points	YES/NO
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required	1 – 25 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required	25 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

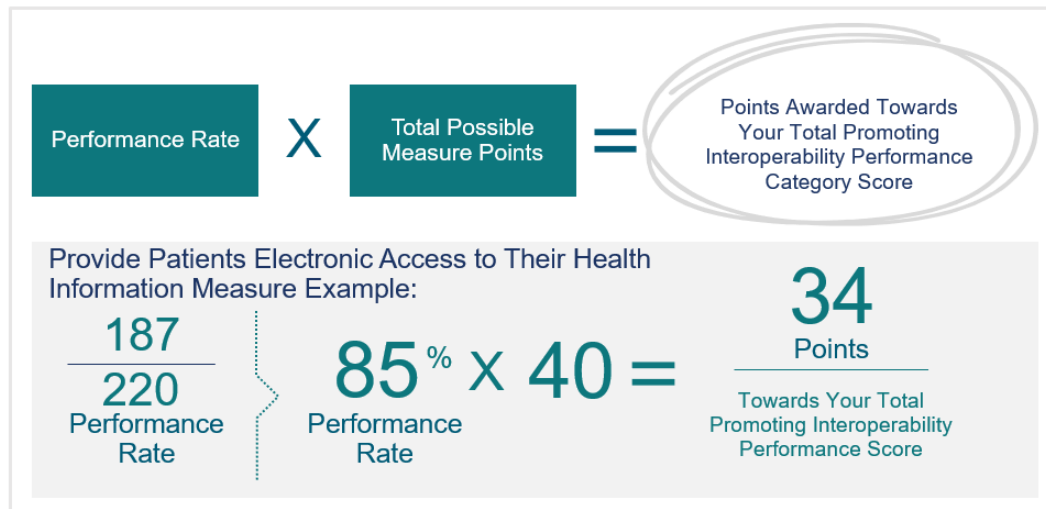


APP: Promoting Interoperability Performance Category

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2023? (Continued)

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 e-Prescribing measure, which is worth up to 10 points.



Important to Note:

- You can earn a maximum of 5 bonus 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).

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.

- 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.)

Example 1:

$$\text{Score} = 8.53 \rightarrow \text{Round up to } 9$$

Example 2:

$$\text{Score} = 8.33 \rightarrow \text{Round down to } 8$$

APP: Promoting Interoperability Performance Category

Scoring Promoting Interoperability Measures Submitted with a Yes/No

For the Query of PDMP measure, you'll receive 10 points for this measure when:

You submit a "yes" for the required measure

If you submit an exclusion, the points will be redistributed to another measure or objective.

For the Public Health and Clinical Data Exchange objective, you'll receive 25 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*.

OR

You submit a "yes" for one required measure

AND

You submit an exclusion for the required measure

If you submit an exclusion for both required measures, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

For Option 2 or 3 in the HIE objective,, you'll receive 25 points for this objective when:

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

OR

You submit a "yes" to participating in a TEFCA.



APP: Promoting Interoperability Performance Category

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

While there are 105 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.

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

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).

$$\text{Promoting Interoperability Performance Category Score} = \frac{\text{Total Points Earned for Completed Measures}}{\text{Total Possible Measure Points}}$$

How Is the Promoting Interoperability Performance Category Scored?

APM Entity Participation

When reporting the APP as an APM Entity, Promoting Interoperability data can be reported at the individual, group or APM Entity level.

Promoting Interoperability Reported at the APM Entity Level

Beginning with the 2023 performance period, APM Entities can submit aggregated Promoting Interoperability data at the APM Entity level on behalf of all MIPS eligible clinicians in the Entity. The score is calculated the same way as for individuals and groups.

The diagram shows a teal hexagon labeled "Promoting Interoperability Performance Category Score" followed by an equals sign. To the right of the equals sign is a green-bordered box containing the formula:
$$\frac{\text{Total Points Earned for Completed Measures}}{\text{Total Possible Measure Points}}$$

Promoting Interoperability Reported at the Individual or Group Level

- 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 any of the optional 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).

The diagram shows a dark blue hexagon labeled "APM Entity's Promoting Interoperability Score" followed by an equals sign. To the right of the equals sign is a green-bordered box containing the formula:
$$\frac{\text{Sum of Points Earned by All MIPS Eligible Clinicians for Required Measures}}{\text{Total MIPS Eligible Clinicians in APM Entity} - \text{MIPS Eligible Clinicians Who Receive Performance Category Reweighting}}$$
 To the right of this box is a plus sign followed by a teal hexagon labeled "5 Bonus Points (if at least one clinician reported an optional measure)".

APP: Promoting Interoperability Performance Category

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 Measures from Public Health and Clinical Data Exchange Objective Reported?
MIPS Eligible Clinician 1	87	Yes
MIPS Eligible Clinician 2	87	No
MIPS Eligible Clinician 3	77	No
MIPS Eligible Clinician 4	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 5	92	No
MIPS Eligible Clinician 6	85	No
MIPS Eligible Clinician 7	0 – didn't meet reporting requirements	No
MIPS Eligible Clinician 8	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 9	49	Yes
MIPS Eligible Clinician 10	82	No

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
Score

=

$$\frac{87 + 87 + 77 + 92 + 85 + 0 + 49 + 82}{10 - 2}$$

Points from Required Measures

Total MIPS Eligible Clinicians in APM Entity

MIPS Eligible Clinicians Who Receive Reweighting

+

5

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

=

74.9%

Can the Promoting Interoperability Performance Category be Reweighted?

Yes. 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 [2023 MIPS Extreme and Uncontrollable Circumstances Exception Application User Guide \(PDF, 1.24MB\)](#) or the [Exceptions Application](#) webpage for more information.
2. An individual or group can submit a [Promoting Interoperability Hardship Exception Application \(PDF, 1.35MB\)](#), 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](#)):



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](#).

Other Reporting Factors

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

Clinician Level	
SPECIAL STATUS Hospital-based	Yes

NOTE: If you have an approved exception or qualify for automatic reweighting, **we'll reweight the 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.

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](#).

Other Reporting Factors

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

Clinician Level

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

Practice Level

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

NOTE: Groups 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 2023 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 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

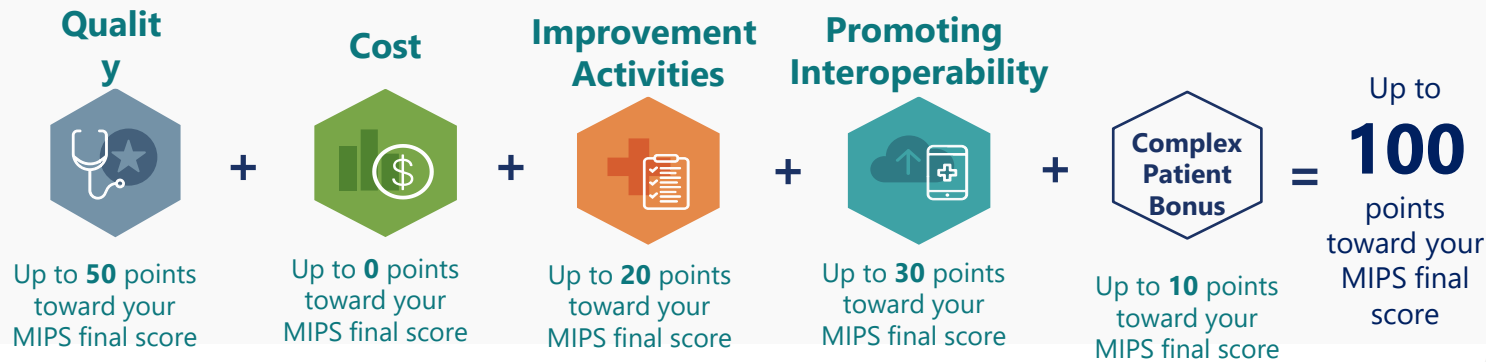


APP: MIPS Final Score

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 2023:

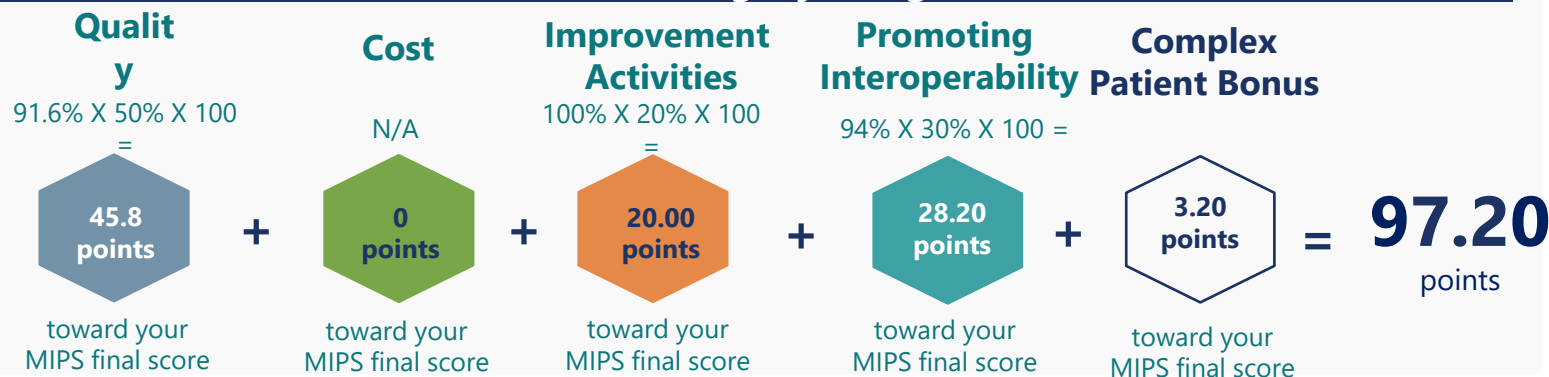


NOTE: The cost performance category is weighted at 0% of the MIPS final score for the APP, because all MIPS APM participants are already responsible for costs under their APMs.

Scoring Example

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

APP Performance Category Weights in 2023:



The MIPS final score can't exceed 100 points

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, and APM Entities.

The complex patient bonus is 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, 2022 – September 30, 2023) of the MIPS determination period.

The complex patient bonus is limited to MIPS eligible clinicians, 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 2022.

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

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, or APM Entity) in performance year 2022.

Step 2

We'll calculate the average HCC risk score and dual eligibility ratio for each MIPS eligible clinician, 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, 2022 and September 30, 2023 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

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, or APM Entity) in the 2022 performance year. (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 2023 average HCC risk score MINUS the 2022 mean HCC risk score from step 1)/ standard deviation for the 2022 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 2023 dual eligibility ratio MINUS the 2022 mean dual eligibility ratio from step 1)/ standard deviation for the 2022 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** = $1.5 + 4 * (\text{standardized score from step 2})$

Step 5

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

- **Social risk complex patient bonus points** = $1.5 + 4 * (\text{standardized score from step 3})$

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



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 2023 MIPS final scores will correlate to 2025 MIPS payment adjustments for MIPS eligible clinicians.

Final Score	Payment Adjustment
75.01 – 100.00 points	<ul style="list-style-type: none">Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)
75.00 points (Performance threshold=75.00 points)	<ul style="list-style-type: none">Neutral MIPS payment adjustment (0%)
18.76 – 74.99 points	<ul style="list-style-type: none">Negative MIPS payment adjustment (between -9% and 0%)
0.00 – 18.75 points	<ul style="list-style-type: none">Negative MIPS payment adjustment of -9%

Reminder: The 2022 performance year/2024 payment year was the last year for the exceptional performance adjustment.

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

MIPS Payment 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 **at** the performance threshold of **75 points** earn a **neutral** adjustment.
- Clinicians with a final score below the performance threshold of **75 points** will receive a **negative** adjustment. The maximum negative adjustment is -9%.

MIPS payment adjustments are calculated to ensure budget neutrality. 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 (lower positive adjustments) 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 (higher positive adjustments) because more MIPS eligible clinicians would have negative MIPS payment adjustments, and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

Reminder: The 2022 performance year/2024 payment year was the last year for the exceptional performance adjustment.



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 the APP or traditional MIPS.

What Might a Clinician or Group Choose to Report Separately From Their Entity?

An individual or group of MIPS eligible clinicians may choose to report 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 the APP?

An individual or group of MIPS eligible clinicians might choose to report 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 the APP?

For performance year 2023, 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 or the alternative 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 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 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.

Will the Health Equity Adjustment under the Shared Savings Program impact my MIPS payment adjustment?

No. For ACOs that report the 3 eCQMs/MIPS CQMs and meet all other eligibility criteria for the health equity adjustment, CMS uses the health equity adjusted quality performance score in several Shared Savings Program determinations. For more information on the Health Equity Adjustment, please see the [Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology v11 Specifications \(PDF, 1.9MB\)](#).

Where Can Clinicians Go for Additional Support?

Please review the 2023 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.



Acronyms and Version History



Acronyms and Version History

Acronyms



Acronyms and Version History

Version History

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

Date	Description
08/23/2024	Revised text explaining the impact of congressional legislation on the payments on slide 6.
05/14/2024	Updated slide 6 to reflect changes to the APM Incentive Payment and conversion factor in performance period 2024.
12/12/2023	Updated Appendix B: Reallocation of Points for Promoting Interoperability Measure(s) on page 71.
09/26/2023	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 2023 Performance Year/2025 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 B: Reallocation of Points for Promoting Interoperability Measure(s)

When an Exclusion is Claimed

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

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed...
e-Prescribing	e-Prescribing		Yes	...the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: <ul style="list-style-type: none"> 5 points to the Support Electronic Referral Loops by Sending Health Information measure 5 points to the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure OR ...the 10 points are redistributed to the HIE Bi-Directional Exchange measure OR ...the 10 points are redistributed to the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	Query of Prescription Drug Monitoring Program (PDMP)		Yes	...the 10 points are redistributed to the e-Prescribing measure
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	...the 15 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	...the 15 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	No	N/A
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	No	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		No	N/A
Public Health and Clinical Data Exchange	Report on the 2 required measures: <ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting 		Yes	...the 25 points are still available in this objective if you claim an exclusion for one of the required measures and submit a “yes” attestation for the other required measure in the objective. ... the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim two exclusions.
	Bonus: <ul style="list-style-type: none"> Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting 		N/A	N/A

NOTE: Even if you claim 1 or 2 exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures, you can still earn a total of 5 bonus points by reporting 1, 2 or 3 of the optional Public Health and Clinical Data Exchange measures (Public Health Registry Reporting, Clinical Data Registry Reporting, or Syndromic Surveillance Reporting).



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)	<p>PY 2023 APP Quality Requirements (All Participants) (ZIP, 3.25MB)</p> <p>PY 2023 APP Quality Requirements (SSP ACOs Only) (ZIP, 5.08MB)</p> <p>Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)</p>	<p>You can report eCQMs if you use technology that meets the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.</p> <p>You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification.</p> <p>If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted.</p> <p>For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.</p>	<ul style="list-style-type: none"> • Individuals • Groups • APM Entities
MIPS Clinical Quality Measures (MIPS CQMs)	<p>PY 2023 APP Quality Requirements (All Participants) (ZIP, 3.25MB)</p> <p>PY 2023 APP Quality Requirements (SSP ACOs Only) (ZIP, 5.08MB)</p> <p>Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)</p>	<p>MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians.</p> <p>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.</p> <p>For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.</p>	<ul style="list-style-type: none"> • Individuals • Groups • APM Entities

Appendix C: 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	2023 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP, 12.6MB) 2023 Part B Claims Reporting Quick Start Guide (PDF, 1.44 MB)	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.	<ul style="list-style-type: none"> • 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) No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2023.
CMS Web Interface	Performance Year 2023 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6.10MB)	Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare patients for each measure within the application.	<ul style="list-style-type: none"> • Shared Savings Program ACOs reporting the APP

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 C: 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	2022 CAHPS for MIPS Overview Fact Sheet (PDF, 1.07MB)	<p>Groups and APM Entities can register between April 1, 2023 and June 30, 2023 to administer the CAHPS for MIPS Survey, a survey measuring patient experience and care within a group, virtual group or APM Entity.</p> <p>This survey must be administered by a CMS Approved Survey Vendor (PDF, 178KB).</p>	<ul style="list-style-type: none"> • 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 CAHPS for MIPS Survey. They're automatically registered.