Quality Payment PROGRAM

2021 Merit-based Incentive Payment System (MIPS) Final Score Preview

Purpose

This document will answer key questions (with supporting screenshots) about the MIPS Final Score Preview available now in performance feedback for practice representatives, MIPS Alternative Payment Model (APM) Entity representatives, individual clinicians, and virtual group representatives.

Third party representatives such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries can't access your performance feedback.

Table of Contents

Each section contains frequently asked questions and supporting screenshots.

Have questions about a particular topic?

Click the links to jump ahead or use the "CTRL-F" function to enter key words.

Fast Facts about Final Score Preview

What Is Final Score Preview?

The Final Score Preview period is a new phase of MIPS performance feedback that provides clinicians the opportunity to preview their final score prior to the release of payment adjustment information. As a reminder, your 2021 final score is what will determine your 2023 MIPS payment adjustment.

The purpose of this MIPS Final Score Preview period is to provide more transparent communication and improve the feedback process based on experiences from prior performance years. We want to make sure your final scores are as accurate as possible and that we identify any potential issues before we calculate payment adjustments.

- **We encourage you to sign in and preview final scores now and to contact the QPP Service Center** with questions or concerns**.**

What Data Are Available During the Final Score Preview Period?

During the Final Score Preview, performance feedback will display data associated with the highest final score that could be attributed to the clinician, group or APM Entity, and all the data required to calculate final scores, which includes:

- Performance category-level scores and weights
- Bonus points
- Measure-level performance data and scores
- Activity-level scores

Final Score Preview **won't** include payment adjustment information or patient-level reports.

Who Can Access MIPS Final Score Preview?

MIPS Final Score Preview is accessible to clinicians and authorized representatives of practices, virtual groups, and APM Entities (including Shared Savings Program ACOs), whether they reported traditional MIPS or the APM Performance Pathway (APP).

- Practice representatives with the Staff User or Security Official role can preview MIPS final scores from individual and/or group participation (if the practice participated at the group level).
- APM Entity representatives with the Staff User or Security Official role can preview MIPS final scores for their APM Entity.
- If you're a Medicare Shared Savings Program Accountable Care Organization's (ACO) QPP Security Official or QPP Staff User contact in the ACO Management System (ACO-MS), then you can preview the ACO's MIPS final score by signing in to the QPP website using your ACO-MS username and password.

Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

- Virtual group representatives with the Staff User or Security Official role can preview MIPS final scores from virtual group participation.
- Individual clinicians with the Clinician role can preview their final score from individual, group, virtual group, or APM Entity participation.

Please review Appendix C more information about what you can and can't see during the MIPS Final Score Preview period based on your access.

How Do I Access Performance Feedback to Preview MIPS Final Scores?

- Sign in to the Quality Payment Program website
- Click "Preview Final Score" on the home page
  - Acknowledge that you understand scores can change.
- Select your organization (Practice, APM Entity, Virtual Group)
  - Practice representatives can access both individual and group feedback through the practice organization.

Can My Scores Change During the Final Score Preview Period?

Yes, scores could change between now and August if we identify any issues during the MIPS Final Score Preview period that require system-wide scoring changes.

What If There's an Error with the Data Displayed During the MIPS Final Score Preview Period?

Please contact the QPP Service Center if you believe there's an error with information displayed during the MIPS Final Score Preview period. Contact the QPP Service Center (Monday-Friday, 8 a.m. - 8 p.m. ET) at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov.

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

- To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

Please note that issues raised during the MIPS Final Score Preview period aren't part of targeted review. The targeted review process allows clinicians to request a review of their MIPS payment adjustment calculation and will be available once we release MIPS payment adjustment information.

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When Will MIPS Payment Adjustments Be Available?

We anticipate that final performance feedback, including MIPS payment adjustment information, will be available in August 2022. Following the release of payment adjustment information, there will be a 60-day targeted review period during which clinicians can request a review of their MIPS payment adjustment calculation.

COVID-19's Impact on 2021 Performance Feedback

We continued to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We applied the **MIPS automatic extreme and uncontrollable circumstances (EUC) policy** to all individual MIPS eligible clinicians for the 2021 performance year. This policy only applies to clinicians participating in MIPS as individuals.

- Clinicians who didn't submit any data, or who only submitted data in one performance category, will automatically receive a neutral payment adjustment in 2023.
- Any performance category for which an individual clinician didn't submit data is weighted at 0% for the 2021 performance year.
- Appendix A outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.

We also extended the deadline for our **MIPS EUC Exception application** to March 31, 2022.

- **Group and virtual groups** could request reweighting of one or more performance categories to 0%; data submission overrode performance category reweighting on a category-by-category basis.
- **APM Entities** were required to request reweighting of all performance categories and data submission **didn't** override reweighting.
- Appendix B outlines performance category weights and payment adjustment implications based on the performance categories selected in approved applications.

Exception: Clinicians who participate in an APM – and groups and virtual groups that include these clinicians – qualify for automatic credit in the improvement activities performance category.

Submitting data for the quality and/or Promoting Interoperability performance categories triggered this automatic credit and overrode reweighting, making the category eligible for scoring.

Finally, we **reweighted the cost performance category** from 20% to 0% for the 2021 performance period **for all MIPS eligible clinicians** regardless of participation as an individual, group, virtual group, or APM Entity. (Cost is already reweighted to 0% when reporting the APM Performance Pathway (APP)).

The 20% cost performance category weight was redistributed to other performance categories.

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Accessing Final Score Preview (Performance Feedback)

Before You Begin

If you don't already have a HCQIS Authorized Roles and Profile (HARP) account or access to your organization on the QPP website, you'll need to create an account, request access, and wait to be approved.

- More information is available in the QPP Access User Guide (ZIP)

Please note that due to a mandatory federal-wide security update, you'll need a CMS-supported version of Firefox or Chrome to access the QPP website. You may encounter errors if you use a different web browser.

- **Please update your browser to the latest version of Firefox or Chrome**

How Can I Access My/Our MIPS Performance Feedback?

You can access Final Score Preview in your performance feedback through the QPP website by signing in with the same credentials that allowed you to submit and view data during the submission period.

Please note that if you are a Shared Savings Program ACO's QPP Security Official or QPP Staff User contact in the ACO Management System (ACO-MS), then you can preview the ACO's final score by signing in to the QPP website using your ACO-MS Username and Password.

If you don't have an account or role for your organization, refer to the following resources for information on creating an account and requesting a role for your organization.

- QPP Access User Guide
- How to Create a QPP Account video
- Connect to an Organization: Practice video
- Connect to an Organization: APM Entity video
- Connect to an Organization: Virtual Group video
- Request the Clinician Role video

Note: We've updated the workflow for some of these actions since recording these videos to improve your experience.

See Appendix C for more information about what you can and can't view during Final Score Preview based on your credentials.

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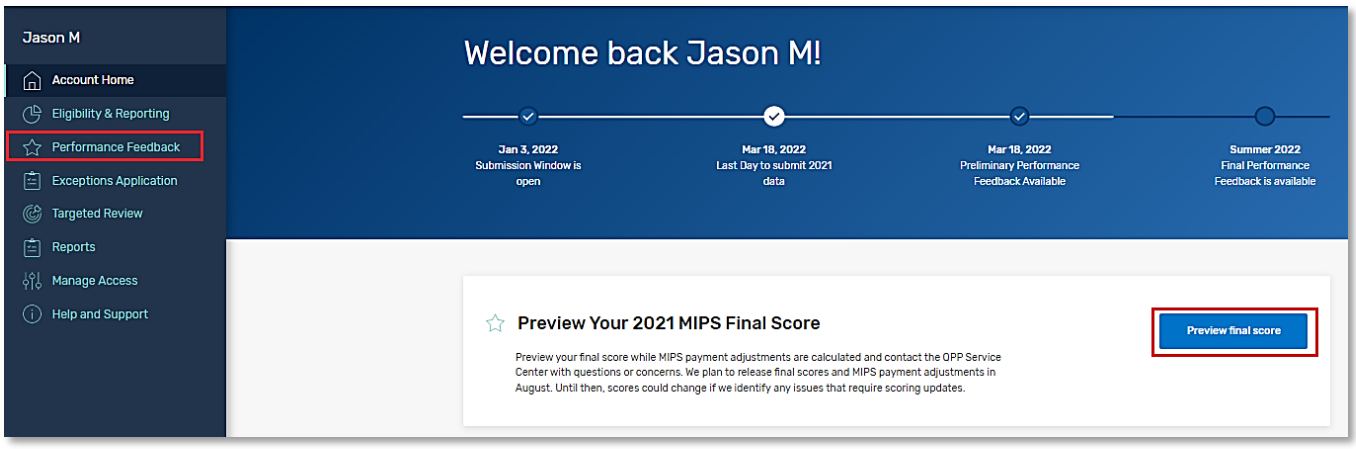
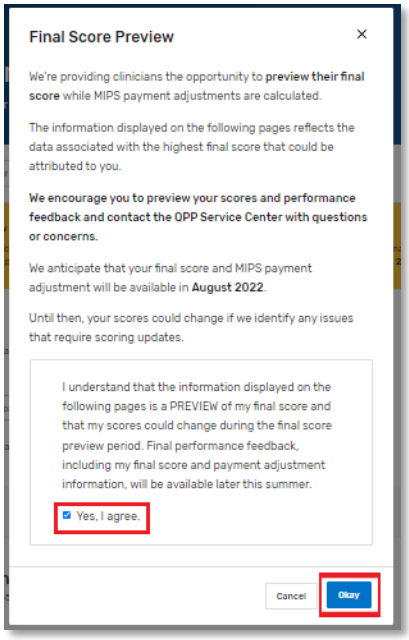
After signing in, select **Preview Your 2021 MIPS Final Score** or **Performance Feedback** from the left-hand navigation.



You must acknowledge that you're previewing your final score and that scores could change prior to selecting **Okay**.



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I'm a Clinician. What Is the Best Way for Me to Access My Performance Feedback?

The **Clinician role** will let you view your performance feedback for all of your associated practices without requesting access to each practice or gaining access to information about other clinicians in your practice.

If you're a clinician in a MIPS APM, this role also lets you directly access performance feedback based on your APM Entity's reporting via traditional MIPS and/or the APP.

Please review the **Register for a HARP Account** and **Connect as a Clinician** documents in the QPP Access User Guide (ZIP).

Can Third Party Intermediaries Access Final Score Preview in Performance Feedback?

Performance feedback (including Final Score Preview) can only be accessed by authorized practice representatives. The Centers for Medicare & Medicaid Services (CMS) doesn't grant direct access to performance feedback for third party intermediaries (including Qualified Registries and QCDRs) because it will contain sensitive information, including payment and patient information.

Third party intermediaries with an account and a role for their Registry (or QCDR) organization can still access their dashboard and view the measures and activities they submitted on behalf of their clients, and the related scoring information. However, they **won't** see:

- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims. (**Reminder:** We didn't calculate cost measures for anyone for the 2021 performance year.)
- Patient-level reports for administrative claims measures.
- Final score or payment adjustment information.

To view their clients' performance feedback, third party intermediaries would need to submit a request for a role for each practice (identified by Taxpayer Identification Number, or TIN)), virtual group, or APM Entity they represent. The Security Official for each organization would decide whether to approve the request, authorizing the third party intermediary to access performance feedback and all of the other information available for the organization once signed into the QPP website.

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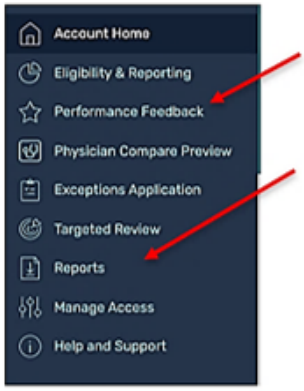
What's the Difference Between the Performance Feedback and Reports Tabs?

Some users may notice the **Reports** tab in their left-hand navigation panel.



You'll access your 2021 MIPS performance feedback through the **Performance Feedback** tab.

The **Reports** tab is where some users will find:

- 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Detail Reports (available in August).
- Historical CMS Web Interface reports for groups that have reported quality measures through the CMS Web Interface in previous years.
- Patient-level reports for quality and cost administrative claims measures (available in August).

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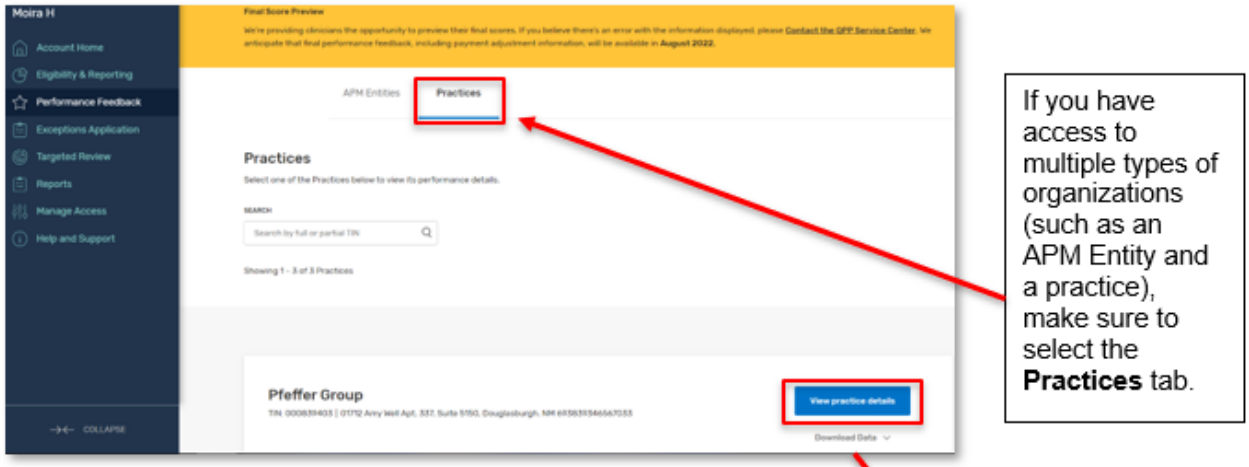
Navigating Into Performance Feedback: Practice Representatives

This section assumes you have either the Staff User or Security Official role for a **Practice** organization. (This is distinct from access to a virtual group and/or APM Entity organization.)

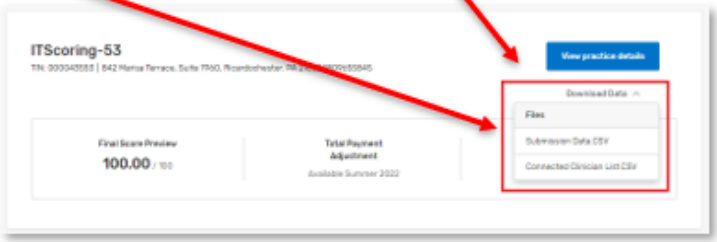
- Practice representatives can view feedback for individual clinicians and the group (if the practice participated as a group).

From **Performance Feedback**, select View Practice Details to access group or clinician level performance feedback.



You can also select **Download Data** to access:

- Your **Submission Data** (data submitted for your entire practice, which may or may not contribute to your final score).
- Your Connected Clinician List.



Select **View group feedback** to the right of the practice's name to access performance feedback based on **group participation** (aggregated data submitted on behalf of all clinicians in the practice).

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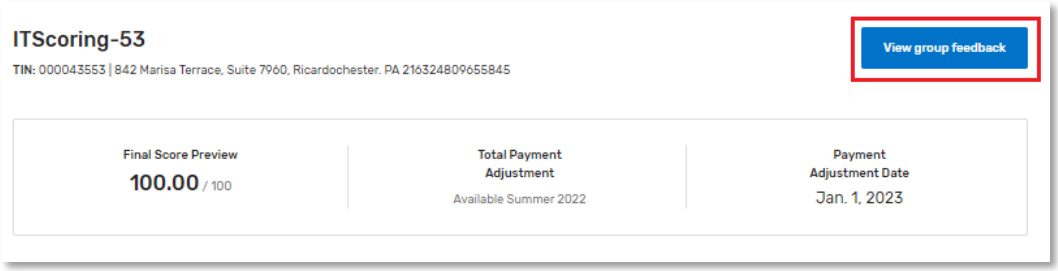
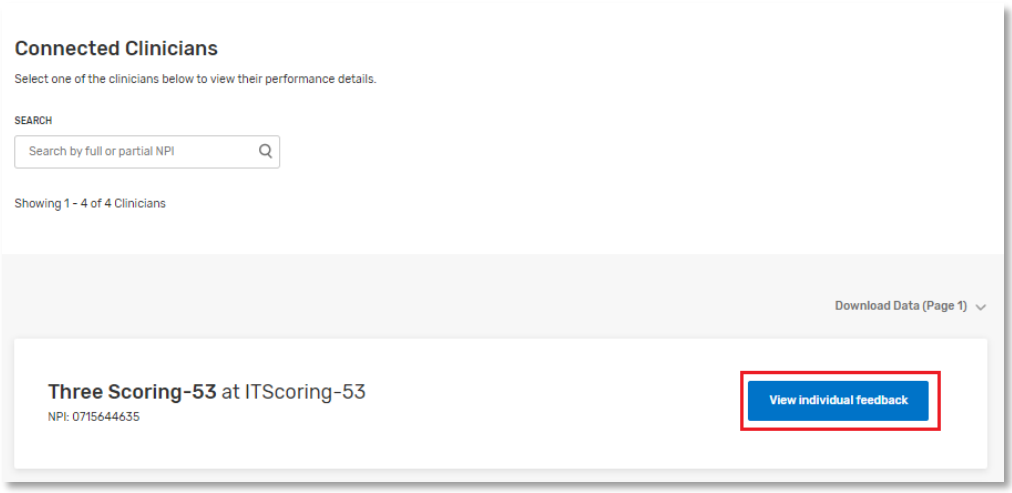


Select **View Individual Feedback** to the right of the clinician's name to access performance feedback based on **individual participation** (i.e., an individual clinician's data.)



Continue with these Frequently Asked Questions or skip ahead to walk through the rest of your feedback.

Our Practice Didn't Participate/Submit Data as a Group. What Will We See in Performance Feedback during Final Score Preview?

If your practice didn't submit data as a group for the 2021 performance year, you'll see a message indicating that your clinicians only reported as individuals:

- "All clinicians in this practice reported as individuals. They'll each receive a separate final score."

You can **View Individual Feedback** for each connected clinician.

We'll also make administrative claims quality measure scores available for informational purposes if they can be calculated.

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What's a 'Connected Clinician' and Who's Included in This List?

Connected clinicians are all of the clinicians, identified by the National Provider Identifier (NPI) associated with your practice (TIN) through Medicare Part B claims billed between 10/1/2020 and 9/30/2021, regardless of their individual MIPS eligibility. Your connected clinicians are displayed on the Practice Details page of performance feedback and can also be accessed through the Connected Clinicians List CSV download on the main Performance Feedback page.

- Clinicians who started billing claims under your TIN between 10/1/2021 and 12/31/2021 will appear in the Payment Adjustment CSV download once final performance feedback is released in August.

Our Practice Includes Clinicians Who Participated in a MIPS APM. What Performance Feedback Will We See?

When you sign in with practice credentials, you'll be able to preview final scores based on the data your practice submitted to QPP at the group or individual level. You **won't** be able to preview final scores at the APM Entity level (if applicable). As a reminder, the APM scoring standard is no longer applicable, and clinicians in MIPS APMs had the option to report traditional MIPS and/or the APP at the individual, group and/or APM Entity level.

We Participate in a Virtual Group. Why Don't I See Our Performance Feedback?

Representatives of solo practitioners and practices participating in a virtual group must have a Staff User role connected to the virtual group to access the virtual group's performance feedback. These permissions are different than the ones that let you access information specific to your practice. Please review the **Connect to an Organization** document in the QPP Access User Guide (ZIP).

Any data submitted by individual clinicians, solo practitioners, or TINs within the virtual group will be considered voluntary and not eligible for a payment adjustment.

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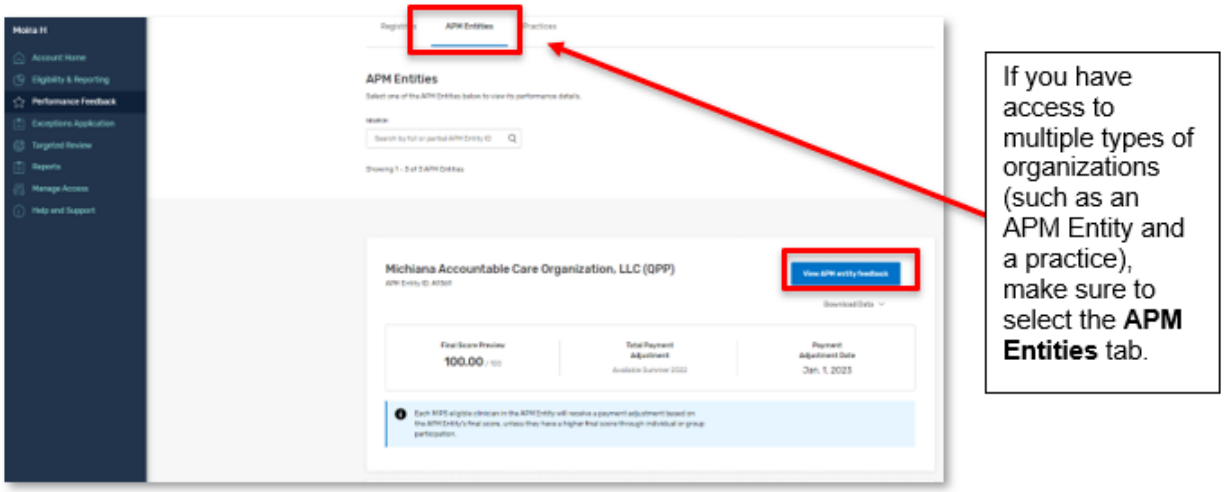
Navigating into Performance Feedback: APM Entity Representatives

This section assumes you have either the Staff User or Security Official role for an **APM Entity** organization. (This is distinct from access to a practice and/or virtual group organization.)

The following programs and models can review 2021 MIPS performance feedback, if applicable and available:

- Shared Savings Program ACO
- Next Generation ACO
- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive End-Stage Renal Disease (ESRD) Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Independence at Home Demonstration
- Maryland Total Cost of Care (TCOC)
- Vermont All Payer ACO
- Oncology Care Model (OCM)
- Primary Care First (PCF)

From Performance Feedback, select **View APM entity feedback** to access APM Entity level performance feedback.



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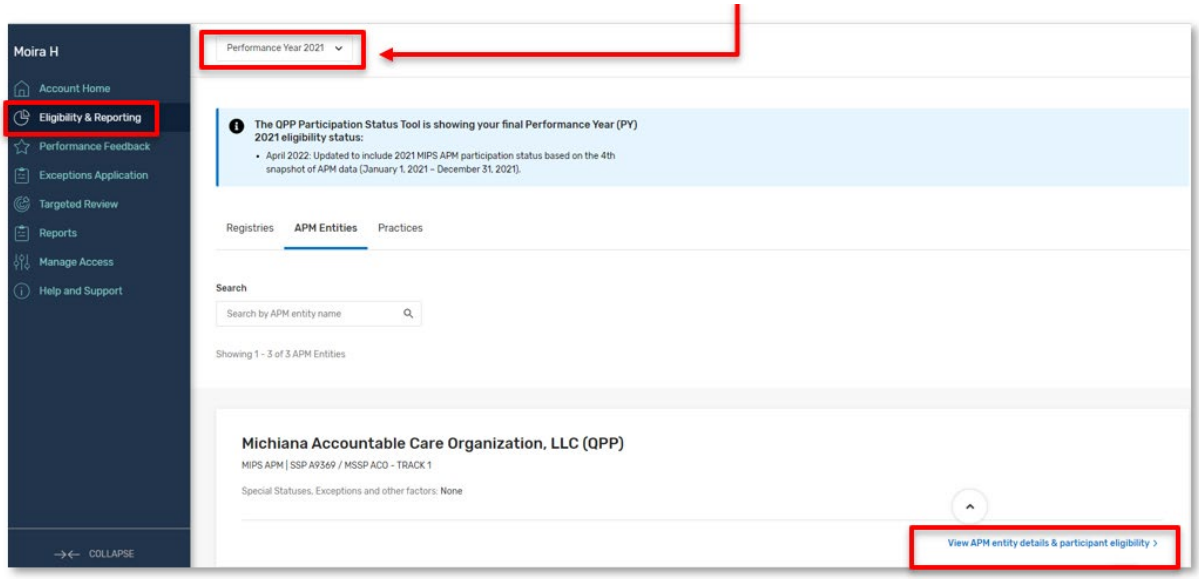
Continue with these Frequently Asked Questions or skip ahead to walk through the rest of your feedback.

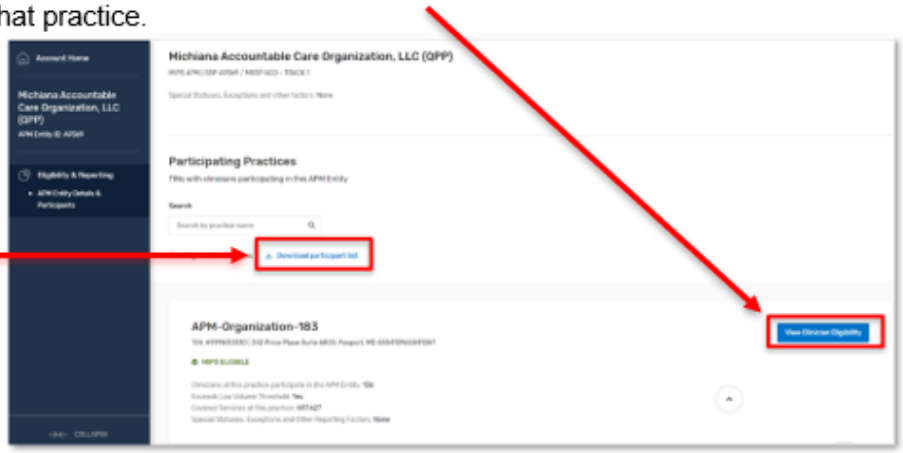
Can We Access a List of the Clinicians Associated with Our APM Entity?

Yes. You can download this list by clicking "**View Participant Eligibility**" from the **Eligibility & Reporting** tab. Make sure that you're looking at the **Performance Year 2021** page.



- Once you land on the APM Entity Details & Participants screen, you can click "**Download Participant List**" for a list of all participating practices and clinicians associated with the APM Entity.

  You can also click "**View Clinician Eligibility**" for any of the practices to view the clinicians within that practice.



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What Should We Expect to See in Feedback?

Users with access to the APM Entity (i.e., a Staff User or Security Official role for the APM Entity organization) will be able to preview:

- The APM Entity's final score.
- Performance category scores (quality, improvement activities, Promoting Interoperability, as applicable).
- A report of the individual and/or group Promoting Interoperability performance category scores that contributed to the APM Entity's Promoting Interoperability score.
- Measure-level scoring for quality measures reported by the APM Entity.

Can Individual Clinicians View Our APM Entity Feedback?

Yes. Individual clinicians in the APM Entity can preview their final score from the APM Entity if they have the clinician role **or** have been approved as a staff user for the APM Entity.

Representatives of Shared Savings Program ACO Participant TINs and practices with clinicians receiving their APM Entity's final score **won't** be able to access the APM Entity's performance feedback unless they have been approved as a staff user for the APM Entity.

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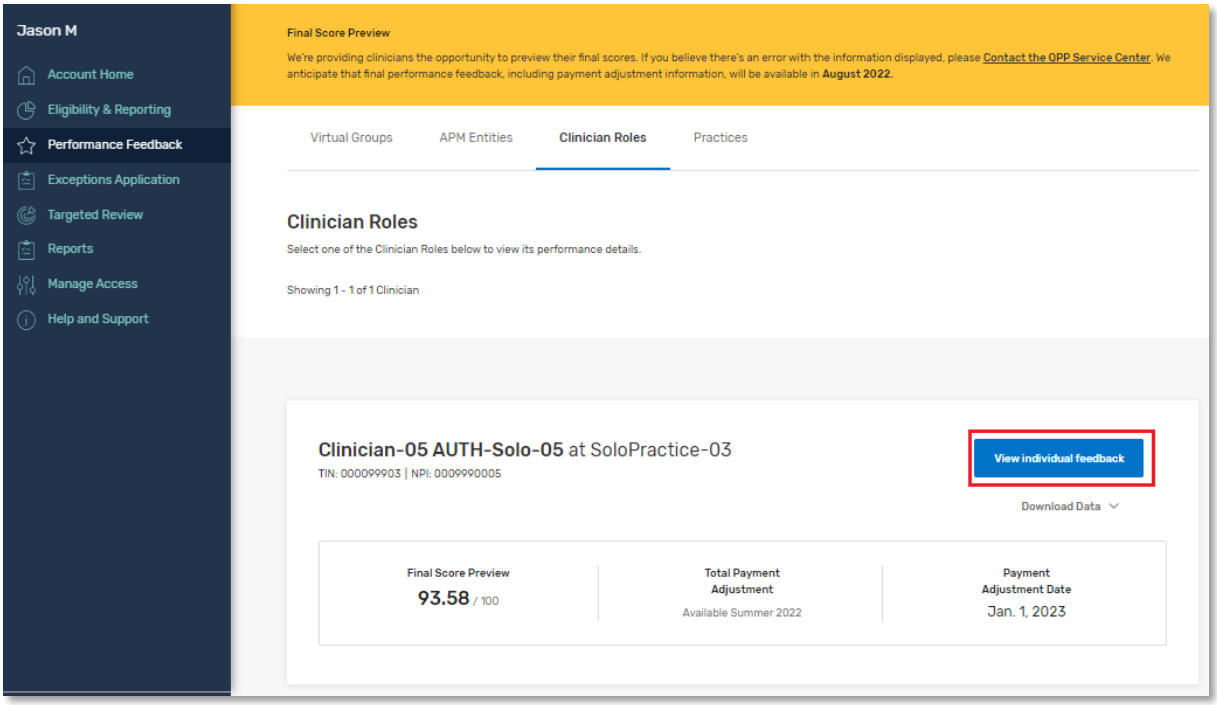
Navigating into Performance Feedback: Individual Clinicians

Note: This section assumes you're a clinician with the Clinician role. (This is different from the Staff User role for a practice, APM Entity or virtual group organization).

From **Performance Feedback**, you'll see a list of all your associated organizations (practices, APM Entities, and virtual groups).

Select **View Individual Feedback** to access your performance feedback associated with this organization. Your feedback at an organization may be based on individual, group or MIPS APM participation.



Continue with these Frequently Asked Questions or skip ahead to walk through the rest of your feedback.

How Do I Identify My Associated Organizations in Performance Feedback?

You should see the same associations on the Performance Feedback tab as you see for the 2021 performance year in the QPP Participation Status Tool or on the Eligibility & Reporting page when you sign in to the QPP website. Click **View Individual Feedback** to preview your final score as well as any individual data you may have submitted.

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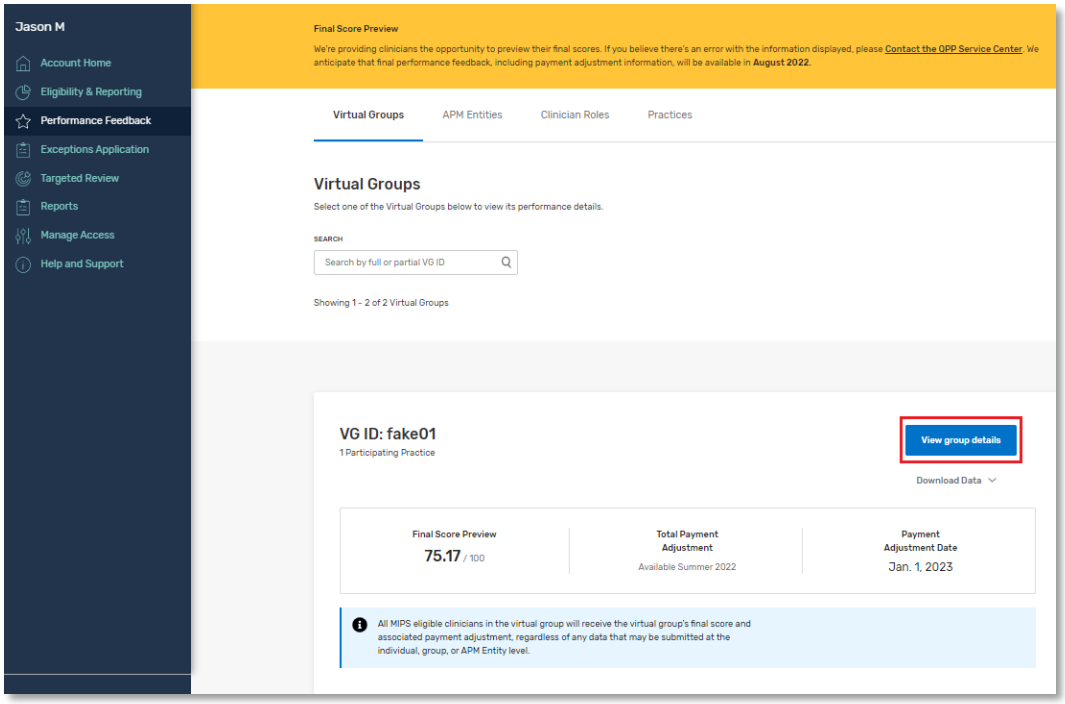
Navigating Performance Feedback: Virtual Group Representatives

This section assumes that you have either the Staff User or Security Official role for a **Virtual Group** organization. (This is distinct from access to a practice and/or APM Entity organization.)

From Performance Feedback, select **View Group Details** to access virtual group level performance feedback.



Continue with these Frequently Asked Questions or skip ahead to walk through the rest of your feedback.

Can the Practices and/or Solo Practitioners Who Participate in Our Virtual Group Access Our Performance Feedback?

Yes, but only if they have an approved Staff User role for your virtual group. This means they connected to your virtual group organization and requested the Staff User role; these permissions are different than the ones that let them access information specific to their practice. For more information, review the **Connect to an Organization** document in the QPP Access User Guide (ZIP).

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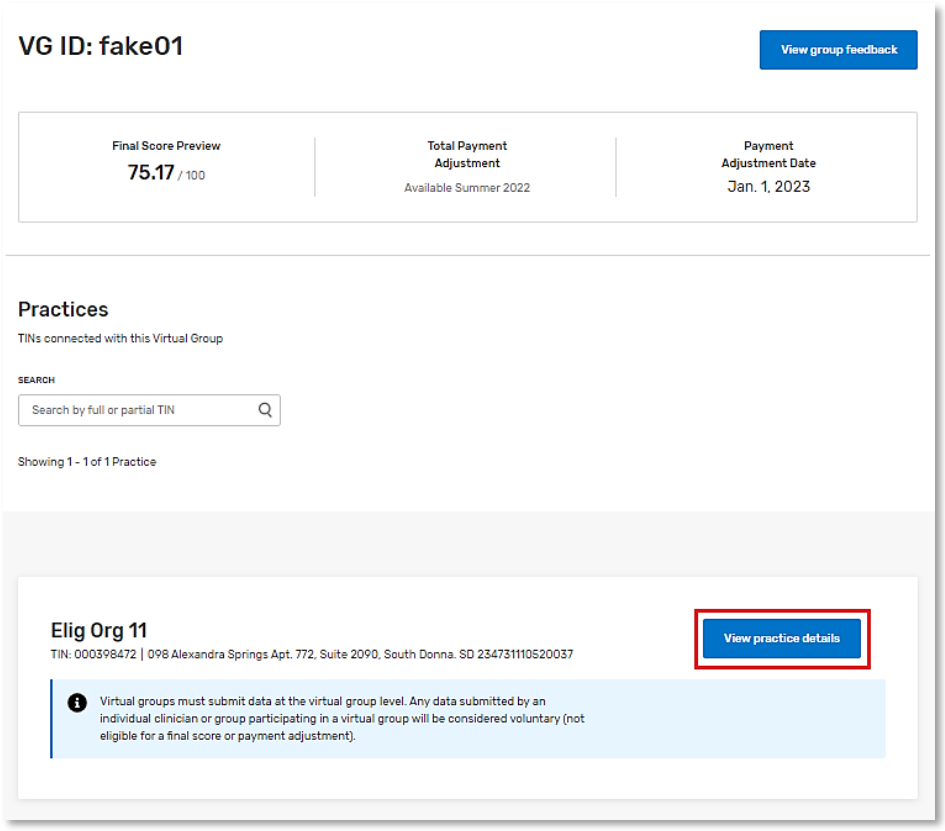
Can I Access a List of the Clinicians Participating in Our Virtual Group?

Yes. You can access a list of clinicians associated with each practice in the virtual group. Select **View practice details** next to each practice name.



We Have Clinicians in Our Virtual Group Who Participate in a MIPS APM. What Kind of Performance Feedback Will We See?

You'll see performance feedback based on the data you submitted to QPP at the virtual group level. Please note that we updated the scoring hierarchy so that clinicians participating in a virtual group will always get the virtual group's final score, even if they participate in a MIPS APM.

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Overview: Final Score Preview

When you navigate into feedback, you'll land on the **Overview** page. From here, you can preview:

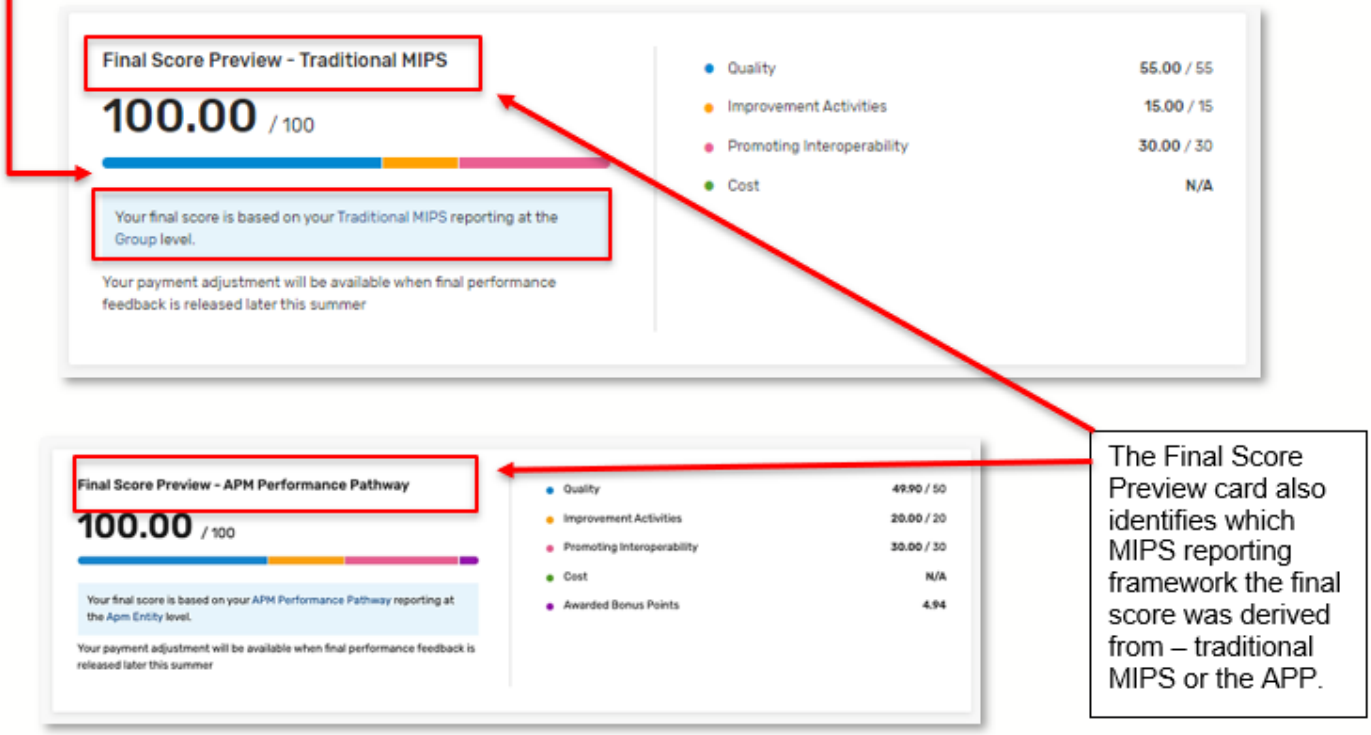
- Your final score, which will be based on reporting for traditional MIPS or the APP
- Your score and the weight for each MIPS performance category

As a reminder, there won't be any payment adjustment information on the Overview page during Final Score Preview.

How Is Our Final Score Determined?

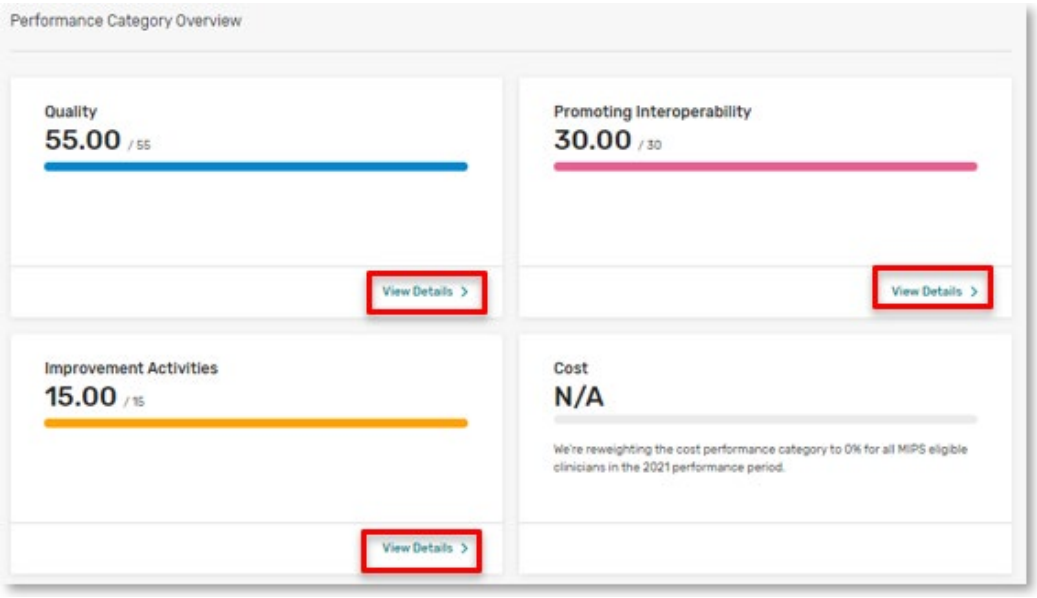
Your final score is the sum of your performance category scores and any points awarded for the complex patient bonus.

Note: If a clinician participated in MIPS multiple ways – for example, your practice reported traditional MIPS at the group level and the clinician also reported as an individual – we'll assign the highest score that could be attributed to the clinician under that TIN/NPI combination. Users with access to an APM Entity will only be able to access performance feedback and the final score for the APM Entity and won't see if the participating clinicians have a higher score from individual or group participation.



How Can I See More Information about the Different Performance Categories?

For individual, group, and virtual group feedback, you can access the scoring details for each performance category by clicking “View Details” on the Performance Category Overview cards below.



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Why Do I See "N/A" for One or More Performance Categories?

When you see "N/A" instead of a score for a performance category, this means that the category was reweighted to 0% of your final score.

- MIPS eligible clinicians who submitted some data as individuals will see "N/A" for every performance category for which they didn't submit data (due to the automatic EUC policy triggered by the COVID-19 pandemic).
- Groups and virtual groups will see "N/A" for every performance category they selected in an approved COVID-19 EUC application, unless data was submitted for that category.
- **Reminder:** Clinicians who participate in an APM – and groups and virtual groups that include these clinicians – qualify for automatic credit in the improvement activities performance category. Submitting data for the quality and/or Promoting Interoperability performance categories triggered this automatic credit and overrode reweighting, making the category eligible for scoring.

We're a Participant TIN in a Shared Savings Program ACO That Reported the APP. Why Do We See a Score of Zero for the Quality Performance Category?

Participant TINs see a quality score of zero because the APP quality measures are reported by the ACO and not the group.

- Participant TINs that reported Promoting Interoperability data for the APP as a group will see a group final score based on the Promoting Interoperability data they reported and the 100% automatic credit for the improvement activities performance category.
- Participant TINs **won't** see the final score attributed to the ACO. Only authorized representatives of the ACO (users with the Staff User or Security Official role for the ACO) or MIPS eligible clinicians in the ACO with the Clinician Role can access the ACO's final score.

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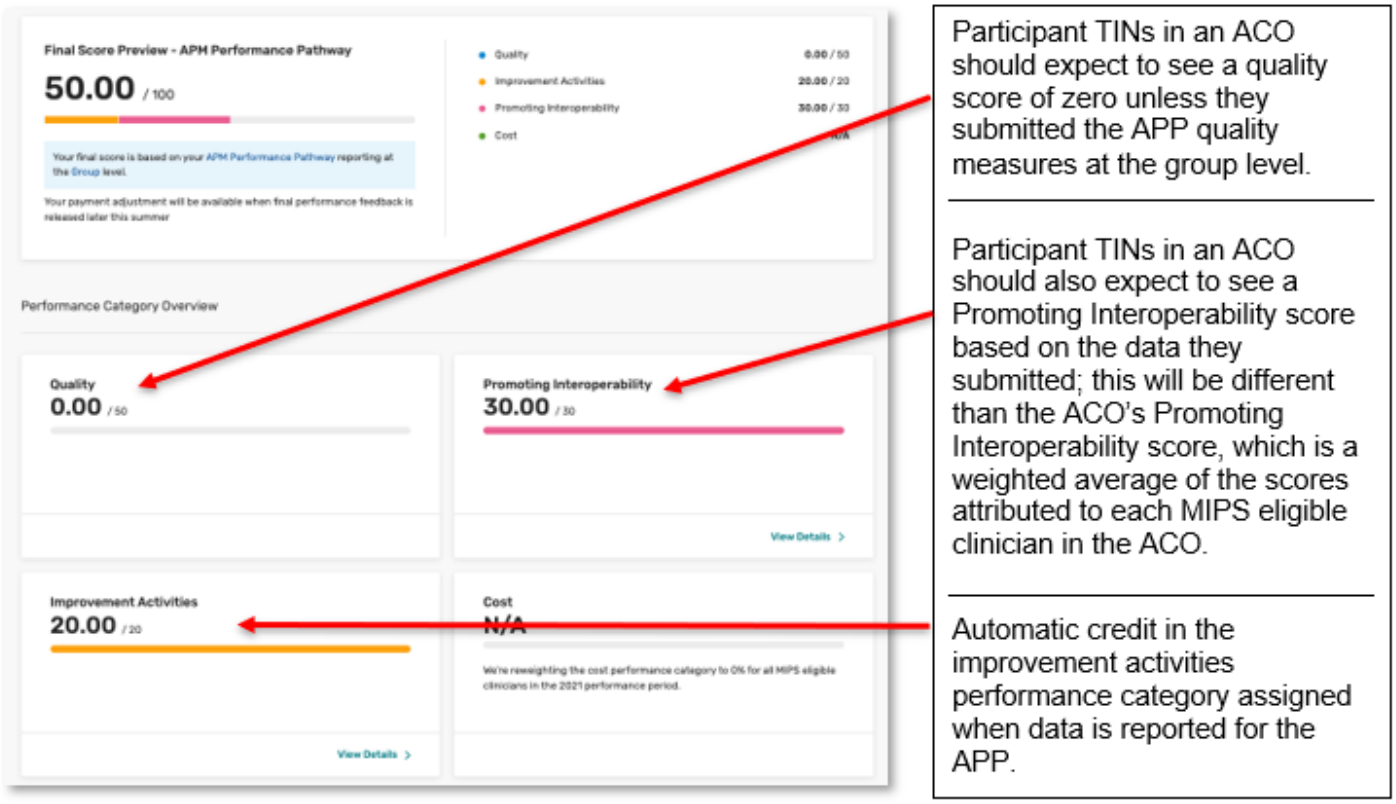

However, the MIPS eligible clinicians in the ACO will receive the highest final score and associated payment adjustment that could be attributed to them.

What Is the Complex Patient Bonus?

The complex patient bonus is based on the overall medical complexity and social risk for the patients treated by a clinician or group. We recognize that there can be challenges and additional costs associated with the care you provide to complex patients.

All MIPS eligible clinicians, groups, virtual groups, or APM Entities that care for complex patients and submit data for at least one MIPS performance category (quality, Promoting Interoperability, or improvement activities) are eligible for the complex patient bonus, whether reporting traditional MIPS or the APP.

The complex patient bonus awards up to 10 bonus points, which are added to your final score and based on a combination of the average Hierarchical Condition Category (HCC) risk score of the Medicare patients you treat and the proportion of dually eligible patients you treat.

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How Is the Complex Patient Bonus Determined?

We use 2 indicators to measure patient complexity:

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

AND

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

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

- Each MIPS eligible clinician, group, virtual group, or APM Entity was evaluated for the complex patient bonus in the 2021 performance year. There was no minimum amount or percentage of dually eligible patients or patients diagnosed with a condition that has an HCC risk score required for the clinician to receive a complex patient bonus.
- As finalized in the CY2022 Physician Fee Schedule (PFS) Final Rule, we doubled the complex patient bonus from 5 to 10 points for the 2021 performance year.

How Is the Complex Patient Bonus Calculated?

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

For PY 2021

*Unique patients must have been treated between 10/1/20 and 9/30/21 to be included in the Complex Patient Bonus calculation.

Please note: All screenshots are for illustrative purposes only.
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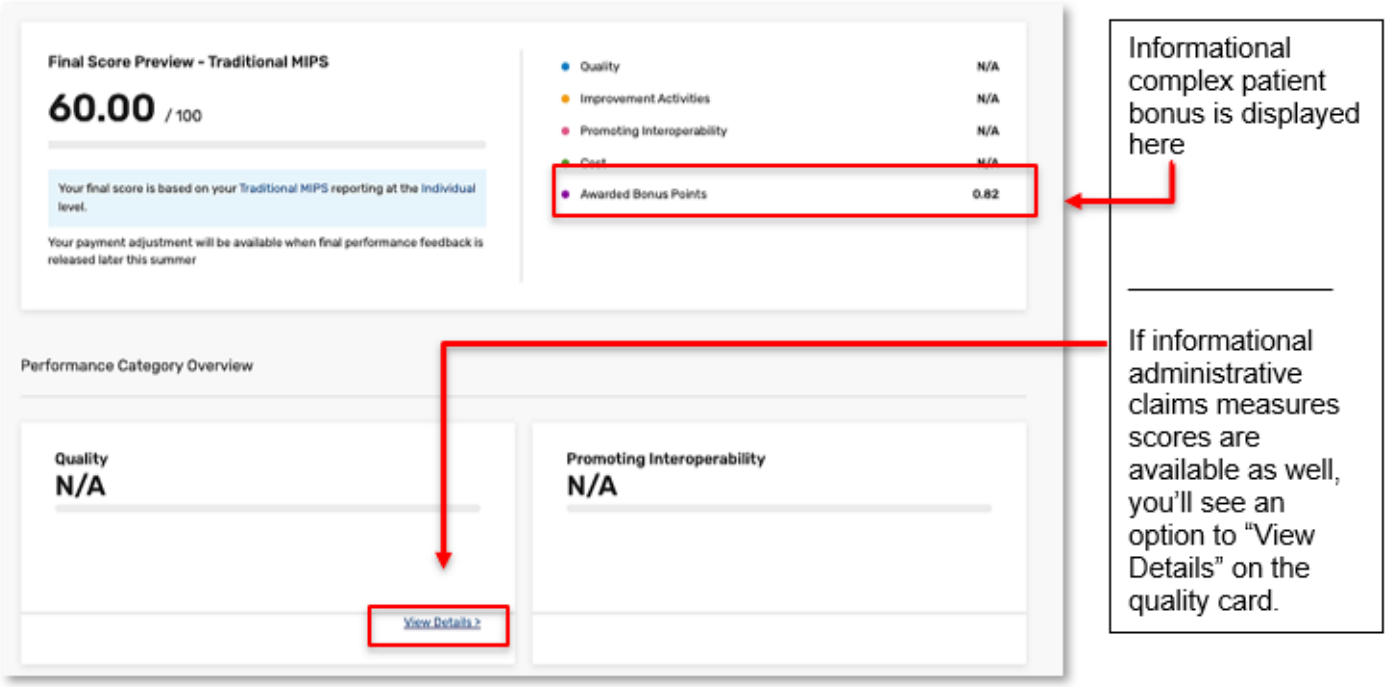
Did you know?

We'll display the complex patient bonus (if it could be calculated) for informational purposes for:

- Clinicians who weren't eligible for MIPS at the individual level but voluntarily reported as an individual.
- Clinicians that were individually eligible but didn't submit data and are receiving a score equal to the performance threshold due to the automatic extreme and uncontrollable circumstances policy.
- Practices that weren't eligible for MIPS at the group level but voluntarily reported as a group.
- Practices that were 1) eligible for MIPS at the group level, **and** 2) didn't report as a group, **and** 3) had either administrative claims quality measures or Items & Services data available for informational purposes.



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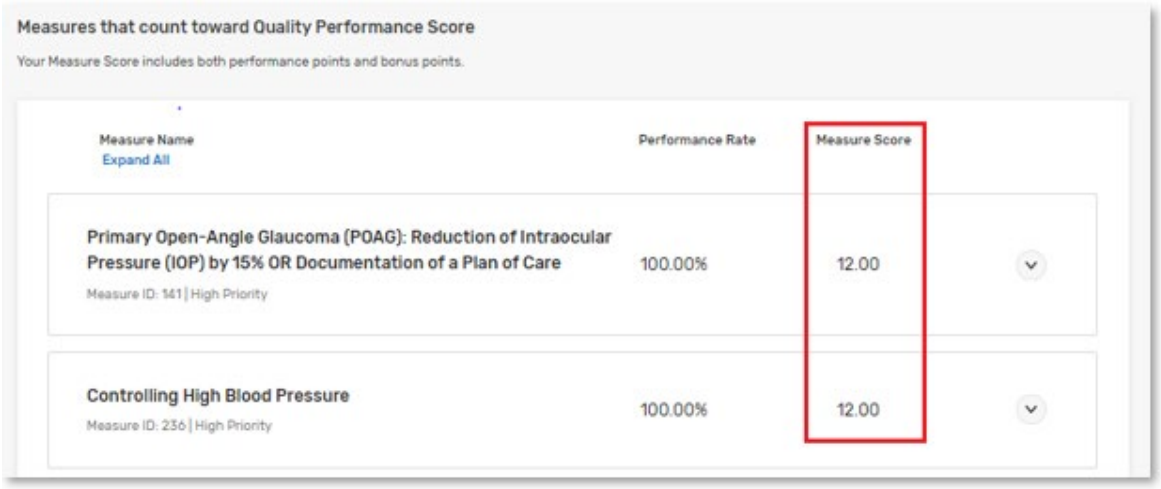
Traditional MIPS: Quality

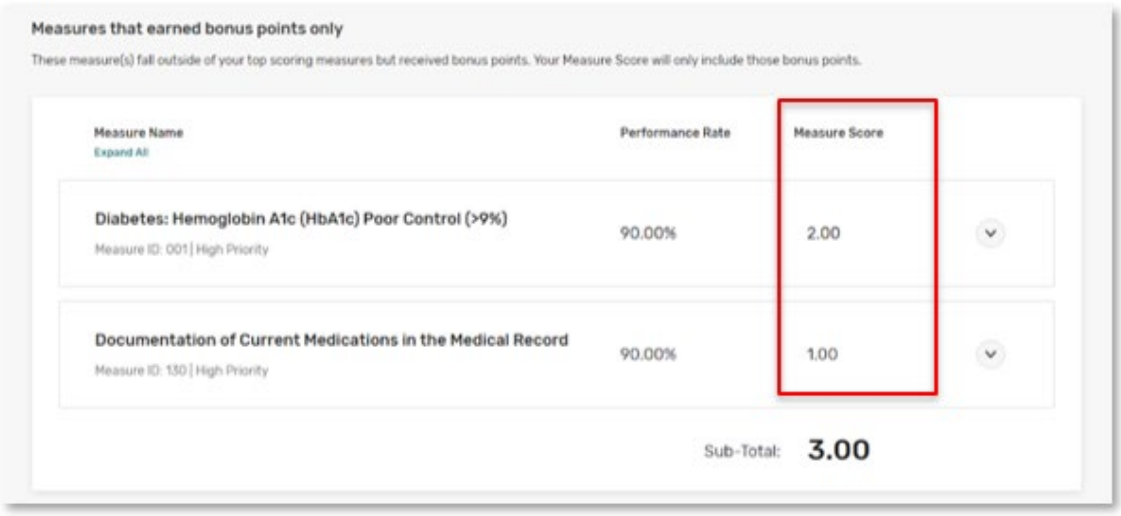
Skip ahead to see details about performance feedback from reporting **the APP**.

When you navigate into the quality section, you may see quality measures divided in up to 3 groups:

1. Measures whose performance points and bonus points count toward your quality performance category score. The measure score will display the sum of your performance and bonus points.



2. Measures whose bonus points contribute to your quality performance category score. You'll see the bonus points earned by these measures.



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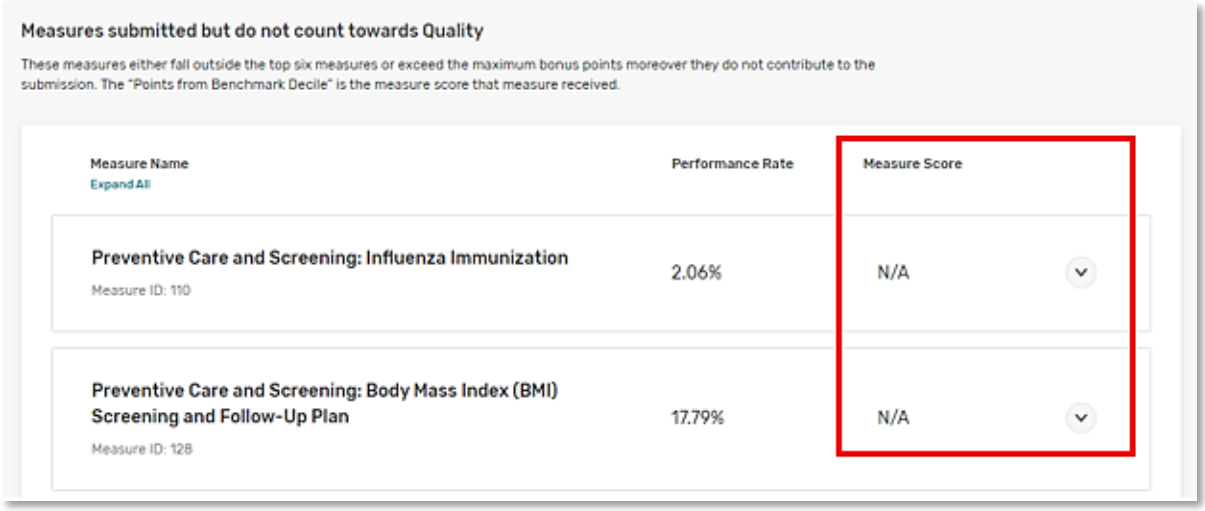
3. Measures that contribute zero points to your quality performance category score. You'll see "N/A" in the measure score.



We Submitted More Than 6 Measures. How Did You Determine Which Ones Counted Towards Our Quality Performance Category Score?

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

When determining which measures are included in the top 6:

- We'll select the highest scoring outcome measure.
    - If you didn't have an outcome measure available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 highest scoring measures.
- If you didn't submit an outcome or high priority measure, we selected your 5 highest scoring measures, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

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

Example: You submit 7 measures, and your 2 lowest scoring measures (after the required outcome measure) were the Colorectal Cancer Screening and Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measures, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top 6 because its measure ID (113) has a lower value than the Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure (320).

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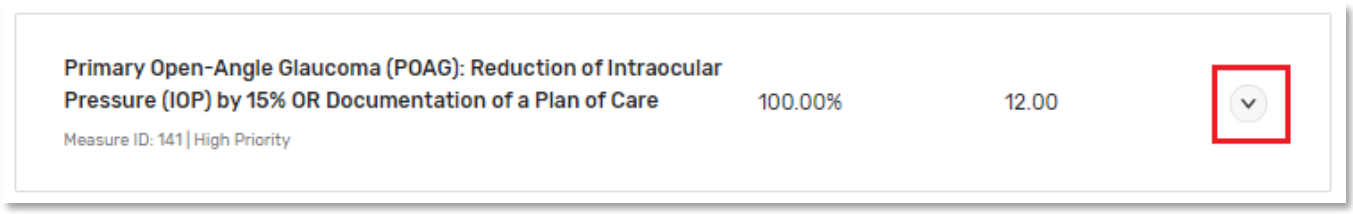
If you submit the same measure through multiple collection types—example, as a Medicare Part B claims measure and as an electronic clinical quality measure (eCQM) —we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2 versions of the same measure count towards your quality performance category score.

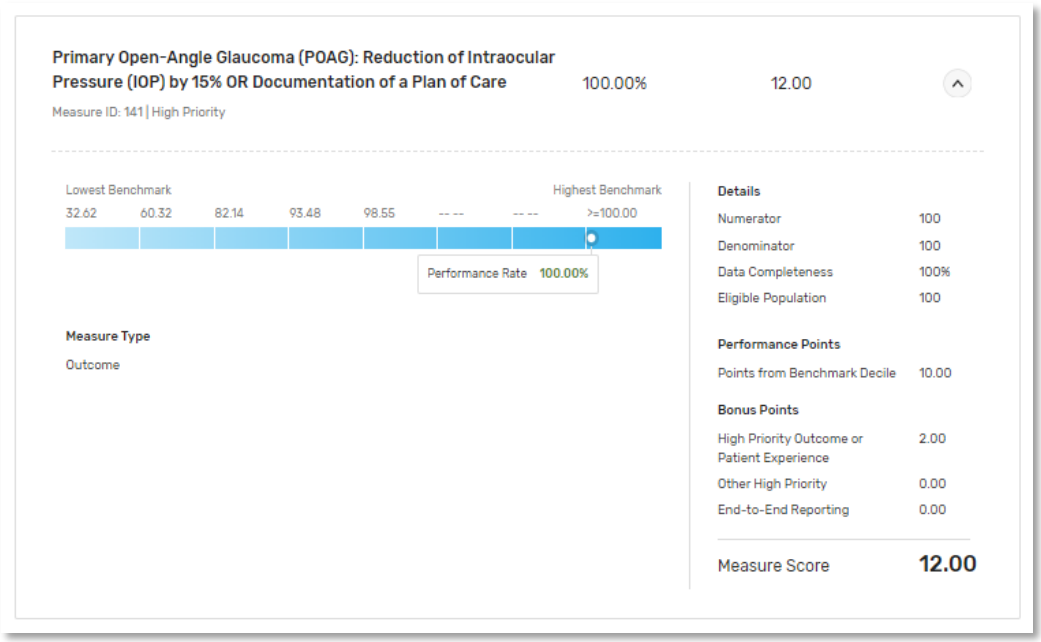
What Does It Mean When I See a Measure Score of "—"?

If you reported through the CMS Web Interface, you'll see '—' as the measure score for measures that were excluded from scoring because there's no benchmark, or because you didn't meet the case minimum.

How Can I Access Details About the Measures I Submitted?

Click the arrow to the right of the measure score to expand and view the measure details such as measure type, numerator, denominator, and data completeness.





Please note: All screenshots are for illustrative purposes only.
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Why Are Measures with Higher Performance Rates Not Counted Towards My Quality Performance Category Score?

We included your highest **scoring** quality measures. Please note that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85% performance rate, 1 measure may earn 7 points while the other measure earns 10 points, based on the benchmarks for each measure.

I Reported 6 Measures and They All Had Benchmarks. Why Was I Only Scored on 5 of Them?

There are a small number of quality measures whose scoring was impacted by:

- Changes to clinical guidelines during the performance period.
- ICD-10-CM code changes during the performance period.
- Specification changes that were later determined to be substantive.

In some cases, the performance period was truncated to 9 months. More frequently, the measure was suppressed from scoring. This means the measure wasn't scored and your quality denominator – the maximum number of points available – was reduced by 10 points.

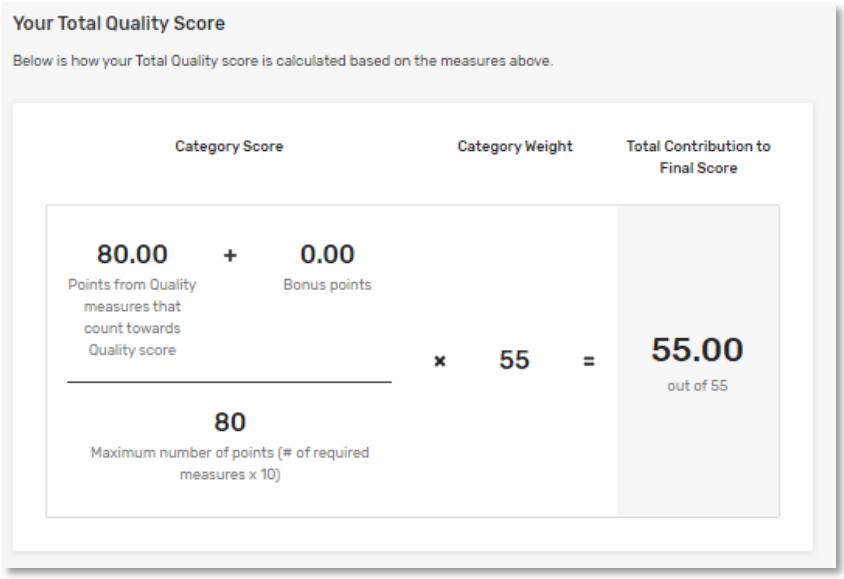
For a complete list of these impacted measures (and their collection types), refer to Appendix D.

How Do You Calculate My Quality Performance Category Score?

At the bottom of the Quality page, you can see how we arrived at the points contributing to your final score.

We divide the sum of your achievement and bonus points by the maximum number of points available to you in the quality performance category, and add that number to your improvement percent score, if applicable.

Finally, we multiply that number by the category weight.



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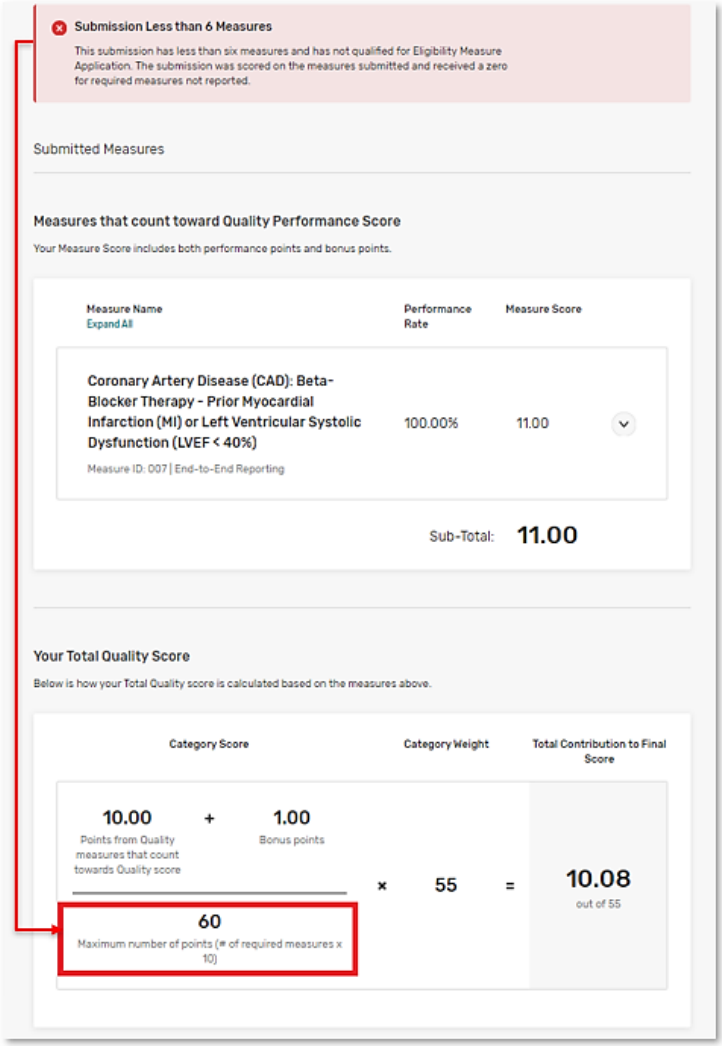
I Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures (CQMs)) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

Clinicians who don't have 6 available quality measures and who report Medicare Part B Claims measures or MIPS CQMs may qualify for the EMA process. This process checks for unreported, clinically related measures and can result in a denominator reduction in the quality performance category.

If you submitted fewer than 6 Medicare Part B claims measures or MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA. Denominator reductions are reflected in the **Total Quality Score** calculation section.

Submission (MIPS CQMS) Doesn't Qualify for Denominator Reduction



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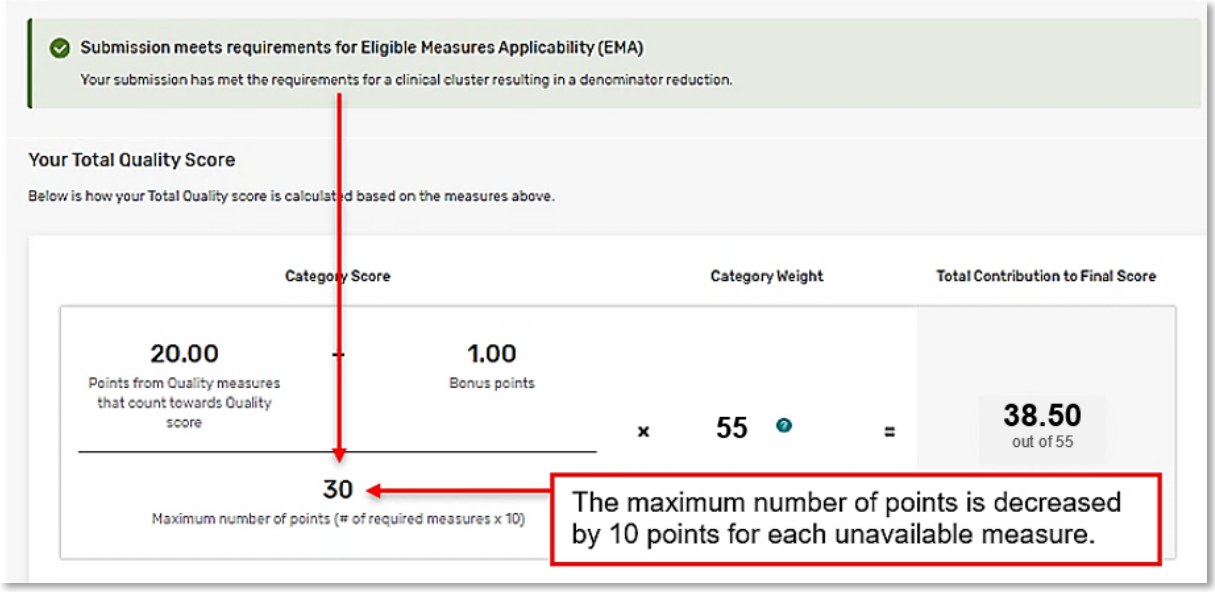
Submission (MIPS CQMs) Qualifies for Denominator Reduction



If you submitted all available Medicare Part B claims measures or MIPS CQMs and were still scored out of 60 total possible points (or 70 if you participated as a group and were scored on the All-Cause Unplanned Readmission measure), please contact the QPP Service Center for assistance.

Our Small Practice Reported Medicare Part B Claims Measures for Individual Clinicians. Why Were We Scored as a Group?

Under current policy, small practices that report Medicare Part B claims automatically receive a quality score at the individual and group level. The 2021 performance year is the final year that small practices will be automatically scored as a group; beginning with the 2022 performance year, small practices will only receive a group level score from Medicare Part B claims if they also submit group-level data for another performance category or categories.

Where Can I Find Information on the Administrative Claims Quality Measures?

There are 2 administrative claims quality measures in the 2021 performance year which will only be displayed in feedback if they could be scored.

Please note: All screenshots are for illustrative purposes only.
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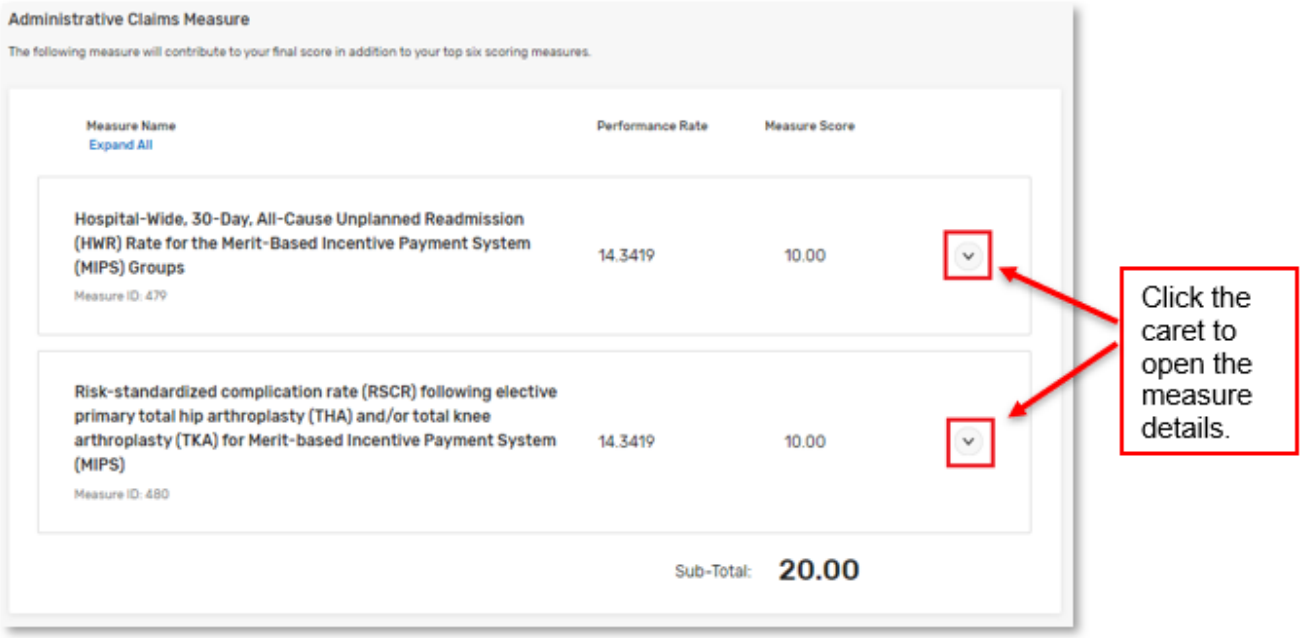

- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups.** (This measure replaced the All-Cause Hospital Readmission (ACR) measure.)
    - This measure is automatically calculated for groups, virtual groups, and APM Entities with at least 16 eligible clinicians that meet the case minimum (200 cases).
    - Review the measure specification.

- **Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).**
    - This measure is automatically calculated for individuals, groups, virtual groups, and APM Entities that meet the case minimum (25 cases).
    - Review the measure specification.

If you don't see these measures displayed in your feedback, then you didn't meet the criteria above.

NEW! We're displaying administrative claims measure scores (if available) for informational purposes for practices that were eligible at the group level but didn't participate as a group.

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What Is Quality Improvement Scoring?

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

You'll be evaluated for improvement scoring for the 2021 performance year when you:

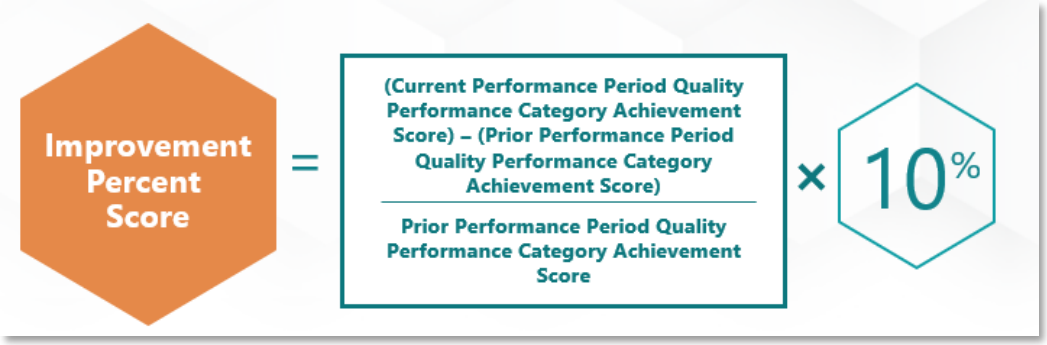
- Meet the quality performance category requirements for the current performance year (i.e., submit 6 measures/specialty measure set with at least 1 outcome/high priority measure OR submit as many measures as were available and applicable OR report all 10 measures in the CMS Web Interface; all measures must meet data completeness requirements).
- Have a quality performance category achievement score based on reported measures for the previous performance year (2020).
- Submit data under the same identifier for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

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 prior to the current performance period.

For example, if your 2020 performance year quality score is derived from facility-based measurement, you aren't eligible for improvement scoring for the 2020 or 2021 performance years.

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2020) performance year to the quality performance category achievement score for the current (2021) performance year. **Measure bonus points aren't included in improvement scoring.**



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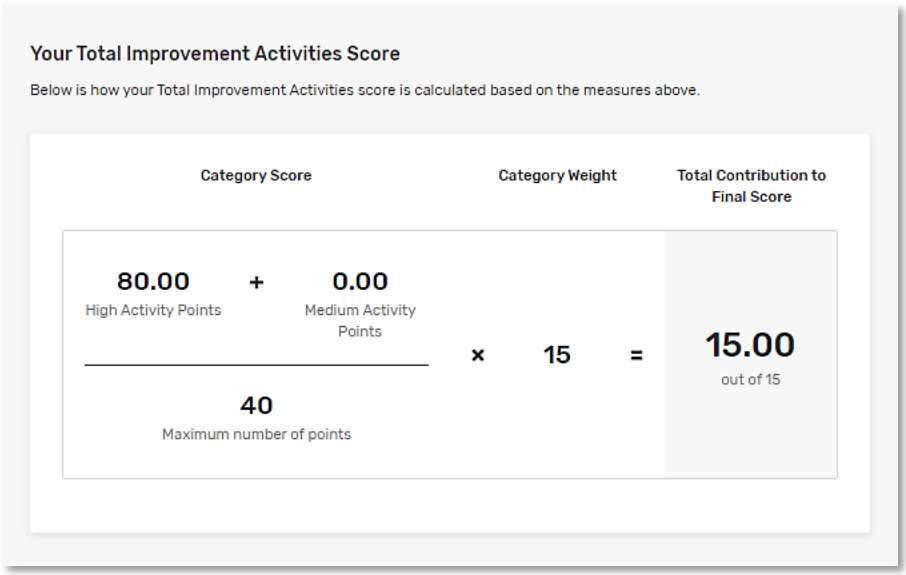
Traditional MIPS: Improvement Activities

The Improvement Activities page will display the name, weight, and points received for each activity you attested to performing. At the bottom of the Improvement Activities page, you can see how we arrived at the points contributing to your final score.

We divide the sum of the points earned for your medium and high weighted activities by 40 (the maximum number of points available), then we multiply that number by the category weight. (The screenshot below shows the maximum points possible at 15.)



We're a Certified Patient-Centered Medical Home. Why Didn't We Receive Full Credit in the Improvement Activities Performance Category?

If you're a MIPS eligible clinician practicing in a certified patient-centered medical home, including Medical Homes Model, or a comparable specialty practice, **you earn full credit for the improvement activities performance category as long you attested to this during the submission period**.

We Were Approved for Reweighting of the Improvement Activities Performance Category. Why Are We Showing 7.5 out of 15 points?

Clinicians that participate in an APM, and groups that include such clinicians, automatically receive 50% credit in traditional MIPS for the improvement activities performance category when data are submitted for the quality and/or Promoting Interoperability performance categories.

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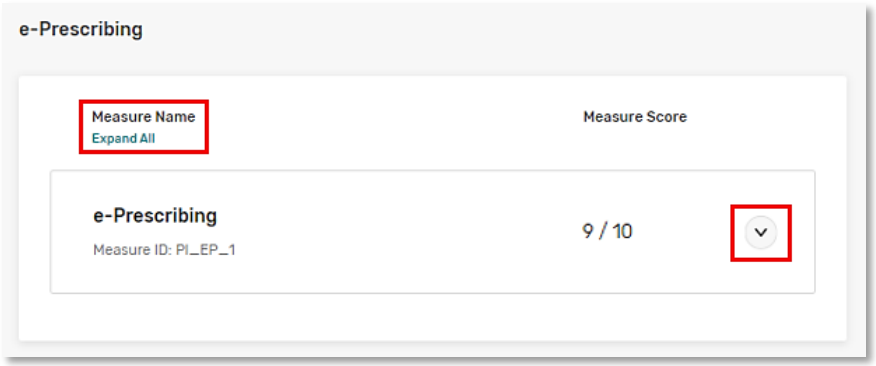
Traditional MIPS: Promoting Interoperability

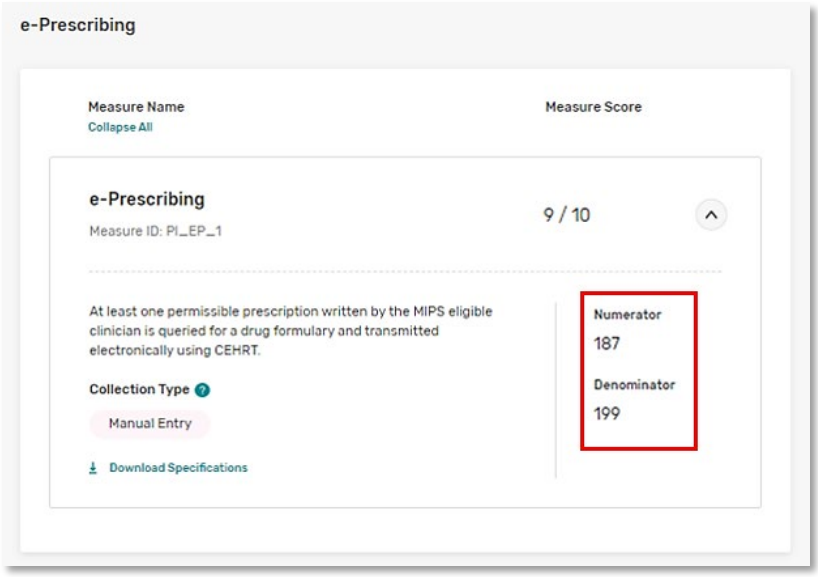
The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed.

Each required measure is worth a specified number of points, though the maximum points per measure could change based on reporting exclusions for other measures.

For measures submitted with a numerator and denominator, we calculated a score for each measure by dividing the numerator you submitted by the denominator you submitted for the measure. Then we multiply the performance rate by the maximum points available for the measure, and then round the value to the nearest whole number.

Click the arrow on the right-hand side of the measure information to see numerator/denominator details or click **Expand All** below Measure Name to see the details of all the measures in that objective.





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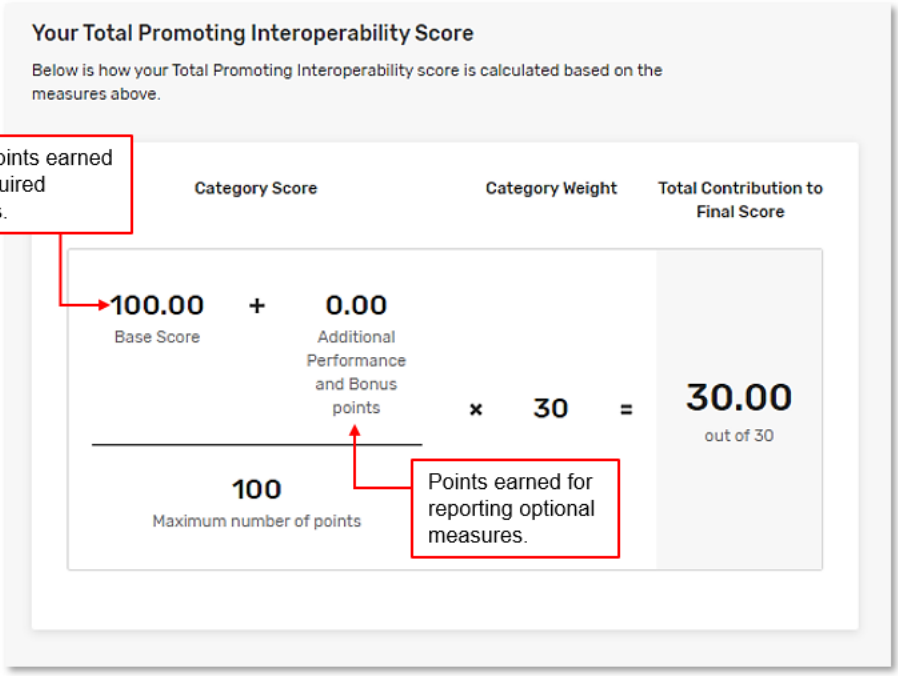
At the bottom of the Promoting Interoperability page, you can see how we arrived at the points contributing to your final score. We divided the points earned by 100 (the maximum number of points available), then we multiplied that number by the category weight.



Why Did I Receive a Performance Category Score of 0 Out of 30 Points When I Qualified for Reweighting?

If a MIPS eligible clinician or group submitted any data for the Promoting Interoperability performance category, CMS scored them according to the data submitted and the category **WASN'T** reweighted to 0%. This includes clinicians and groups who started data entry (such as entering a performance period) on the Manual Entry page during the submission period.

Note: If you didn't submit data and received a performance category score of 0 out of 30 points but should've qualified for reweighting based on your clinician type, special status, and/or exception status, please contact the QPP Service Center for assistance.

Why Did I Receive a Performance Category Score of 0 Out of 30 Points When I Submitted All of My Data?

If you reported Promoting Interoperability data through multiple submission types (for example, manual entry and file upload) and there was any conflicting data, you received a score of 0 out of 30 points for the performance category.

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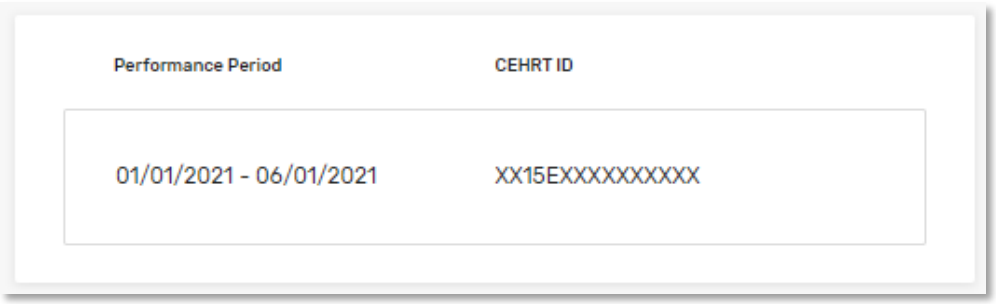
What Is a CEHRT ID?

The CEHRT identification number (ID) is the CMS Certification ID for your EHR product(s) proving that it's certified by The Office of the National Coordinator for Health Information Technology (ONC) to the 2015 Edition. 2015 Edition Certified EHR Technology (CEHRT) is required for reporting your MIPS Promoting Interoperability measures.

Submissions without a valid CEHRT ID result in a performance category score of zero.



Performance Period	CEHRT ID
01/01/2021 - 06/01/2021	XX15EXXXXXXXXXX

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Traditional MIPS: Cost

Why Don't I See Any Cost Measure Information?

CMS is reweighting the cost performance category from 20% to 0% for the 2021 performance period for all MIPS eligible clinicians, regardless of participation as an individual, group, virtual group, or APM Entity. The 20% cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(E).

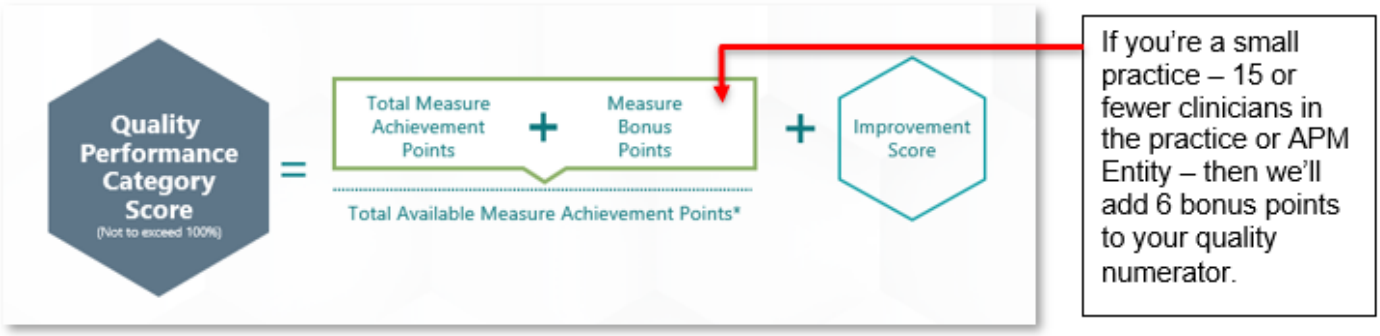
As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they'll receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2023 MIPS payment year. This reweighting of the cost performance category applies in addition to the EUC policy under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), §414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3).

Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC will still have their cost performance category weighted to 0%.

APM Performance Pathway: Quality

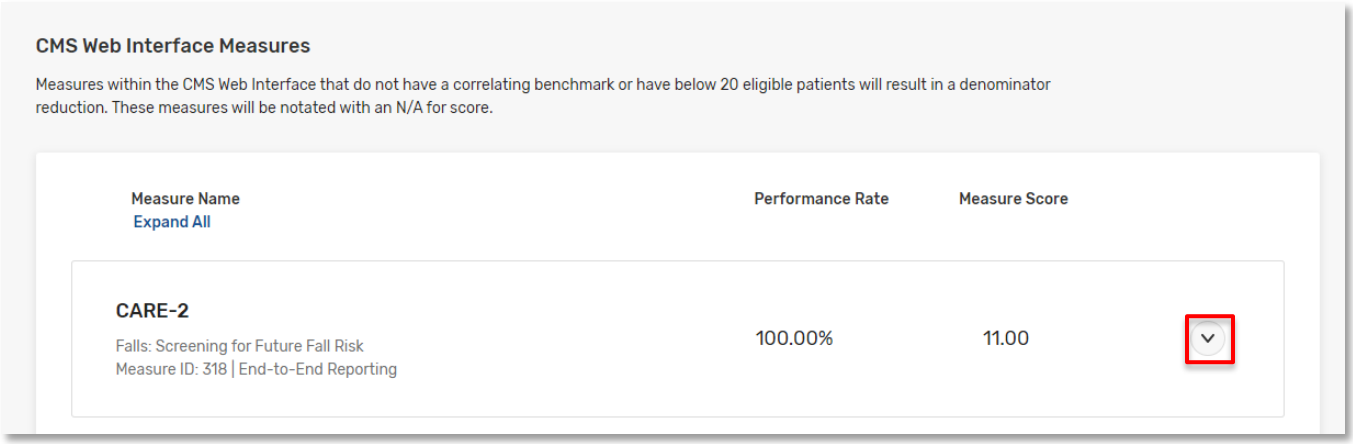
How was our quality score calculated?

We use the following formula to calculate your quality performance category score.



As you scroll down the page, you'll see all of the measures that contributed to your score. Because the APP requires a specific set of measures, you'll see "0.00" points for any measure that was required but unreported.

To access measure details, click the caret to the right of the measure score.



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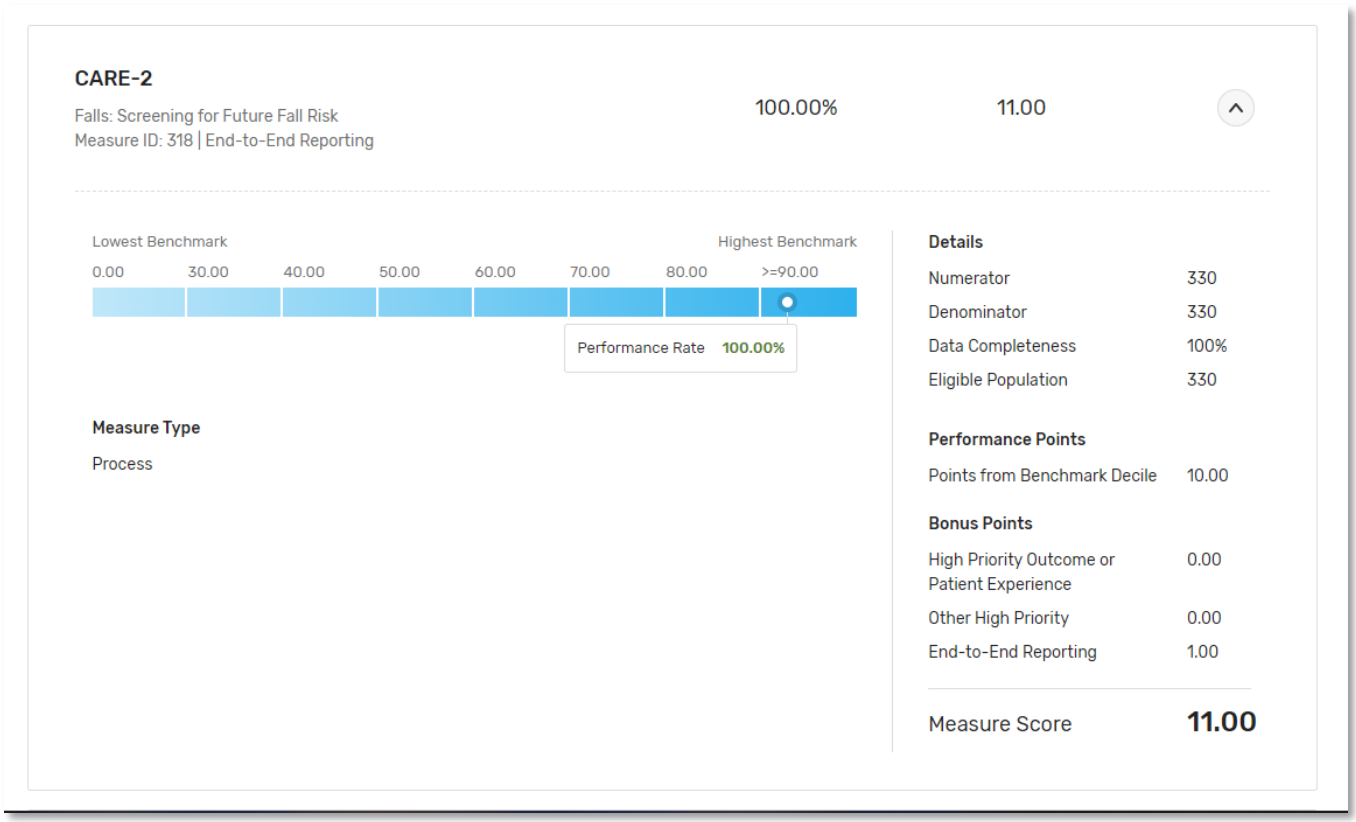
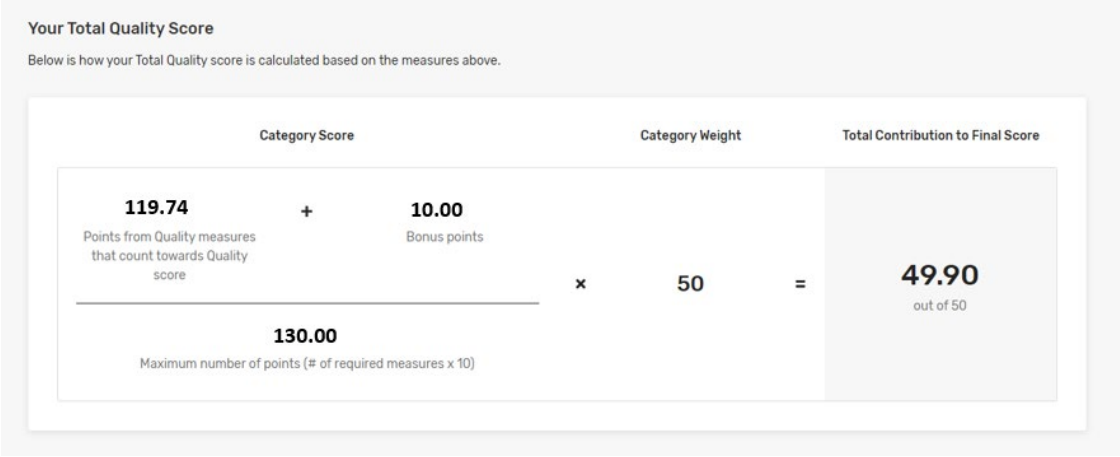


At the bottom of the page, you'll see the calculation to arrive at your quality score. (In the example screenshot below, the participant didn't qualify for improvement scoring.)



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What Is Quality Improvement Scoring?

You can earn up to 10 additional percentage points in the quality performance category based on your rate of 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 there's no improvement, the improvement score will be 0%. The improvement score can't be negative.

You'll be evaluated for improvement scoring for the 2021 performance year when you:

- Meet the quality performance category requirements for the current performance year
- Have a quality performance category achievement score based on reported measures for the previous (2020) performance year.
- Submit data under the same identifier (such as ACO ID or TIN) for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2020) performance year to the quality performance category achievement score for the current (2021) performance year. **Measure bonus points aren't included in improvement scoring.**

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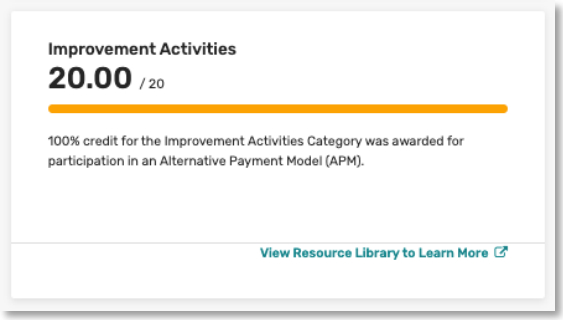
APM Performance Pathway: Improvement Activities

Why Can't I Access Details about the Improvement Activities Performance Category?

There aren't any details for this performance category because clinicians, groups and APM Entities automatically received full credit under the APP as indicated by the text on the improvement activities card.



APM Performance Pathway: Promoting Interoperability

We're a Shared Savings Program ACO. How Did We Get Our Score for the Promoting Interoperability Performance Category?

When reporting the APP as an APM Entity (such as a Shared Savings Program ACO), the MIPS eligible clinicians in the Entity reported their Promoting Interoperability measures as individuals or as a group. We score the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity.

- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- The APM Entity received 10 bonus points if at least one individual or group in the APM Entity reported the optional Query of PDMP measure, but the Promoting Interoperability performance category score can't exceed 100%.

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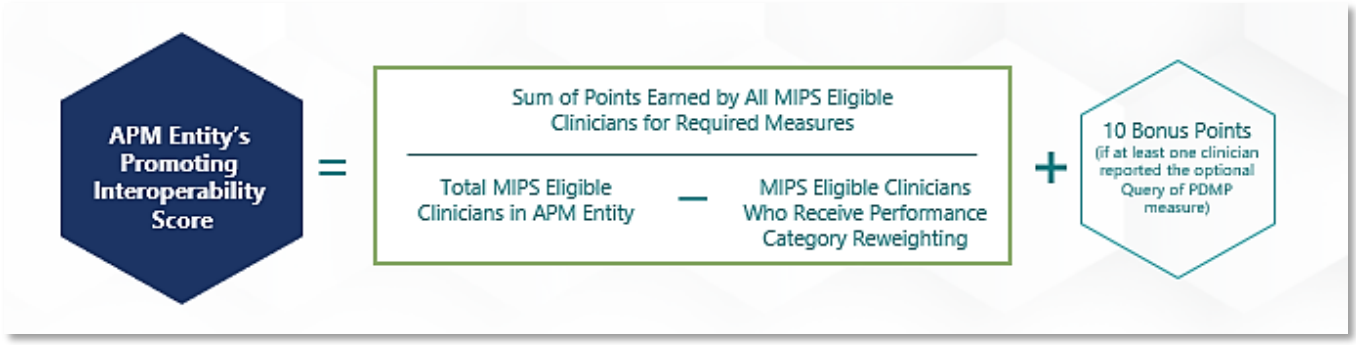
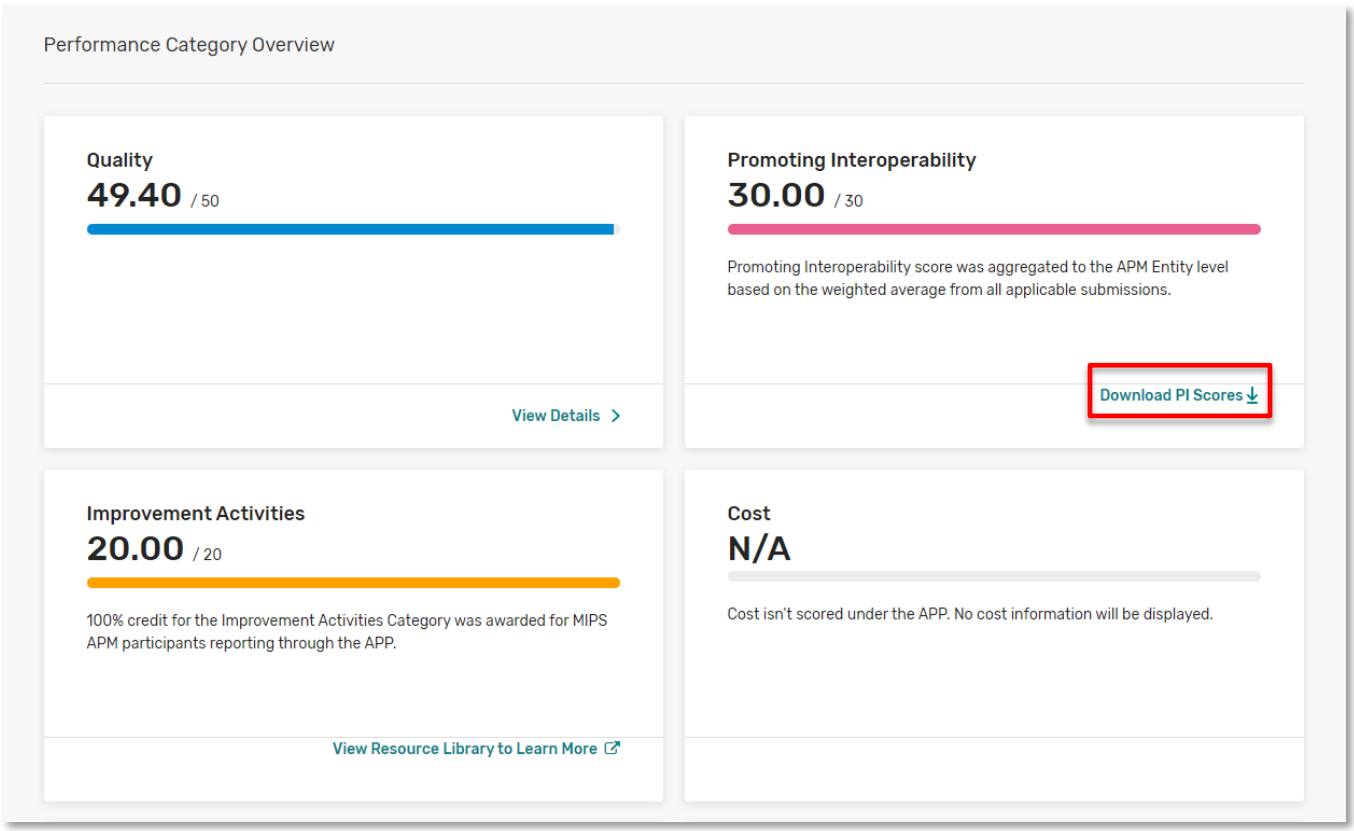


How Can We View the Individual Promoting Interoperability Scores for the Clinicians in Our ACO?

You can download a report of these scores from the Overview page. Click **Download PI Scores** on the Promoting Interoperability card.



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Facility-Based Scoring

Why Don't I See Any Facility-Based Scoring Information?

There's no facility-based scoring available in the 2021 MIPS performance year. As announced through the QPP listserv on 8/26/2021, CMS finalized a measure suppression policy in the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) PPS final rule for several hospital reporting programs, including the Hospital Value-Based Purchasing (VBP) Program. As a result, CMS didn't calculate a total performance score under the Hospital VBP Program for any hospital for FY 2022 due to COVID-19's effect on many measures in the program.

We use the total performance score from the Hospital VBP Program to calculate facility-based scores for facility-based clinicians and groups in the quality and cost performance categories. The FY 2022 total performance score is what we would use to determine these scores for the 2021 MIPS performance period.

- Because the FY 2022 total performance score from the Hospital VBP Program wasn't available, we couldn't calculate MIPS facility-based scores for the 2021 MIPS performance year.

Items and Services

What Is the Purpose of the Items and Services Section of MIPS Performance Feedback?

The Items and Services section of performance feedback provides clinicians with additional information about the healthcare and emergency department (ED) services received by their patients throughout a calendar year (CY). Please note that the Items and Services data is provided for informational purposes only and won't affect your MIPS performance scores.

How Are You Defining the Types of Items and Services Used by Patients?

We define the types of items and services using Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS codes represent a standard coding system for procedures, supplies, products, and services billed by healthcare providers. The data in the Items and Services section of performance feedback is aggregated by ranges of HCPCS codes.

What Is a HCPCS Code and How Are They Classified by Level?

The HCPCS is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare patients and to individuals enrolled in private health insurance programs. The codes are divided into 2 levels:

- **Level I HCPCS Codes:** Codes and descriptors copyrighted by the American Medical Association's (AMA) Current Procedural Terminology (CPT®), fourth edition (CPT-4). These are 5 position numeric codes representing services of physicians, non-physician practitioners and other suppliers.

- **Level II HCPCS Codes:** These codes are alpha-numeric codes consisting of a single alphabetical letter followed by 4 numeric digits. Level II HCPCS codes are used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes and descriptors are maintained and distributed by CMS.[1]

What Is a CPT Code?

CPT codes offer healthcare professionals a uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency. All CPT codes are 5 digits and can be either numeric or alphanumeric, depending on the category. As noted above, Level I of the HCPCS is comprised of CPT-4 codes, a numeric coding system maintained by the AMA.

[1] Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures (PDF)

How Are HCPCS Codes Categorized in the Items and Services Section of Performance Feedback?

In the Items and Services section of performance feedback, the HCPCS codes are categorized as follows:[2]

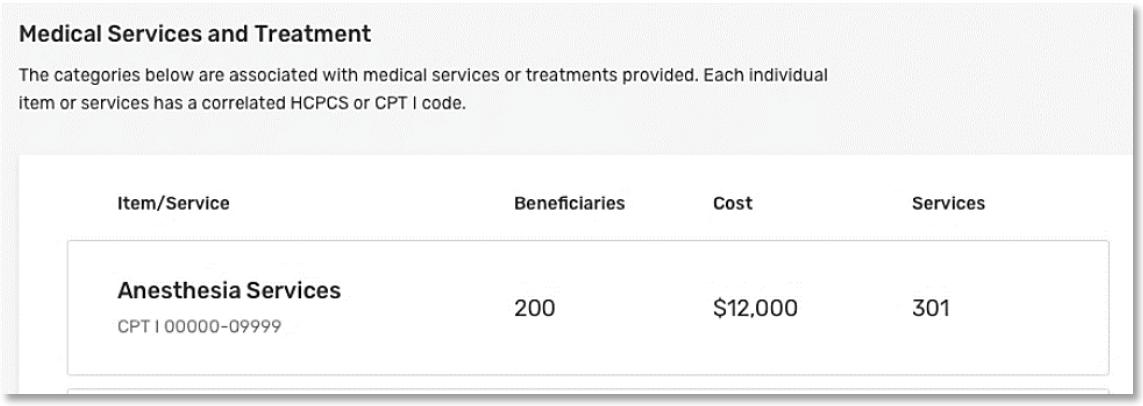
HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS	
00000-09999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital, maternity care, and delivery system
60000-69999	Endocrine, nervous, eye and ocular adnexa, auditory system
70000-79999	Radiology services
80000-89999	Pathology and laboratory services
90000-99999	Evaluation and management services
Level 2 HCPCS	
HCPCS A	Transportation services including ambulance, medical & surgical supplies
HCPCS B	Enteral and parenteral therapy
HCPCS C	Temporary codes for use with outpatient prospective payment system
HCPCS E	Durable medical equipment (DME)
HCPCS G	Procedures or professional services (temporary codes)
HCPCS H	Alcohol and drug abuse treatment services or rehabilitative services
HCPCS J	Drugs administered other than oral method, chemotherapy drugs
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS U	Codes for Coronavirus lab tests
HCPCS V	Vision, hearing and speech-language pathology services

[2] https://hcpcs.codes/section/

Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

What Data Are Being Used in the Items and Services Section of Performance Feedback?

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Type 71 and 72) billed with dates of services between January 1, 2021, and December 31, 2021, and received by CMS within 60 days of December 31, 2021 (a "60-day runout").



How Is the Number of "Beneficiaries" Displayed in the Items and Service Section of Performance Feedback Derived?

For individual clinicians, this number includes all unique Part B-enrolled patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during CY 2021 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.

For groups, this number includes all Part B-enrolled patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2021 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.

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How Is the "Cost" per CPT Code Range in the Items and Service Section of Performance Feedback Derived? Is the Cost Adjusted and/or Price Standardized?

The cost reflected in the Items and Services section of performance feedback is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines with dates of service between 1/1/2021-12/31/2021. These numbers are raw allowed charge amounts and aren't payment standardized, risk adjusted, nor specialty adjusted.

For individual clinicians, the number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during CY 2021 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any provider during CY 2021.

For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2021 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2021.

How Is the Number of "Services" in the Items and Services Section of Performance Feedback, Derived?

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during CY 2021 AND received at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2021.

For groups, this number is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2021 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2021.

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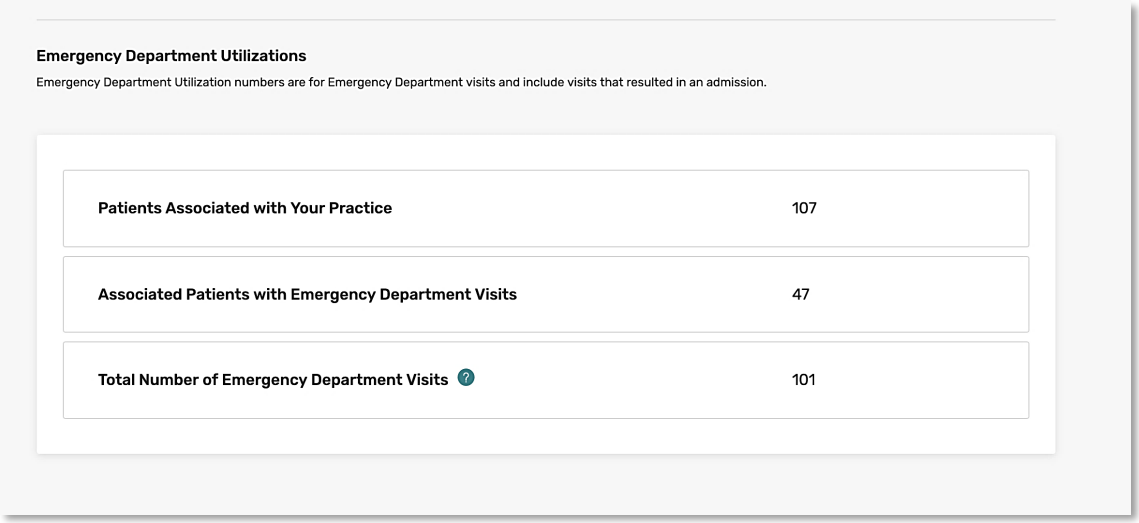
Emergency Department Utilization



Which Patients Are Counted in the "Patients Associated with Your Practice" Entry Under the "Emergency Department Utilization" Heading?

In this context, "patients associated with your practice" is defined as patients attributed to an individual clinician's TIN/NPI or to a group's TIN (depending on the chosen level of reporting) via the following method:

Patients are attributed to a single TIN/NPI based on the amount of primary care services received, and the clinician specialties that performed those services, during the performance period.

Only patients who received a primary care service during the performance period can be attributed to a TIN/NPI. A patient is attributed to a single TIN/NPI or a single entity's CMS Certification Number (CCN) assigned to either a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in 1 of 2 steps, described below.

Note: If a patient is attributed to an FQHC or RHC's CCN, then that patient and their services aren't included in the provision of Items & Services data for an individual MIPS eligible clinician or group.

Step 1: If a patient received more primary care services from an individual TIN/NPI that's classified as either a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) than from any other TIN/NPI during the performance period, then the patient is attributed to that TIN/NPI. If, during the performance period, a patient received more primary care services from an entity's CCN than from any other TIN/NPI, then the patient is attributed to the CCN.

Step 2: If a patient didn't receive a primary care service from a TIN/NPI classified as either a PCP, NP, PA, or CNS during the performance period, then the patient may be assigned to a

TIN/NPI in “Step 2.” If a patient received more primary care services from a specialist physician’s TIN/NPI than from any other clinician’s TIN/NPI during the performance period, then the patient is assigned to the specialist physician’s TIN/NPI.

For a list of CMS specialty codes for PCPs and non-physician practitioners included in the first step of attribution, see Appendix E. See Appendix F for a list of medical specialists, surgeons, and other physicians included in the second step of attribution. For a list of HCPCS codes that identify primary care services, please refer to Appendix G.

A patient is excluded from the population measured for purposes of providing Items & Services data if:

- The patient wasn’t enrolled in both Medicare Parts A & B for every month of the performance period.
- The patient was enrolled in a private Medicare health plan during any month of the performance period.
- The patient resided outside the United States (including territories) during any month of the performance period.
- The patient was enrolled in Medicare Parts A & B for a partial year because he/she newly enrolled in Medicare or he/she died during the performance period.

The case minimum for provision of Items & Services data is 20. For a MIPS eligible clinician participating in MIPS as an individual, 20 patients must be assigned to the individual MIPS eligible clinician’s TIN/NPI for Items & Services data to be provided. For groups of clinicians participating in MIPS as a group, a total of 20 patients must be assigned to TIN/NPIs across the TIN/NPIs under the group’s TIN for Items & Services data to be provided.

Which Patients Are Counted in the “Associated Patients with Emergency Department Visits” Entry Under the “Emergency Department Utilization” Heading?

This metric reflects the number of attributed patients who also had an ED visit in CY 2021. An ED visit is defined as any CY 2021 claim with a claim line containing any of the following ED revenue center codes: 0450-0459 and/or 0981.

How Is the “Total Number of Emergency Department Visits” Entry Under the “Emergency Department Utilization” Heading Defined?

The figure reflects the actual number of ED visits across all attributed patients in CY 2021.

General

Can I Download Feedback Reports?

Yes, you can print performance feedback using the **Print** button accessible on each page within Performance Feedback. (This feature uses your browser's native print functionality.) You can also download a spreadsheet with all of your submitted data (even if it didn't count towards your final score.)

What If We Find an Error during Final Score Preview?

If you believe there's an error with information displayed during the Final Score Preview period, please contact the QPP Service Center at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET) or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. For Shared Savings Program ACOs, please reach out to your ACO Coordinator with your QPP Service Center ticket number for assistance with resolving your inquiry.

What's a Targeted Review?

A targeted review is a process where MIPS eligible clinicians, groups, and MIPS APM participants (individual clinicians, participating groups, and the APM Entity) can request that CMS review the calculation of their MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. The 2021 performance year targeted review process will be available in August 2022 when performance feedback is finalized and 2023 payment adjustments are released.

We continue to listen to you and make improvements to the system based on your feedback.
There may be slight variation between the information and screenshots in this document and what you see on your screen.
Contact the Quality Payment Program if you have questions about a discrepancy.

Where Can I Learn More?

- Quality Payment Program website
- 2021 Traditional MIPS Scoring Guide (PDF)
- 2021 APM Performance Pathway Toolkit (ZIP)

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Please contact the QPP Service Center at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET) or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Comment
6/23/2022	Original Posting Date

Appendix A: Automatic Extreme and Uncontrollable Circumstances Policy

Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2021 performance category reweighting policies that apply to individual clinicians under the MIPS automatic EUC policy, including those that submit MIPS data as individuals. (This doesn't reflect reweighting for clinicians scored under the APM scoring standard.)

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for One Performance Category					
Quality Only	100%	0%	0%	0%	Neutral
Promoting Interoperability Only	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities **and** Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality **and** Improvement Activities **and** Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral

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Appendix B: Extreme and Uncontrollable Circumstances Exception Application

Performance Category Reweighting Scenarios

The table below identifies the performance category reweighting scenarios applicable to groups and virtual groups with an approved EUC application for the 2021 performance year. (APM Entities could also submit EUC applications but were required to request reweighting in all performance categories.)

Please note that we have updated the table to reflect the 0% reweighting of the cost performance category for everyone in the 2021 performance year.

- The quality, improvement activities, and/or Promoting Interoperability performance categories could be reweighted due to an approved EUC application.
- The Promoting Interoperability performance category could also be reweighted due to clinician type, an approved hardship exception or special status.

Reweighting Scenario	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No additional reweighting from an approved EUC application, approved Promoting Interoperability hardship exception, clinician type or special status					
No Cost	55%	30%	15%	0%	Positive, Negative, or Neutral
Reweight 2 Performance Categories					
No Cost and No Promoting Interoperability	85%	0%	15%	0%	Positive, Negative, or Neutral
No Cost and No Quality	0%	85%	15%	0%	Positive, Negative, or Neutral
No Cost and No Improvement Activities	70%	30%	0%	0%	Positive, Negative, or Neutral
Reweight 3 Performance Categories					
No Quality, No Cost, No Improvement Activities	0%	100%	0%	0%	Neutral
No Quality, No Cost, No Promoting Interoperability	0%	0%	100%	0%	Neutral
No Cost, No Improvement Activities, No Promoting Interoperability	100%	0%	0%	0%	Neutral
Reweight 4 Performance Categories					
All performance categories reweighted to 0%	0%	0%	0%	0%	Neutral

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Appendix C: Final Score Preview Based on Access

This table provides a snapshot of what you **can** and **can't view** during Final Score Preview based on your access and organization type.

With This Access	You CAN	You CAN'T
Staff User or Security Official for a **Practice** (Includes solo practitioners)	✓ View and download group-level ("practice") performance feedback and preview the group's final score ✓ View and download clinician-level performance feedback and preview their final score (excluding APM participants)	X View APM Entity level performance feedback **Example:** If you're a participant TIN in a Shared Savings Program ACO, you won't be able to view performance feedback or payment adjustment information for the ACO. You'll only be able to view feedback on the data submitted at the individual or group level. X View performance feedback for your virtual group X View payment adjustment data (will be available in August) X Access patient-level reports for administrative claims cost and quality measures (will be available in August)
Staff User or Security Official for an **APM Entity**	✓ View and download MIPS performance feedback for the entire APM Entity and preview the final score ✓ View and download Promoting Interoperability scores for each MIPS eligible clinician in the APM Entity	X View and download payment adjustment data for all clinicians in the APM Entity (will be available in August) X Access patient-level reports for administrative claims quality measures (will be available in August)
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ View preliminary scoring for your clients based on the data you submitted for them (same information that was available during the submission period)	X View performance feedback or payment adjustment information for your clients, which may include: ○ Data submitted by your clients directly ○ Data submitted by another third party on behalf of your clients ○ Data collected and calculated by CMS on behalf of your clients
Clinician Role	✓ View your performance feedback for all and preview final scores applicable to all of your TIN/NPI combinations	X View performance feedback for other clinicians X View payment adjustment (will be available in August)

Please note: All screenshots are for illustrative purposes only.
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With This Access	You CAN	You CAN'T
Staff User or Security Official for a **Virtual Group**	✓ View virtual group-level performance feedback	x View performance feedback about data submitted by individuals or practices in your virtual group x View payment adjustment (will be available in August) x Access patient-level reports for administrative claims cost and quality measures (will be available in August)

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Appendix D: Quality Measures with Scoring Changes

The following measures have MIPS scoring changes due to clinical guideline changes during the 2020 performance period, or because specifications were determined during or after the performance period to have substantive changes. CMS hasn't identified any MIPS quality measures requiring performance data to be truncated to a 9-month performance period for 2021 due to the annual ICD-10 code update.

Quality Measure ID/ Name	Collection Type	Reason for Measure Change	Impact to Scoring, Submission and Feedback Expectations
Measure 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Medicare Part B Claims	The 2021 Medicare Part B Claims measure specification includes quality data codes (3051F and 3052F) that weren't activated during the annual Current Procedural Terminology (CPT) Category II update process.	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring.
Measure 111: Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims MIPS Clinical Quality Measure (CQM)	Guidelines have been revised to allow 20-valent pneumococcal conjugate vaccine by itself or the 15-valent vaccine followed by the 23-valent vaccine for adults aged 65 years or older who haven't received a pneumococcal conjugate vaccine before — or whose vaccination status is unknown — and people aged 19 to 64 years who have an underlying medical condition or other risk factors and who also haven't received a pneumococcal vaccine.	Performance period was truncated to 9 months (January – September 2021).
Measure 111: Pneumococcal Vaccination Status for Older Adults	Electronic Clinical Quality Measure (eCQM)	Guidelines have been revised to allow 20-valent pneumococcal conjugate vaccine by itself or the 15-valent vaccine followed by the 23-valent vaccine for adults aged 65 years or older who haven't received a pneumococcal conjugate vaccine before — or whose vaccination status is unknown — and people aged 19 to 64 years who have an underlying medical condition or other risk factors and who	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring.

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		also haven't received a pneumococcal vaccine.	
Measure 117: Diabetes: Eye Exam	Medicare Part B Claims	The 2021 Medicare Part B Claims measure specification includes quality data codes (2023F, 2025F, and 2033F) that weren't activated during the annual Current Procedural Terminology (CPT) Category II update process.	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring.
Measure 128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	eCQM	Misalignment was identified between the numerator header in the measure narrative and the numerator logic.	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring.
Measure 134: Preventive Care and Screening: Screening for Depression and Follow Up Plan	CMS Web Interface	CMS determined that coding changes made to the 2021 PREV-12 were substantive changes to the measure.	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. Your feedback will show "- -" if measure was reported, but excluded from scoring.

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Appendix E: Specialty Codes for PCPs and Non-Physician Practitioners Included in the First Step Attribution

Specialty Description (CMS Specialty Code)
Primary Care Physicians
General Practice (01)
Family Practice (08)
Internal Medicine (11)
Geriatric Medicine (38)
Non-physician Practitioners
Clinical Nurse Specialist (89)
Nurse Practitioner (50)
Physician Assistant (97)

Note: For claims for either FQHC or RHC services: All primary care services are considered in the first step of attribution unless the FQHC or RHC participates in an ACO but the attending physician does not. If the FQHC or RHC participates in an ACO but the attending physician does not, then the service is considered in the first step only if the attending physician is a PCP as defined in the table (Medicare Shared Savings Program 2014).

Appendix F: Medical Specialists, Surgeons, and Other Physicians Included in the Second Step Attribution

Specialty Description (CMS Specialty Code)	
Medical Specialists	**Other Physicians**
Addiction Medicine (79)	Anesthesiology (05)
Allergy/Immunology (03)	Chiropractic (35)
Cardiac Electrophysiology (21)	Diagnostic Radiology (30)
Cardiology (06)	Emergency Medicine (93)
Critical Care (Intensivists) (81)	Interventional Radiology (94)
Dermatology (07)	Nuclear Medicine (36)
Dentist (C5)	Optometry (41)
Endocrinology (46)	Pain Management (72)
Gastroenterology (10)	Pathology (22)
Geriatric Psychiatry (27)	Pediatric Medicine (37)
Hematology (82)	Podiatry (48)
Hematology/Oncology (83)	Radiation Oncology (92)
Hospice and Palliative Care (17)	Single or Multispecialty Clinic or Group Practice (70)
Infectious Disease (44)	Sports Medicine (23)
Interventional Cardiology (C3)	Unknown Physician Specialty (99)
Interventional Pain Management (09)	
Medical Oncology (90)	
Nephrology (39)	
Neurology (13)	

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Appendix F (continued)

Specialty Description (CMS Specialty Code)	
Neuropsychiatry (86)	
Osteopathic Manipulative Medicine (12)	
Physical Medicine and Rehabilitation (25)	
Preventive Medicine (84)	
Psychiatry (26)	
Pulmonary Disease (29)	
Rheumatology (66)	
Sleep Medicine (C0)	
Surgeons	
Cardiac Surgery (78)	
Colorectal Surgery (28)	
General Surgery (02)	
Gynecological/Oncology (98)	
Hand Surgery (40)	
Maxillofacial Surgery (85)	
Neurosurgery (14)	
Obstetrics/Gynecology (16)	
Ophthalmology (18)	
Oral Surgery (Dentists Only) (19)	
Orthopedic Surgery (20)	
Otolaryngology (04)	
Peripheral Vascular Disease (76)	
Plastic and Reconstructive Surgery (24)	
Surgical Oncology (91)	
Thoracic Surgery (33)	
Urology (34)	
Vascular Surgery (77)	

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Appendix G: Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes

HCPCS Codes	Brief description
99201–99205	New patient, office, or other outpatient visit
99211–99215	Established patient, office, or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	New or established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
99487, 99489	Complex chronic care management
99495-99496	Transitional care management
99490	Chronic care management
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
G0463	Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only)

Note: Services billed with HCPCS code 99304-99318 that are performed in a skilled nursing facility (place of service code 31) will not be considered as primary care services.

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