Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Traditional MIPS Scoring Guide for the 2022 Performance Year

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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How to Use This Guide

Table of Contents

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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.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

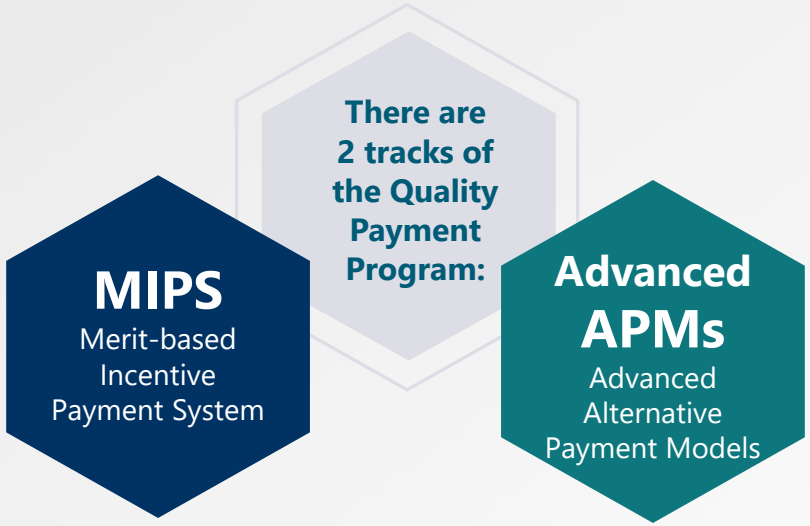
COVID-19 and 2022 Participation

The 2019 Coronavirus (COVID-19) public health emergency continues to impact clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2022 performance year, we'll continue to use our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, virtual groups, and APM Entities to submit an application requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency. The application will be available in spring 2022 along with additional resources.

For more information about the impact of COVID-19 on QPP participation, see the Quality Payment Program's COVID-19 Response webpage.

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA advances a forward-looking, coordinated framework for clinicians to participate in the Quality Payment Program, which rewards value in 1 of 2 ways:



If you're a MIPS eligible clinician, you'll be subject to a performance-based payment adjustment through MIPS.

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

This guide will only cover the **MIPS participation in the Quality Payment Program**. For more information on participating in an Advanced APM, visit our Advanced APM Overview webpage and check out our APM related resources in the Quality Payment Program Resource Library.

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program describes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our health care system.

If you're eligible for MIPS in 2022:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options web pages on the Quality Payment Program website.
- View the 2022 MIPS Quick Start Guide.
- Check your current participation status using the QPP Participation Status Tool.

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

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

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

In addition to traditional MIPS, 2 other MIPS reporting frameworks, designed to reduce reporting burden, will be available to MIPS eligible clinicians.

- The **APM Performance Pathway (APP)** is a streamlined reporting framework available beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs)** are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, MVPs incorporate a foundational layer that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities. **There are 7 MVPs that will be available for reporting in the 2023 performance year:**

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

We encourage clinicians interested in reporting an applicable MVP to become familiar with the MVP's requirements in advance of the 2023 performance year. For more information on the finalized MVPs, please refer to the Calendar Year (CY) 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to MIPS Value Pathways section of the QPP website.

Getting Started: Reviewing MIPS Terms

Collection Type*

Collection Type is a set of quality measures with comparable specifications and data completeness criteria, identified as:

- Electronic clinical quality measures (eCQMs).
- MIPS clinical quality measures (MIPS CQMs) (formerly referred to as "Registry measures").
- Qualified Clinical Data Registry (QCDR) measures.
- Medicare Part B Claims measures (available to small practices).
- CMS Web Interface measures (available to groups, virtual groups, and APM Entities with 25 or more clinicians).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure (available to groups, virtual groups, and APM Entities with 2 or more clinicians).
- Administrative claims measures.

The term "Collection Type" is unique to the quality performance category and doesn't apply to the other 3 performance categories.

Submitter Type

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

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 Program Interface, or API).
- Sign in and upload (attaching a file).
- Sign in and attest (manually entering data).
- Medicare Part B Claims.
- CMS Web Interface.

**There isn't a submission type for the cost performance category because we collect and calculate your cost measures from administrative claims data submitted for payment.

Data Aggregation and Multiple Submissions

Measures and activities submitted via multiple submission types can count toward a single performance category score, but there's some variation between performance categories. Please see **Data Aggregation and Multiple Submissions** within each performance category section for more information.

- Quality performance category
- Improvement activities performance category
- Promoting Interoperability performance category

Traditional MIPS: Quality Performance Category

Traditional MIPS: Quality Performance Category

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What are the Quality Performance Category Requirements?

You can select from **200** available MIPS quality measures finalized for the 2022 performance period, in addition to hundreds of QCDR measures approved by CMS outside of rulemaking.

You'll need to collect and submit data for each quality measure for the entire calendar year of 2022 (January 1 – December 31, 2022.)

We'll aggregate MIPS quality measures collected through multiple collection types into a single quality performance category score.

NOTE: The CMS Web Interface measures won't be scored in combination with other collection types, except for the CAHPS for MIPS Survey measure and/or administrative claims measures.

Individual, Group, and Virtual Group Participation

Quality

30% of MIPS Score

APM Entity Participation

55% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data

40% of MIPS Score

To meet the quality performance category requirements, an individual, group, virtual group, or APM Entity can:

Submit at least 6 MIPS quality measures for the 12-month performance period:

- 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
- The CAHPS for MIPS Survey measure counts as 1 of the 6 measures for groups, virtual groups, and APM Entities that registered to administer the CAHPS for MIPS Survey. The CAHPS for MIPS Survey measure is a patient experience measure and can be counted as a high priority measure if there aren't any applicable outcome measures.
- If you're reporting fewer than 6 measures, you'll be evaluated to determine if there were any clinically related measures that should have been reported.

OR

Submit a defined specialty measure set.
If the specialty measure set has fewer than 6 measures, you'll need to submit all measures within the specialty set to meet quality reporting requirements.

OR

Submit all 10 CMS Web Interface measures.
This option is available to groups, virtual groups, and APM Entities with 25 or more eligible clinicians that registered for the CMS Web Interface.

We've extended the CMS Web Interface as a collection and submission type in traditional MIPS for the 2022 performance period.

Traditional MIPS: Quality Performance Category

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What are the Quality Performance Category Requirements? (Continued)

There are also 3 MIPS quality measures that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- **Hospital-Wide All-Cause Unplanned Readmission Measure.**
  - This measure replaced the All-Cause Readmission measure beginning with the 2021 performance period.
  - This measure has a case minimum of **200 cases** and will apply to **groups, virtual groups, and APM Entities with at least 16 clinicians**.
- **Hip Arthroplasty and/or Knee Arthroplasty Complication Measure.**
  - This measure has a case minimum of **25 cases** and will apply to **individuals, groups, virtual groups, and APM Entities**.
  - This measure has a **3-year performance period** (consecutive 36-month timeframe).
    - For the 2022 MIPS performance year, the Hip Arthroplasty and Knee Arthroplasty Complication Measure's performance period starts on October 1, 2019 (3 years prior to the performance period) and ends on September 30, 2022 (current performance period), with a 3-month numerator assessment period.
- **NEW: 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 only apply to **groups, virtual groups ad APM Entities with at least 16 clinicians.**

Are the Quality Performance Category Requirements Different for the CMS Web Interface?

Yes. Registered groups, virtual groups, and APM Entities using the CMS Web Interface will submit data for all the required MIPS quality measures in the CMS Web Interface for a full year.

Traditional MIPS: Quality Performance Category

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What Is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

UPDATED August 2022

CMS recently announced that it won't calculate any FY 2023 total performance scores for the Hospital VBP Program.

This means that facility-based clinicians won't be able to receive quality and cost scores from facility-based measurement in the 2022 performance year.

For more information, please review the 2022 Facility-Based Quick Start Guide (PDF).

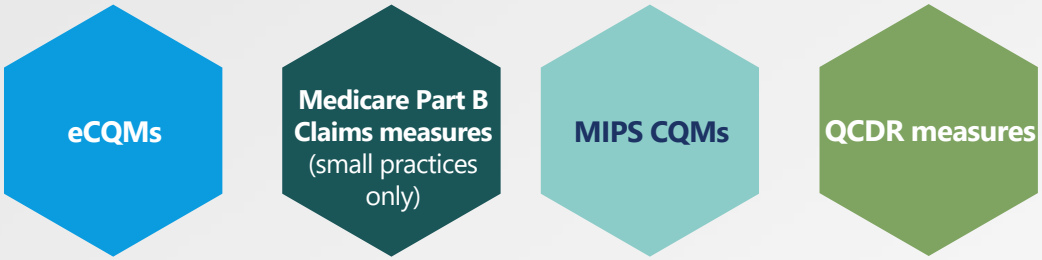
Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

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

How are Measures Assessed in the Quality Performance Category for the 2022 Performance Period?

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

Benchmarks are differentiated by collection type. There may be different benchmarks for the same measure if it can be reported through multiple collection types.



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 prior to the applicable performance period. The historical benchmarks for the 2022 MIPS performance period were established from quality data submitted for the 2020 MIPS performance period.

Administrative Claims Measures: We intend to calculate performance period benchmarks for the 3 administrative claims measures.

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

Did you know? If you submit **eCQMs,** you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eCQM data. The CEHRT used to collect the data must be certified to the 2015 Edition, the 2015 Edition Cures Update criteria, or a combination of both by December 31, 2022.

CAHPS for MIPS Survey Measure:
We established historical benchmark for the summary survey measures (SSMs) in the CAHPS for MIPS Survey measure. Refer to the 2022 Quality Benchmarks (ZIP).

Each SSM with a benchmark is awarded 3 to 10 points by comparing performance to the benchmark.

The final CAHPS for MIPS Survey measure score is calculated as the average number of points across all scored SSMs.

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

What if a Quality Measure Doesn't Have a Historical Benchmark?

For a measure without a historical benchmark, we'll try to calculate a benchmark based on performance data submitted for the 2022 performance period on those measures.

Performance period benchmarks can be calculated when 20 or more individuals, groups, virtual groups, or APM Entities submit the measure through the same collection type where the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured).
- Meets or exceeds the 70% data completeness criteria.
- Has a performance rate greater than 0% (or less than 100% for inverse measures).

Individuals, groups, virtual groups, and APM Entities must be included in MIPS (i.e., not voluntarily reporting) for their data to be used in the creation of a benchmark.

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, your submission must identify the total eligible population (or denominator) as outlined in the measure's specification. (For small practices reporting Medicare Part B claims measures, we identify the eligible population based on the claims you submit.)
- To meet data completeness criteria, you must then report performance data (performance met or not met, or denominator exceptions) for at least 70% of the total eligible population (denominator).
- Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking"), wouldn't be considered true, accurate, or complete and may subject you to audit.
- Note that data completeness is specific to Medicare patients for Medicare Part B claims measures only; QCDR measures, MIPS CQMs and eCQMs should include all-payer data. **Measures that don't meet data completeness will earn zero points, unless you're a part of a small practice in which case the measure will earn 3 points**.

Traditional MIPS: Quality Performance Category

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

Measure Achievement Points for the 2022 Performance Period

Measures that can be reliably scored against a benchmark

Measure achievement points are based on your performance for a measure in comparison to a benchmark. A measure can be reliably scored against a benchmark when:

- A benchmark (historical or performance period) is available.
- Data completeness and case minimum criteria are met.

7 – 10 points

You'll earn 7 – 10 points for new measures in their **first year** of the program that can be reliably scored against a benchmark.

For the 2022 performance period, this applies to Quality IDs 481 – 483 and QCDR measures added to the program in the 2022 performance period.

5 – 10 points

You'll earn 5 – 10 points for new measures in their **second year** of the program that can be reliably scored against a benchmark.

For the 2022 performance period, this applies to QCDR measures added to the program in the 2021 performance period.

3-10 points*

You'll earn 3 – 10 points for measures in their **third year** (or later) of the program that can be reliably scored against a benchmark.

Beginning in the 2023 performance period, these measures will receive 1 - 10 points.

Did you know?
These new measure scoring policies are effective beginning with the 2022 performance period and **don't** apply to administrative claims or CMS Web Interface measures.

***Exception:** There are specified, topped out measures that are capped at 7 points. (These measures are identified in the 2022 MIPS Quality Historical Benchmarks Excel file – see column Q – in the 2022 Quality Benchmarks (ZIP).)

Traditional MIPS: Quality Performance Category

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

Measure Achievement Points for the 2022 Performance Period

Measures that can't be reliably scored against a benchmark

When a measure meets data completeness criteria but can't be reliably scored against a benchmark, it means either a benchmark (historical or performance period) is unavailable OR the measure didn't meet case minimum criteria.

7 points

You'll earn 7 points for new measures in their **first year** of the program that can't be reliably scored against a benchmark

For the 2022 performance period, this applies to Quality IDs 481 – 483 and QCDR measures added to the program in the 2022 performance period.

5 points

You'll earn 5 points for new measures in their **second year** of the program that can't be reliably scored against a benchmark.

For the 2022 performance period, this applies to QCDR measures added to the program in the 2021 performance period.

3 points

You'll earn 3 points for measures in their **third year** (or later) of the program that can't be reliably scored against a benchmark.

Beginning in the 2023 performance period, these measures will receive 0 points. (Small practices will continue to earn 3 points).

Did you know?
These new measure scoring policies are effective beginning with the 2022 performance period and **don't** apply to administrative claims or CMS Web Interface measures.

Traditional MIPS: Quality Performance Category

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

Measure Achievement Points for the 2022 Performance Period

Required but unreported measures

0 (out of 10) **points**

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

Measures that don't meet data completeness criteria

0 (out of 10) **points**

If you aren't in a small practice (small practices have 15 or fewer clinicians), you'll continue to receive 0 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

3 points

Small practices will continue to receive 3 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

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

Measure Bonus Points

Beginning in the 2022 performance period, there are **no bonus points available** for reporting additional outcome and high priority measures (beyond the one required) or for measures that meet end-to-end electronic reporting criteria.

Small Practice Bonus

Small practices will continue to receive 6 bonus points, added to the numerator of the quality performance category, if they report at least one MIPS quality measure.

- This bonus is available to individuals, groups, virtual groups and APM Entities with the small practice special status.
- This bonus isn't available to small practices that receive a quality performance category score from facility-based measurement. (Reminder: Facility-based measurement won't be available for the 2022 performance year.)

Small Practices Reporting Quality Measures through Medicare Part B Claims

Beginning in the 2022 performance year, we'll only calculate a group-level quality score from Medicare Part B claims measures if the practice submits data for another performance category as a group, signaling their intention to participate as a group.

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

What if I Submit More Than 6 Measures?

If you submit more than 6 measures, only 6 of those measures will contribute to the measure achievement points for your quality performance category score.

When determining which submitted measures are included in the top 6:

- We'll select the highest scoring outcome measure.
  - If no outcome measure is available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we'll select your 5 highest scoring measures, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

Remember 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, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

When there are multiple measures with the same score, we'll 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 outcome measure) were Measure 113: Colorectal Cancer Screening and Measure 425: Photodocumentation of Cecal Intubation, 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 Photodocumentation of Cecal Intubation measure (425).

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.

If you submit the same measure through multiple collection types (i.e., as a Medicare Part B claims measure and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points from 2 collection types of the same measure.

Traditional MIPS: Quality Performance Category

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

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

Maximum Points by Participation Level
Individuals:

60 points
For 6 required MIPS quality measures

70 Points
For 6 required MIPS quality measures + Hip Arthroplasty and Knee Arthroplasty Complication measure

Maximum Points by Participation Level
Groups/Virtual Groups/APM Entities:

60 points
For 6 required MIPS quality measures

70 Points
For 6 required MIPS quality measures + 1 administrative claims measure

80 Points
For 6 required MIPS quality measures + 2 administrative claims measures

90 Points
For 6 required MIPS quality measures + 3 administrative claims measures

Individuals, groups, virtual groups, and APM Entities that don't submit at least 1 available measure will receive 0 points in this performance category unless you qualify for the performance category to be reweighted.

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

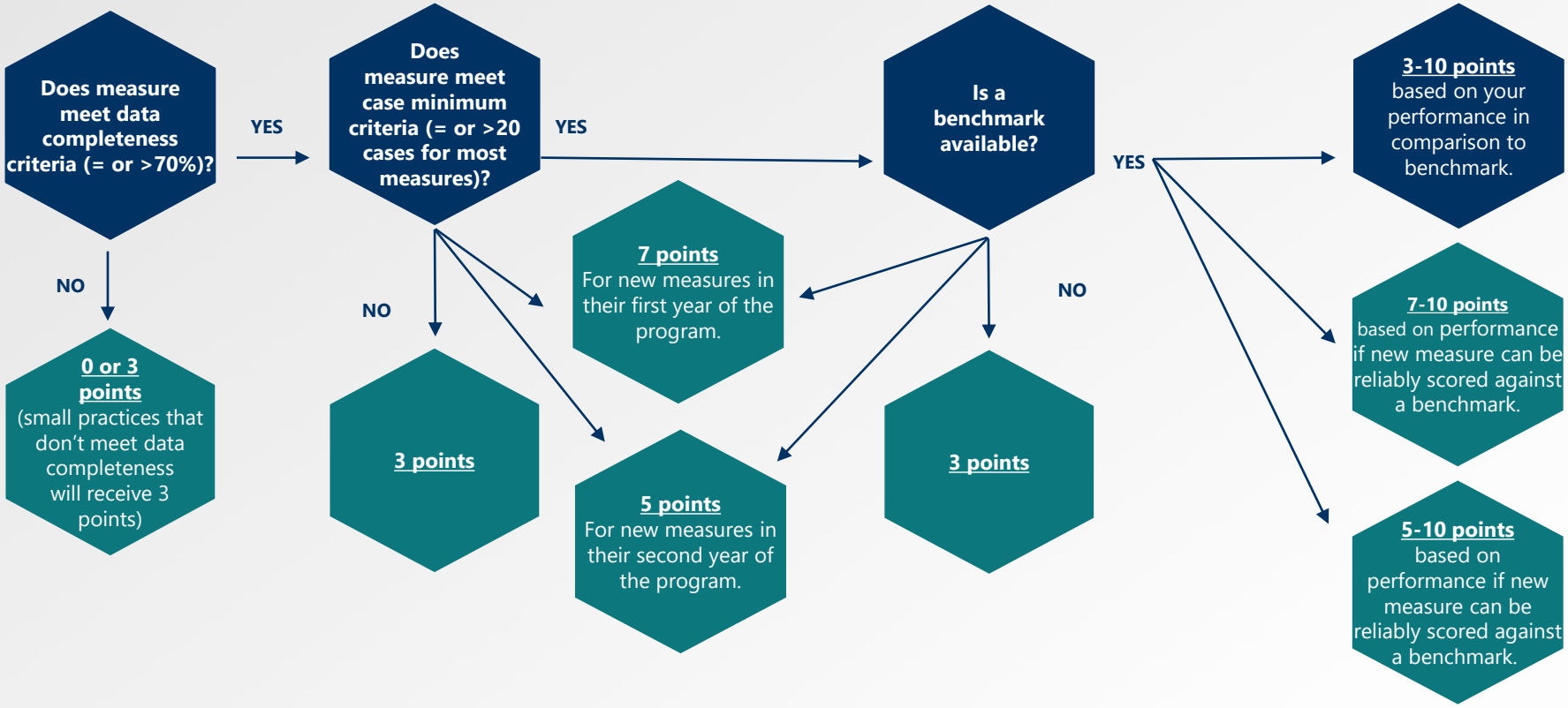
Can the Denominator (Maximum Number of Points) be Lower than 60 Points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower than 60 points.

IF…	THEN…
You submit a complete specialty measure set with fewer than 6 measures by either Medicare Part B claims or MIPS CQMs.	We'll lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B claims measures or MIPS CQMs **AND** the EMA process determines no additional measures were available. **How?** We compare the measures you submitted with a predefined list of clinically related measures.	We'll lower the denominator by 10 points for each measure that isn't available. **NOTE:** If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the quality performance category and you'll earn a score of 0 out of 10 for each of these measures.
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. **(02/02/2023:** Refer to slides 25 - 27 for suppressed measure scoring examples.) To the extent feasible, we'll identify suppressed measures by the beginning of the submission period. Refer to Appendix D for a list of affected measures.	We'll lower the denominator by 10 points for each impacted measure. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification or held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we'll truncate the performance period and score the measure instead of suppressing the measure and reducing the denominator.
Your group, virtual group, or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements **AND** submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS Survey measure.

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

What Are the Steps to Score Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs?



Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.
Skip ahead to review how we calculate the quality performance category score.

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

Suppressed and Truncated Measures: Submission and Scoring Examples.

SUPPRESSED MEASURES: MIPS eligible clinicians, groups, virtual groups, and APM Entities submitting data for 6 measures, including 1 or more suppressed measures, must submit data for all 6 measures to meet the reporting requirements for the quality performance category. Suppressed measures must still meet data completeness and case minimum requirements. Your quality performance category score would be based on the measures you submitted that aren't suppressed.

TRUNCATED MEASURES: A truncated measure will have performance assessed based on data from the first 9 months of the 2022 performance period (January through September of 2022). Measure data must be truncated prior to the submission for MIPS CQMs. For MIPS eligible clinicians, groups, virtual groups, and APM Entities submitting data for 6 measures, including 1 or more of truncated measures, your quality performance category score would be based on the submission of your 6 measures, including truncated measures.

Example 1.

You're reporting eCQMs collected in your CEHRT and have performance data for 6 measures. One of the measures you intend to submit has been suppressed for the 2022 performance period (see Appendix D).

You submit the 5 eCQMs that aren't suppressed and don't submit the eCQM that is suppressed.

- **5 submitted measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **1 unsubmitted, suppressed measure:** Receives 0 out of 10 points because it wasn't submitted. (CMS doesn't know that you intended to submit a suppressed measure unless you submit it.)
- **Quality denominator:** 60 points/not reduced. No suppressed measures were submitted.

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

Suppressed and Truncated Measures: Submission and Scoring Examples.

Example 2.

You're reporting eCQMs collected in your CEHRT and have performance data for 6 measures. Two of the measures you intend to submit have been suppressed for the 2022 performance period (see Appendix D).

You submit the 6 eCQMs, including the 2 suppressed measures.

- **4 submitted (not suppressed) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **2 submitted, suppressed measures:** Excluded from scoring because the measures were suppressed.
- **Quality denominator:** Reduced by 20 points (10 points for each submitted, suppressed measure). Quality denominator is 40 points unless you can be scored on any administrative claims measures.

Example 3.

You're working with a qualified registry to report your quality measures.

Your registry submits 9 measures on your behalf, including 2 measures that have been suppressed (see Appendix D).

- **Quality denominator:** Reduced by 20 points (10 points for each submitted, suppressed measure).
- **Quality numerator:** The 4 highest scoring measures out of the 7 measures that weren't suppressed.

TIP: If you're reporting more than the 6 required measures and want to be scored on your 6 highest scoring measures, don't submit any suppressed measures.

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

Suppressed and Truncated Measures: Submission and Scoring Examples.

Example 4.

You submit 6 suppressed measures.

- The quality performance **category isn't reweighted**; you would receive a **quality performance category score of zero points**, regardless of whether you submitted additional measures that aren't suppressed.

> **TIP:** If you submitted 6 suppressed measures because there were no other measures available, you can submit a targeted review (when final performance feedback is available) to request reweighting of the entire quality performance category.

Example 5.

You're working with a qualified registry to report your quality measures.

Your registry submits 6 measures on your behalf, including measure 134, which has been suppressed (see Appendix D).

Your EHR also contains the eCQM version of measure 134 and reports your measures on your behalf.

- **Quality denominator:** Reduced by 10 points (10 points for each submitted, suppressed measure).
- **Quality numerator:** The 5 highest scoring measures, excluding measure 134. Measure 134 won't be scored because the eCQM version is suppressed and was submitted.

Submitting CMS Web Interface Measures

REMINDER: This guide focuses on scoring for traditional MIPS and doesn't address scoring policies for Shared Savings Program Accountable Care Organizations (ACOs) reporting CMS Web Interface measures for the APP.

How Are the CMS Web Interface Measures Assessed in the Quality Performance Category for the 2022 Performance Period?

When you submit data for the 10 required measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. Groups, virtual groups, and APM Entities submitting their quality measures through the CMS Web Interface will be assessed against benchmarks established under the Shared Savings Program.

NOTE: CMS Web Interface measures can't be combined with other collection types, except the CAHPS for MIPS Survey measure and administrative claims measures.

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

Unlike other collection types, we won't attempt to calculate a performance period benchmark if there isn't an existing benchmark for MIPS scoring. CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet data completeness requirements for such measures.

NOTE: In the CY 2023 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (PFS NPRM) (87 FR 46148-46150), we proposed to retroactively establish policies for setting quality performance benchmarks for the CMS Web Interface measures for the 2022 performance year. Specifically, we proposed to establish quality performance benchmarks for the CMS Web Interface measures using the methodology described in 42 C.F.R. § 425.502(b), which is the methodology that was previously used to establish quality performance benchmarks under the Medicare Shared Savings Program (Shared Savings Program). Additionally, **we proposed to use flat percentage benchmarks to score the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134/PREV-12) measure and the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226/PREV-10) measure for performance year 2022**.

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

Measure Achievement Points

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

3 – 10 points

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

0 (0 out of 10 points)

You'll receive 0 points (0 out of 10) for measures that don't meet data completeness requirements.

N/A (0 out of 0 points)

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

N/A (0 out of 0 points)

You won't be scored on measures without an existing benchmark provided that data completeness requirements are met.

Like other collection types, the CMS Web Interface measures have a case minimum of 20 patients. However, data completeness requirements for the CMS Web Interface measures differ from other collection types:

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

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

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 each measure.

***Please note:** The tables below reflect scoring information based on proposed policy described at 87 FR 46148-46150. There are proposals in the CY 2023 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (PFS NPRM) to establish flat benchmarks for PREV-10 and PREV-12 for the 2022 performance period. We'll update this information as needed pending the release of the CY 2023 PFS Final Rule.

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

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

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

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

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

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

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

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

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

Which is rounded to 0.8

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

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

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

Measure Bonus Points

Beginning with the 2022 performance period, there are **no bonus points available** for CMS Web Interface reporting. We've removed the bonus points in the quality performance category for reporting additional outcome and high priority measures (beyond the one required) or for measures that meet end-to-end electronic reporting criteria.

Traditional MIPS: Quality Performance Category

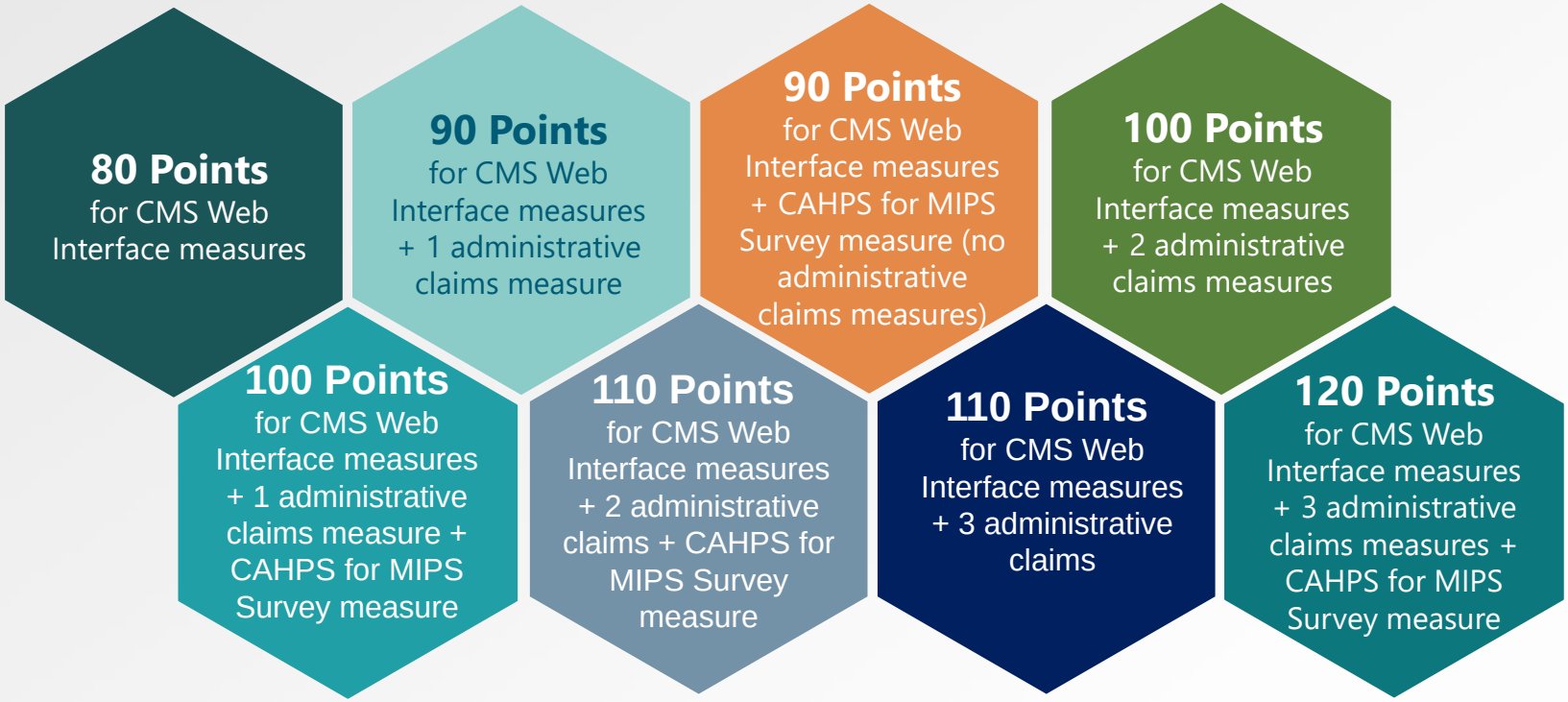
Quality Payment PROGRAM

Submitting CMS Web Interface Measures (Continued)

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

Please note: The maximum points below reflects scoring information based on proposed policy described at 87 FR 46148-46150. There are proposals in the CY 2023 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (PFS NPRM), to establish flat benchmarks for PREV-10 and PREV-12 for the 2022 performance period. We'll update this information as needed pending the release of the CY 2023 PFS Final Rule.

Maximum Points by Participation Level
Groups/Virtual Groups/APM Entities:



Submitting CMS Web Interface Measures (Continued)

Please note: This information reflects scoring information based on proposed policy described at 87 FR 46148-46159. We'll update this information as needed pending release of the CY 2023 PFS Final Rule.

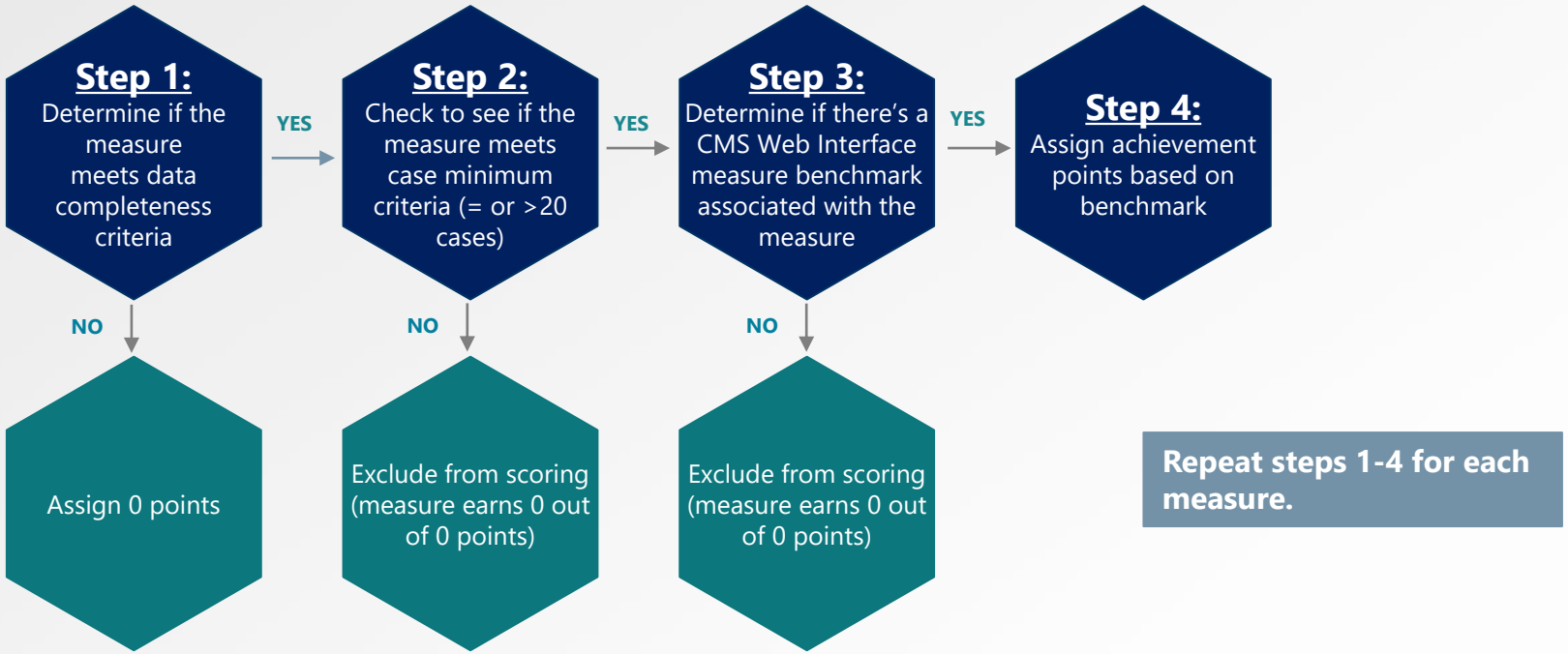
Can the Denominator (Maximum Number of Achievement Points) be Lower than 60 Points?

Yes, your denominator will be lowered if:

- You have fewer than 20 Medicare patients in a measure's sample (doesn't meet the case minimum).
  AND
- You submit complete data for all of the Medicare patients in the sample (meet data completeness requirements).

If you meet data completeness requirements, then we'll lower the denominator (maximum number of points) by 10 points for each measure that doesn't meet the case minimum as long as the reporting requirements are met for such measures.

What are the Steps to Score CMS Web Interface Measures?



Repeat steps 1-4 for each measure.

Quality Payment PROGRAM

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, Virtual Groups, and APM Entities

For individuals, groups, virtual groups, and APM entities that aren't a small practice, the quality performance category score is calculated as:

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

For individuals, groups, virtual groups, and APM entities that are part of a small practice, the quality performance category score is calculated as:

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

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

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

Calculating the Quality Performance Category Score (Continued)

Scoring for Individuals, Groups, Virtual Groups, and APM Entities (Continued)

- 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 1 quality measure** (these bonus points are available to small practices through individual, group, virtual group, and APM Entity participation).
- Your quality performance category score is then multiplied by the quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100% of the category weight. **If the quality performance category is weighted at 30%, there's a maximum of 30 points that the quality performance category can contribute to your MIPS final score.**

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

How is My Quality Performance Category Score Calculated?

What is Improvement Scoring?

MIPS eligible clinicians can earn up to 10 additional percentage points in the quality performance category based on the rate of their improvement in the quality performance category from the previous year. The improvement score—calculated at the category level and represents 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.

Eligibility for these additional percentage points is determined by meeting the following criteria:

1. Full participation in the quality category for the current performance period:
   - Submits 6 measures (with at least 1 outcome/high priority measure).
   - Submits a complete specialty measure set (which may have fewer than 6 measures; submits all measures in the set).
   - Submits all the measures in the CMS Web Interface.

   All submitted measures must meet data completeness requirements.
2. Data sufficiency standard is met, meaning there's data available and can be compared:
   - There's a quality performance category achievement score (the score earned by measures based on performance excluding bonus points) for the previous performance period (2021 performance period) and the current performance period (2022 performance period).
   - Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did you know?

Improvement scoring isn't available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period.

Reminder: Facility-based measurement wasn't available in the 2021 performance period and won't be available in the 2022 performance period.

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

How is My Quality Performance Category Score Calculated? (Continued)

Scoring Example

A small practice, participating as a group, reports 2 Medicare Part B claims measures and 3 eCQMs. They also registered to administer the CAHPS for MIPS Survey but were unable to administer the survey because they didn't meet the Medicare patient sampling requirements.

Measure Type	Collection Type	Achievement Points
Outcome Measure #1	Medicare Part B claims	7.8
Process Measure	Medicare Part B claims	7.1
Process Measure	eCQM	6.9
Outcome Measure #2	eCQM	8.2
Process Measure	eCQM	6.1
Total Points		36.1

Because they're a **small practice**, they qualify for **6 bonus points**.

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

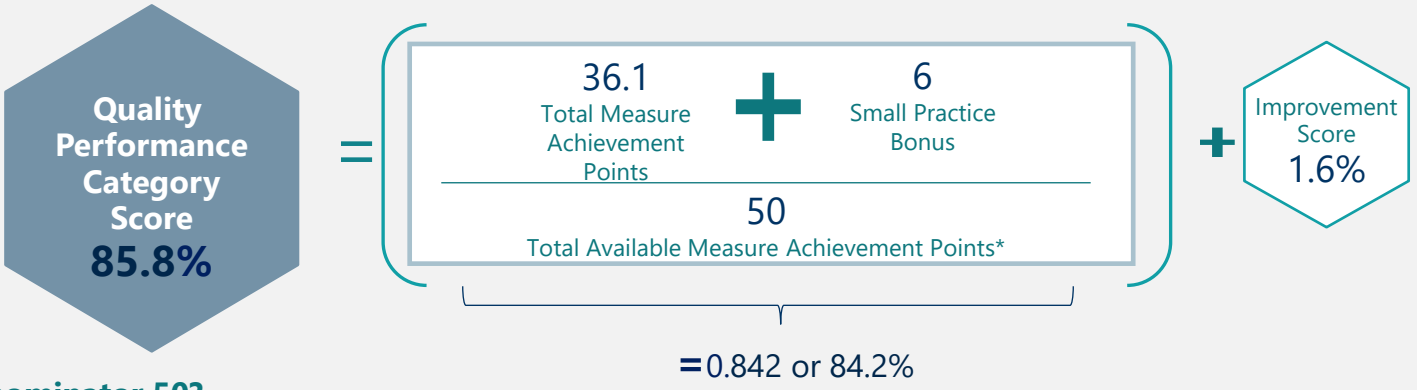
- Their 2022 achievement score = 36.1/50 = 72.2%
- Their 2021 achievement score = 62.2%
- The increase in their achievement score = 72.2% - 62.2% = 10%
- Their improvement score = (10% ÷ 62.2%) x 10 = 1.6%

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

How is My Quality Performance Category Score Calculated? (Continued)

Scoring Example (Continued)



Why is Their Denominator 50?

The group registered for, but didn't meet the sampling requirements for, the CAHPS for MIPS Survey measure and submitted less than 6 quality measures, so we reduced the denominator by 1 required measure.

Can the Quality Performance Category be Reweighted?

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

1. We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the Quality Payment Program COVID-19 Response Fact Sheet (PDF), 2021 MIPS EUC Application Guide (PDF), or the Exceptions Application webpage for more information.
2. We anticipate that reweighting of the quality performance category for lack of available measures would be a rare occurrence because there are quality measures applicable and available for most clinicians.
   - Please contact QPP at 1-866-288-8292 (Monday-Friday 8 a.m. - 8 p.m. ET) or by e-mail at QPP@cms.hhs.gov if you believe there aren't any MIPS quality measures available to you. 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.
   - Please refer to Appendix B for more information on the reweighting of the quality performance category, including the extreme and uncontrollable circumstances policy.

Traditional MIPS: Cost Performance Category

Traditional MIPS: Cost Performance Category

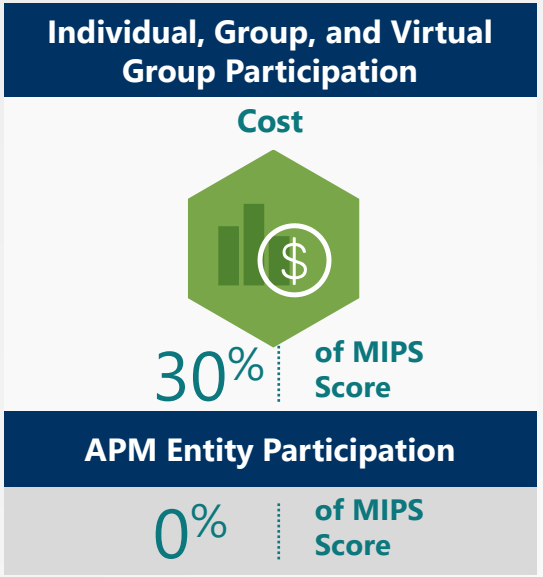
Quality Payment PROGRAM

What are the Cost Performance Category Data Submission Requirements?

There are no additional data submission requirements for this performance category. We use the Medicare claims data you already submit to calculate your cost measure performance.

How are MIPS Cost Measures Scored?

For a cost measure to be scored, an individual MIPS eligible clinician, group, or virtual group must meet or exceed the case minimum for that cost measure. Each of the 25 MIPS cost measures can earn a maximum of 10 achievement points. The table on the next page outlines the case minimum for each of the 20 MIPS cost measures.



Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

How are MIPS Cost Measures Scored? (Continued)

MIPS Cost Measure	Episode-based Measure Type	Case Minimum
Total Per Capita Cost for All Attributed Beneficiaries (TPCC) Measure	N/A	20
Medicare Spending Per Beneficiary (MSPB Clinician) Measure	N/A	35
Elective Outpatient Percutaneous Coronary Intervention (PCI) Measure	Procedural	10
Knee Arthroplasty Measure	Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation Measure	Procedural	10
Screening/Surveillance Colonoscopy Measure	Procedural	10
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	10
(NEW) Colon and Rectal Resection	Procedural	10
Elective Primary Hip Arthroplasty	Procedural	10
Femoral or Inguinal Hernia Repair	Procedural	10
Hemodialysis Access Creation	Procedural	10
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	10
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	10
(NEW) Melanoma Resection	Procedural	10
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	10
Renal or Ureteral Stone Surgical Treatment	Procedural	10

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

How are MIPS Cost Measures Scored? (Continued)

MIPS Cost Measure	Episode-based Measure Type	Case Minimum
Intracranial Hemorrhage or Cerebral Infarction Measure	Acute inpatient medical condition	20
(NEW) Sepsis	Acute inpatient medical condition	20
Simple Pneumonia with Hospitalization Measure	Acute inpatient medical condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) Measure	Acute inpatient medical condition	20
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	20
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	20
(NEW) Diabetes	Chronic Condition	20
Asthma/COPD (NEW)	Chronic Condition	20

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

How are MIPS Cost Measures Scored? (Continued)

To assess your MIPS cost measure performance, we'll:

- Establish a benchmark for each cost measure based on the performance period
  - There are no historical benchmarks established for cost measures.
- Compare performance (expressed as a dollar amount) on each measure to the performance period benchmark(s).
- Assign 1 to 10 achievement points to each scored measure based on that comparison. The amount of achievement points assigned to each measure is determined by identifying which benchmark decile range the individual or group's measure performance falls in between.
- Partial achievement points are awarded to scored measures according to the following formula:

$$\text{decile \#}\ X + \frac{[\,q\ (\text{measure score, expressed as a dollar amount}) - a\ (\text{bottom of decile range})\,]}{[\,b\ (\text{bottom of next highest decile range}) - a\ (\text{bottom of decile range})\,]} = \text{Achievement Points}$$

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

How Many Points Can I Earn in the Cost Performance Category?

Clinicians, groups, and virtual groups can earn a maximum of 250 achievement points in the cost performance category, or 10 achievement points for each of the 25 cost measures. This amount of points is available only to individual clinicians, groups, and/or virtual groups who meet the minimum case volume for, and is scored on, each of the 25 MIPS cost measures.

Can the Denominator (Maximum Number of Points) be Lower than 250?

Yes, we'll lower the denominator by 10 points for each measure for which you don't meet the case minimum. For example, if you meet the case minimum (and can therefore be scored) on 3 measures, your denominator will be 30 points.

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

How is my Cost Performance Category Score Calculated?

The cost performance category score is the equally weighted average of all scored measures. For example, if only 1 measure can be scored, then that measure's score will serve as the performance category score. If only 4 out of 25 measures can be scored, then the maximum number of points available (the denominator) will be 40.

Cost Performance Category Score =

$$\frac{\text{Total Achievement Points Earned for Scored Measures}}{\text{Total Available Measure Achievement Points*}}$$

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

In the CY 2023 PFS proposed rule, we proposed to add up to 1 percentage point for improvement scoring in the cost performance category beginning with the 2022 performance period. We'll update this slide as needed following the release of the CY 2023 PFS final rule.

Scoring Example

Let's continue with the previous example of the small practice reporting as a group. They only met the case minimum for the TPCC measure.

When evaluated against the performance period benchmark, they earn 6.3 points out of 10 points for the measure.

Cost Performance Category Score 63% =

$$\frac{\text{Total Achievement Points Earned for Scored Measures: } \mathbf{6.3}}{\text{Total Available Measure Achievement Points: } \mathbf{10}}$$

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

What Is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

UPDATED August 2022

CMS recently announced that it won't calculate any FY 2023 total performance scores for the Hospital VBP Program.

This means that facility-based clinicians won't be able to receive quality and cost scores from facility-based measurement in the 2022 performance year.

For more information, please review the 2022 Facility-Based Quick Start Guide (PDF).

Can the Cost Performance Category be Reweighted?

If you can't be scored on any of the cost measures (you don't meet the case minimum for any of them, or we're unable to establish a benchmark for any of the measures for which you do meet the case minimum), you won't be scored on this performance category, and it will be reweighted to 0% of your final score.

Our extreme and uncontrollable circumstance policy is also available for all performance categories. Clinicians who have an approved extreme and uncontrollable circumstance application that includes the cost performance category, or who qualify for the automatic extreme and uncontrollable circumstance policy, won't be scored on cost regardless of any other data submitted by or for the clinician.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

Traditional MIPS: Improvement Activities Performance Category

Traditional MIPS: Improvement Activities Performance Category

Quality Payment PROGRAM

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

You can earn up to 40 points in the improvement activities performance category by attesting to between 2 and 4 improvement activities.

To report (or "submit") an improvement activity, you simply attest to having completed it. No data needs to accompany the attestation as part of the submission.

You don't have to submit any supporting documentation when you attest to completing an improvement activity, but you must keep documentation of the efforts you (or the group or virtual group) undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the 2022 MIPS Data Validation Criteria (ZIP).

Individual, Group, and Virtual Group Participation

Improvement Activities

15% of MIPS Score

APM Entity Participation

15% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data

30% of MIPS Score

Data Aggregation and Multiple Submissions

We'll combine improvement activities submitted through attestation, file upload, and/or direct submission into a single performance category score (not to exceed 100%). If you submit the same activity through multiple submission types, the improvement activity will be counted once.

Participating as a Group, Virtual Group or APM Entity

If reporting as a group, virtual group or APM Entity, at least 50% of the eligible clinicians in the group, virtual group, or APM Entity must implement the same activity during any continuous 90-day period (or as the period specified in the activity description) in the same performance year in order to attest to that activity.

Traditional MIPS: Improvement Activities Performance Category

Quality Payment PROGRAM

How are Activities Assessed and Scored?

Improvement activities are assigned to 1 of 2 categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities. High-weighted activities address areas with the greatest impact on patient care, safety, health, and well-being, or require significant investment of time and resources.

Generally speaking, clinicians, groups, virtual groups, and APM Entities that don't have certain special status designation(s) will receive the following points for their submitted activities:

Medium-weighted activities =
10 points

High-weighted activities =
20 points

To earn the maximum score of 40 points for the improvement activities performance category, you can pick any of these:

4 medium-weighted activities =
40 points

2 medium-weighted activities + 1 high-weighted activity =
40 points

2 high-weighted activities =
40 points

NOTE: APM participants reporting traditional MIPS will automatically receive 50% credit for the improvement activities performance category for the 2022 performance year.

Traditional MIPS: Improvement Activities Performance Category

Quality Payment PROGRAM

How are Activities Assessed and Scored? (Continued)

To earn the maximum 40 points for the improvement activity performance category, you can complete either:

40 points =

2 medium-weighted activities

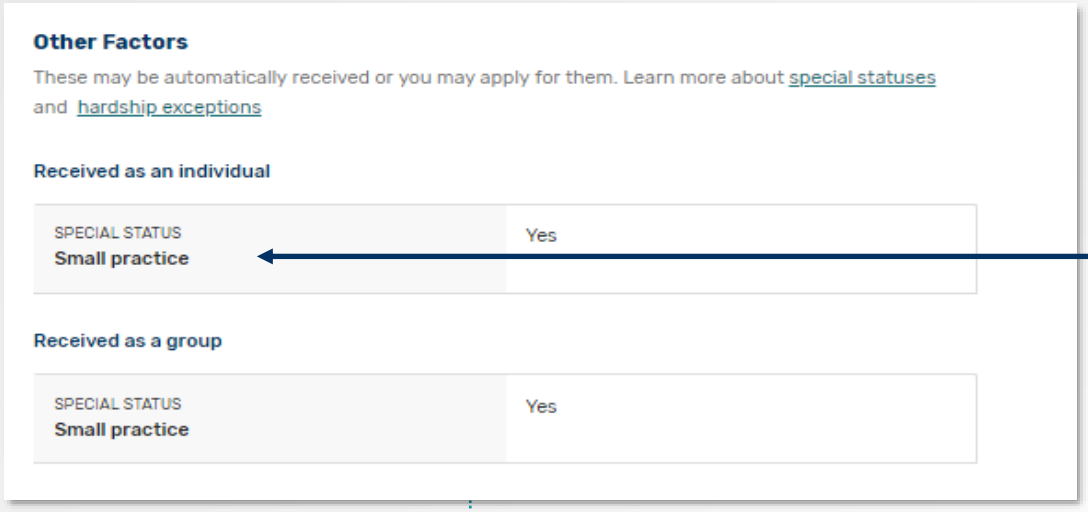
OR

1 high-weighted activity

MIPS eligible clinicians, groups, virtual groups, and APM Entities with certain special status designations will receive the following points for their submitted activities:

Medium-weighted activities = **20 points**

High-weighted activities = **40 points**



These points are assigned to activities submitted by clinicians, groups, virtual groups, and APM Entities identified on the QPP Participation Status Tool with the following special status designations:

1) a small practice (15 or fewer NPIs), **2)** non-patient facing, **3)** health professional shortage area (HPSA), or **4)** rural.

To learn more, see the 2022 MIPS Improvement Activities User Guide (PDF) or review the 2022 Improvement Activities Inventory (ZIP).

Traditional MIPS: Improvement Activities Performance Category

Quality Payment PROGRAM

How Many Points Can I Earn in the Improvement Activities Performance Category?

Clinicians, groups, virtual groups, and APM Entities can earn a maximum of 40 points in the improvement activities performance category. The improvement activities score, like all performance categories, is capped at 100%.

Can the Maximum Number of Points be Lower than 40?

No, you'll always be scored out of 40 points in the improvement activities performance category, though you may receive more points per activity based on your special status.

How is My Improvement Activities Performance Category Score Calculated?

Improvement Activities Performance Category Score

$$= \frac{\text{Total Points Earned for Completed Activities}}{\text{Total Possible Points (40)}}$$

Traditional MIPS: Improvement Activities Performance Category

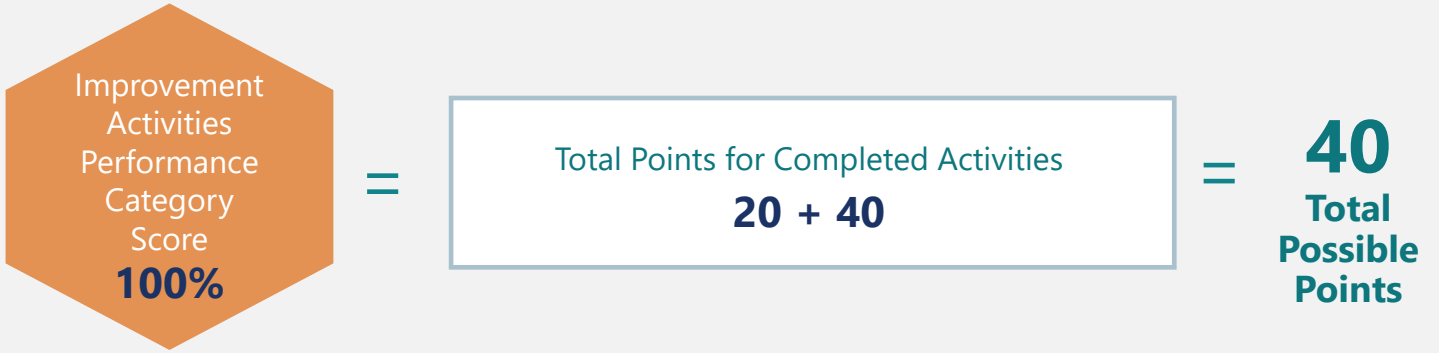
Quality Payment PROGRAM

How is My Improvement Activities Performance Category Score Calculated? (Continued)

Scoring Example

Let's continue our previous example of the small practice reporting as a group. They can't attest to having participated in CAHPS as an improvement activity because they didn't meet patient sampling requirements. They selected 2 improvement activities, 1 medium-weighted and 1 high-weighted. Because they're a small practice, they earn double points for each activity reported.

Even if you submit additional activities, you can't earn more than 100% in the performance category.



How Does Scoring Work if I'm in a Patient-centered Medical Home?

If you're in a certified or recognized patient-centered medical home or comparable specialty practice, you'll earn full credit (100%) for the improvement activities performance category. You **must attest** to your status as a patient-centered medical home or comparable specialty practice during the performance year 2022 submission period in order to receive full credit for the improvement activities performance category.

Can the Improvement Activities Performance Category be Reweighted?

We continue to make our extreme and uncontrollable circumstances policy available for all performance categories, and you may request performance category reweighting through the Extreme and Uncontrollable Circumstance (EUC) application. Please check the 2022 MIPS Extreme and Uncontrollable Circumstances Exception Application Guide (PDF) or the Exceptions Application webpage for more information.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

Traditional MIPS: Promoting Interoperability Performance Category

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

Overview

The Promoting Interoperability performance category focuses on 4 objectives:

- e-Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

These objectives are comprised of 5 or 6 required measures (dependent on which measure(s) you choose to report for the HIE measure objective) in addition to the required attestations and optional measures.

Individual, Group, and Virtual Group Participation

Promoting Interoperability

25% of MIPS Score

APM Entity Participation

30% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data

0% of MIPS Score

When participating as an APM Entity, Promoting Interoperability is still reported at the individual or group level, even though your APM Entity is reporting quality and improvement activity data.

2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the 2 are required for participation in this performance category. For additional information, review the 2022 Promoting Interoperability Quick Start Guide (PDF).

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

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

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

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

*The **HIE Bi-Directional Exchange measure** serves as an **alternative** measure to the 2 existing required HIE objective. You're expected to report either option 1 (the 2 original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective.

You wouldn't submit both options.

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

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

- Use 2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the 2 to meet the measures above and collect your data (certified by the last day of your 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 a "yes" that you have completed the Security Risk Analysis measure during 2022
- Submit a "yes" or "no" to completing the High Priority Practices Guide of the SAFER Guides measure during 2022
- Submit the CMS EHR Certification identification code for your EHR product(s) as proof that it's certified by ONC to the 2015 Edition and/or 2015 Edition Cures Update (you can find this information at Certified Health IT Product List).

If any of these requirements **aren't met**, you'll get **0 points** in the Promoting Interoperability performance category.

Data Aggregation and Multiple Submissions

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.

- Sign in to the QPP website before the submission period ends to ensure there are no conflicting data submitted.

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

Each required measure will be scored based on the performance data you report.

For measures with a numerator and denominator, we calculate the performance rate on the submitted numerator and denominator.

The Query of PDMP measure (optional/bonus measure), Public Health and Clinical Data Exchange objective measures (required and optional/bonus), HIE Bi-Directional Exchange measure, and the Security Risk Analysis and High Priority Practices Guide of the SAFER Guides attestation measure 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.

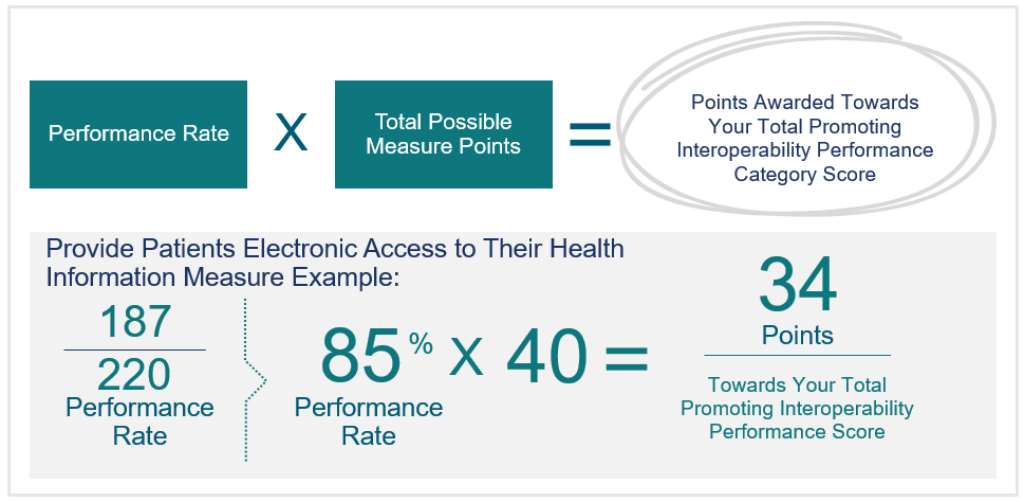
Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

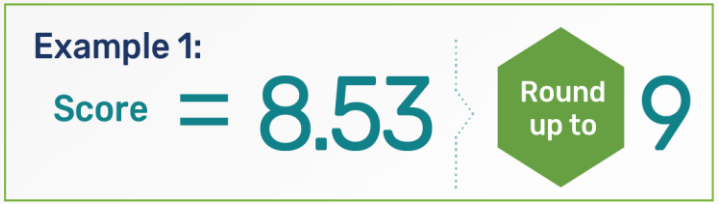
Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance. For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator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

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



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

- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as at 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.)



Important to Note:

- The Query of Prescription Drug Monitoring Program (PDMP) bonus measure in the e-Prescribing objective will earn 10 points (if submitted along with the required e-Prescribing measure).
- 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).

Traditional MIPS: Promoting Interoperability Performance Category

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

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

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

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

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

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

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

AND

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

* If you submit an exclusion for:

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

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

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

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

While there are 115 total points available, clinicians, groups, and virtual groups 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.

Please see Appendix D for detailed information about how points are reallocated when an exclusion(s) is claimed.

How is the Promoting Interoperability Performance Category Scored?

We'll add the scores for each of the individual measures (or objective) together and 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).

Individual, Group, and Virtual Group Participation:

Promoting Interoperability Performance Category Score = [Total Points Earned for Completed Measures] (Including Bonus Points) / Total Possible Measure Points

APM Entity Participation:

APM Entity's Promoting Interoperability Score = Sum of Points Earned by All MIPS Eligible Clinicians for Required Measures / (Total MPIS Eligible Clinicians in APM Entity - MIPS Eligible Clinicians Who Receive Performance Category Reweighting) + **15 Bonus Points** (if at least one clinician reported an optional measure)

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

Promoting Interoperability Performance Category Scoring Example

Let's continue our example of the small practice participating as a group. While small practices qualify for automatic reweighting of the Promoting Interoperability performance category, this small practice was able and chose to submit data for this performance category. The group has EHR technology certified to the 2015 Edition and/or the 2015 Edition Cures Update and completed the required attestations and measures.

Objective	Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
e-Prescribing	e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
	Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	Not reported	10 bonus points	N/A
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	180 / 250 (0.72)	20 points → 25 points re-allocated from e-Prescribing	0.72 x 25 = 18 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	176 / 200 (0.88)	20 points → 25 points (5 points re-allocated from e-Prescribing)	0.88 x 25 = 22
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	187 / 220 (0.85)	40 points	0.85 x 40 = 34 points
Public Health and Clinical Data Exchange	Report the 2 required measures Immunization Registry Reporting • Electronic Case Reporting	• Reported "yes" to Immunization Registry Reporting measure • Claimed exclusion for Clinical Data Registry Reporting measure	10 points	10 points (this objective is all or nothing)
	Bonus (optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Reported "yes" to the optional Public Health Registry Reporting measure	5 points	5 points
Required Measure Point Total				**84 points**
Optional Measure Point Total				**5 points**
Promoting Interoperability Performance Category Score				**89 points / 100 points = 89%**

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

Can the Promoting Interoperability Performance Category be Reweighted?

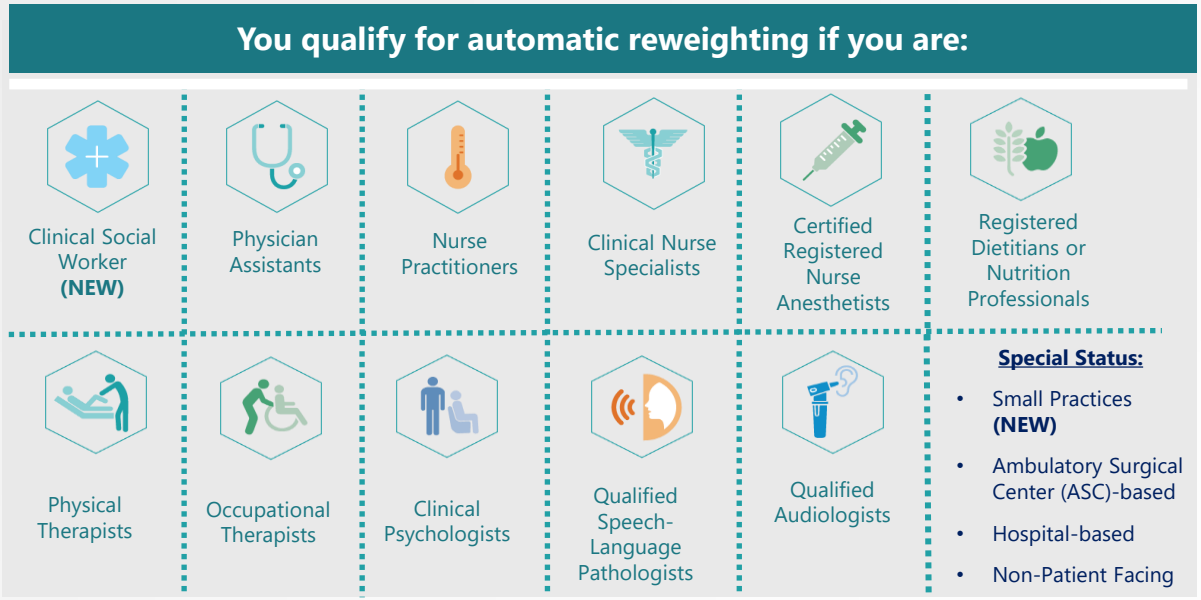
Yes. There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

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

1. You request reweighting for multiple performance categories through the Extreme and Uncontrollable Circumstance (EUC) application. Please check 2022 Extreme and Uncontrollable Circumstances Exception Application Guide (PDF) or the Exceptions Application webpage for more information.
2. You submit a Promoting Interoperability Hardship Exception Application, 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** if you are any of the following (see the QPP Participation Status Tool):



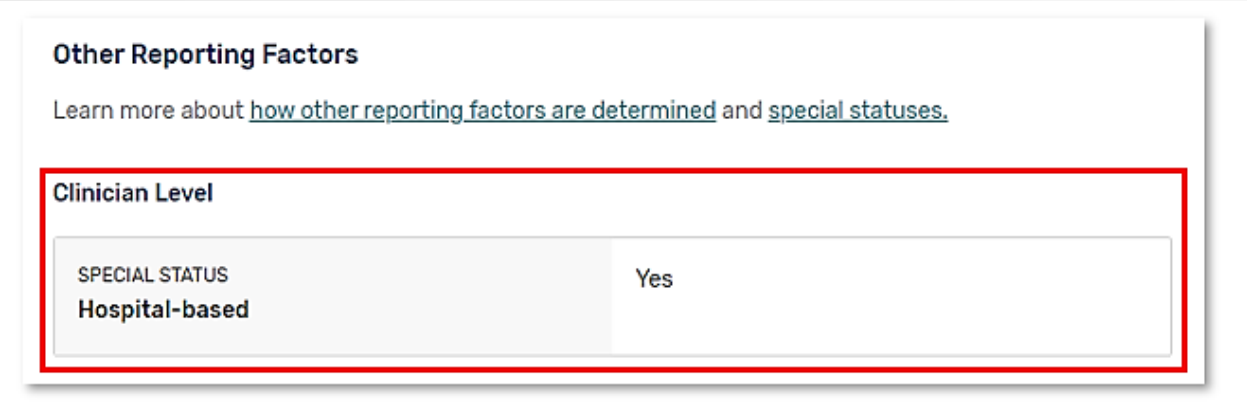
Traditional MIPS: Promoting Interoperability Performance Category

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

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

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

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



NOTE: If you have an approved exception or qualify for automatic reweighting, we'll reweight the category to 0% and typically redistribute the 25% weight to the quality performance category so you can earn up to 100 points in your MIPS final score. However, you can still report if you want to.

If you submit data on the measures for the Promoting Interoperability performance category either as an individual, a group, or virtual group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 25% of the final score.

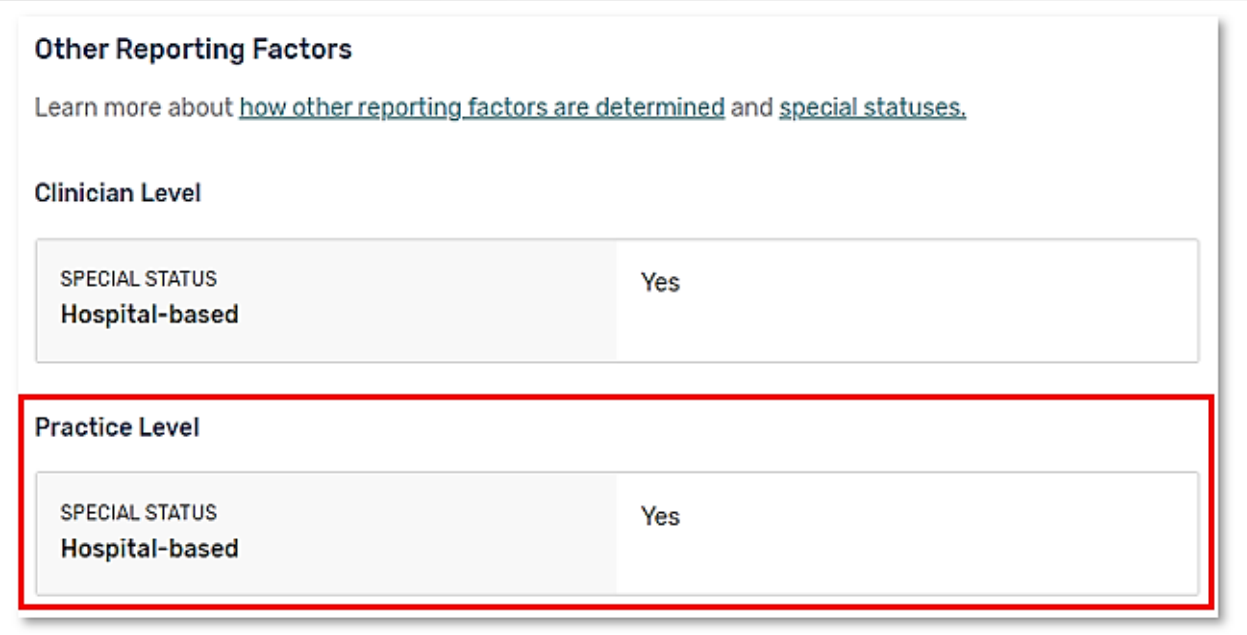
Traditional MIPS: Promoting Interoperability Performance Category

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

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

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

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



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

Just as with individual participation, groups and virtual 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 25% of the final score.

Traditional MIPS: Promoting Interoperability Performance Category

Quality Payment PROGRAM

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

Individual MIPS eligible clinicians and groups in the 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 determining the APM Entity's score, but they'll 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 Entity for the 2022 performance period. This could occur when all of the clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

MIPS Final Score

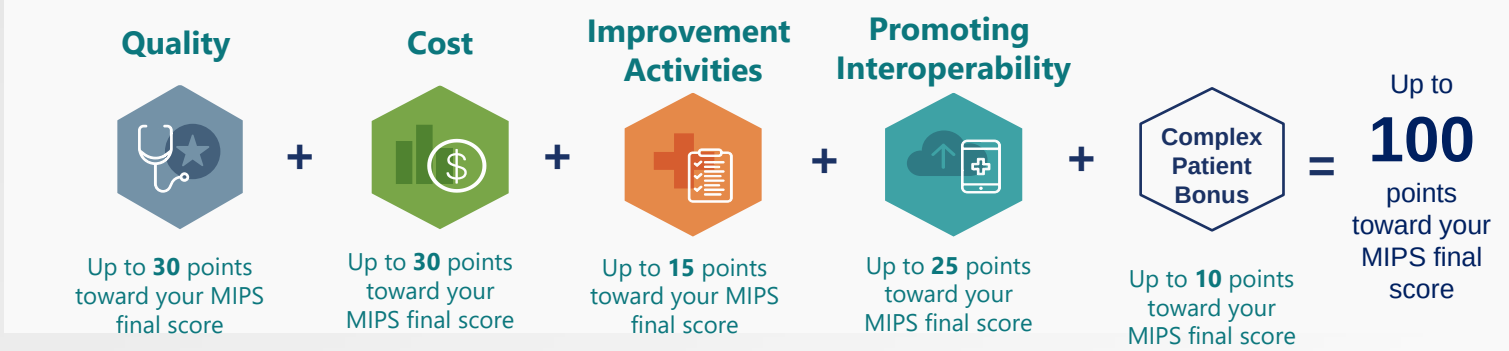
MIPS Final Score

Quality Payment PROGRAM

How is My Final Score Calculated?

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

Traditional MIPS Performance Category Weights in 2022:



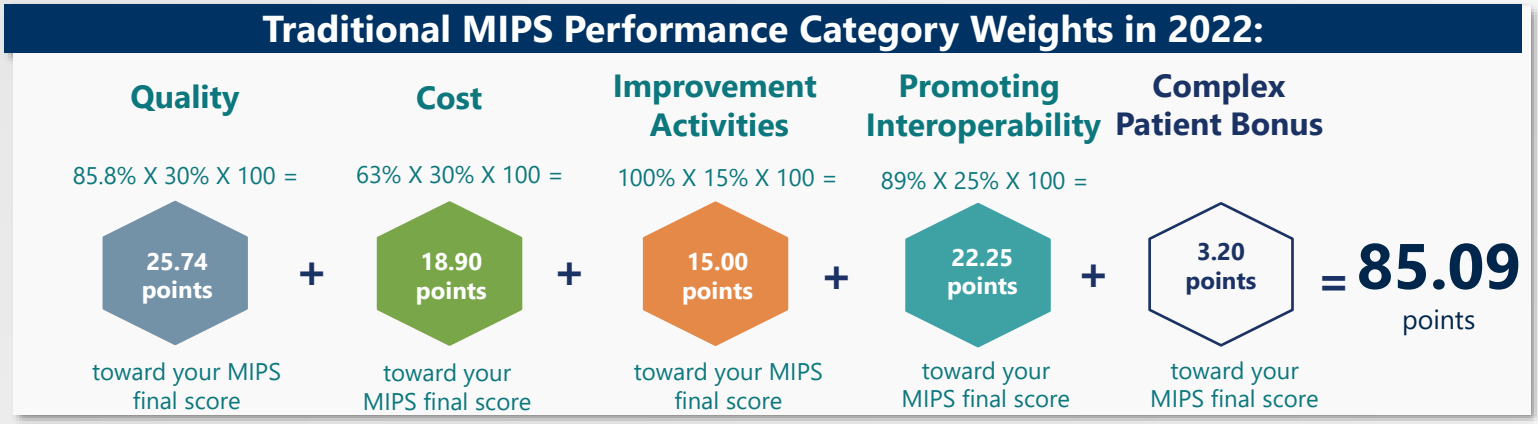
The MIPS final score can't exceed 100 points.

MIPS Final Score

How is My Final Score Calculated?

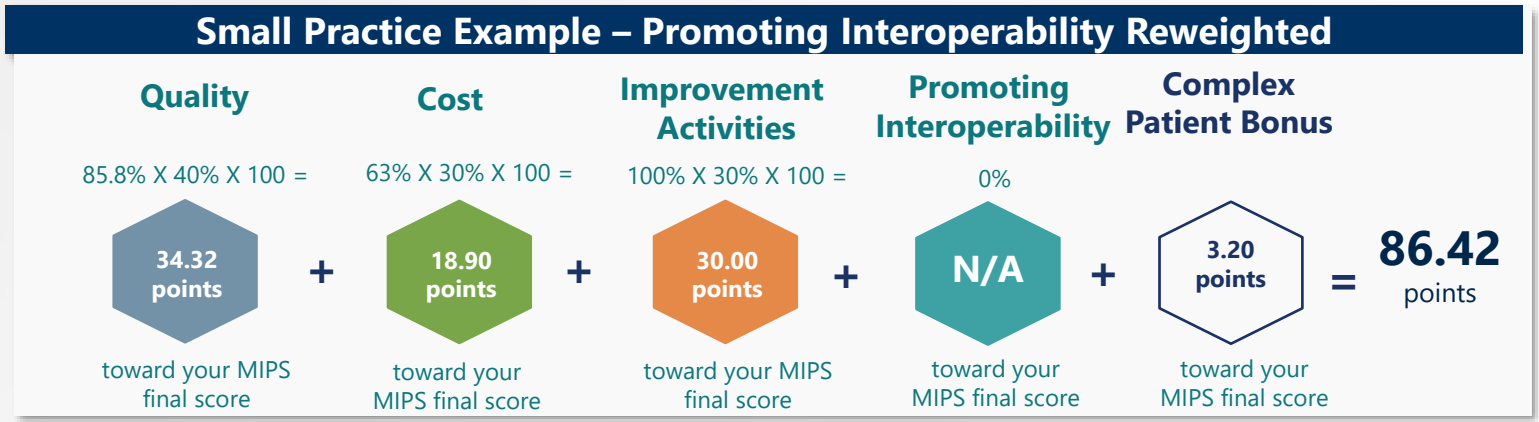
Scoring Example 1.

Let's continue our example of the small practice reporting as a group and review how the final score is calculated. (As a reminder, small practices qualify for automatic reweighting of Promoting Interoperability, but the small practice in this example had CEHRT and chose to report data for this performance category.)



Scoring Example 2.

Now let's look at what the small practice's final score would have been if they **didn't** report data for the Promoting Interoperability performance category. This performance category will automatically be weighted at 0% unless data is submitted. Small practices have a different redistribution of performance category weights when 1 or more performance categories are reweighted.
See Appendix B, Table 2.



MIPS Final Score

What is the Complex Patient Bonus?

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

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

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

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

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

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

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

MIPS Final Score

Eligibility for the Complex Patient Bonus

Step 1

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

Step 2

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

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

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

Step 3

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

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

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

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

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, virtual group or APM Entity) in performance year 2021. (This is different than the median calculated to determine eligibility.)

Step 2

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

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

Step 3

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

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

Step 4

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

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

Step 5

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

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

Step 6

We'll calculate your total complex patient bonus

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

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

MIPS Final Score and Payment Adjustment

MIPS Final Score and Payment Adjustment

Quality Payment PROGRAM

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be. **Why?** MIPS is required by law to be a budget neutral program, which generally means that the amount of the payment adjustments will be dependent on the overall participation and performance of clinicians in the program for that year.

Final Score	Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (greater than -9% and less than 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 88.99 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)
89.00 – 100.00 points (Additional performance threshold=89.00 points)	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) AND Additional positive payment adjustment for exceptional performance (scaling factor applied to account for funding pool) **The 2022 performance year/2024 payment year is the last year for the exceptional performance adjustment.**

MIPS Final Score and Payment Adjustment

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

There are 2 components of the MIPS payment adjustments. The first applies to all MIPS eligible clinicians, and the second is an additional payment adjustment for exceptional performance that applies only to those MIPS eligible clinicians with a final score of 85 points or higher.

1. **MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality.
   - Clinicians with a final score **at** the performance threshold of **75 points** earn a **neutral** adjustment.
   - Clinicians with a final score **above** the performance threshold of **75 points** earn a **positive** adjustment (subject to a scaling factor).
   - Clinicians with a final score **below** the performance threshold of **75 points** will be subject to a **negative** adjustment. The maximum negative adjustment is -9%.

The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

2. **Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 89 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled due to available funds; it will depend on the scores and the number of clinicians receiving a score of 89 points or higher.

Reminder: The 2022 performance year/2024 payment year will be the last year the additional payment adjustment for exceptional performance is available.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

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

Contact the Quality Payment Program 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.

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

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Resources

The following resources are available on the QPP Resource Library:

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

- **Quality:**
  - 2022 Quality Benchmarks (ZIP)
  - 2022 MIPS Quality Measures List (XLSX)
  - 2022 CAHPS for MIPS Overview Fact Sheet (PDF)
  - 2022 Medicare Part B Claims Measure Specifications (ZIP)
  - 2022 MIPS Clinical Quality Measure Specifications (ZIP)
  - 2022 QCDR Measure Specifications (XLSX)
  - 2022 CMS Web Interface Measure Specifications (ZIP)

- **Cost:**
  - 2022 MIPS Cost User Guide (PDF)
  - 2022 MIPS Cost Measure Codes Lists (ZIP)
  - 2022 MIPS Summary of Cost Measures (PDF)
  - 2022 MIPS Cost Measure Information Forms (ZIP)

- **Improvement Activities:**
  - 2022 MIPS Improvement Activities User Guide (PDF)
  - 2022 Improvement Activities Inventory (ZIP)

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

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Glossary

Help, Resources, and Version History

Version History

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

Date	Description
02/02/2023	Updated Appendix D with measures truncated or suppressed as a result of ICD-10 coding changes.
12/07/2022	Updated dual eligibility ratio bullet in step 2 on slide 71.
09/06/2022	Updated to indicate that facility-based scoring won't be available for the 2022 performance year (slides 14, 21, 34, 43, and 44). Updated 2022 CMS Web Interface measures benchmark information (slides 26 – 31).
06/27/2022	Original Posting.

Appendices

Appendices

Appendix A: Scoring Quality Measures

02/02/2023: We've updated this scoring example. As noted in Appendix D, the eCQM collection type for several measures in this example (including 236) have been suppressed for the 2022 performance period and will be excluded from scoring.

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

1. **Find the benchmark and figure achievement points based on collection type for the measure.**
   - Achievement points are figured by mapping the performance rate to the benchmark for the measure, specific to collection type.
   - **Example:** Small practice reporting as a group submits Measure 236 as an eCQM.

Measure Reported	Type of Measure	Collection Type	Measure Performance Rate	Cases Reported
Measure 236 – Controlling High Blood Pressure	Intermediate Outcome	MIPS CQM	66.74 (mapped to highlighted decile below)	90

   - This is an extract from the 2022 benchmarking file showing the range of performance rates associated with each decile for each collection type (Remember that Measure 236 is subject to the flat benchmark methodology, which is reflected in the 2022 Historical Quality Benchmarks file):

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

Appendix A: Scoring Quality Measures (Continued)

2. **Figure achievement points in a decile.**
   - Determine the decile that the performance rate falls in:
   - Measure performance rate = 66.74

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

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

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

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

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

...which is rounded to 0.7

Appendix A: Scoring Quality Measures (Continued)

3. **Repeat assignment of achievement points for each submitted measure.**
   - **Example:** Small practice submits 5 eCQMs, 2 MIPS CQMs and 2 Medicare Part B claims measures, meeting data completeness for all measures.

Measures Reported	Collection Type	Types of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
Measure 236 Controlling High Blood Pressure	MIPS CQM	Outcome	66.74	86	7.7	Compare to benchmark; required outcome measure
Measure 130 Documentation of Current Medications in the Medical Record	eCQM	Process	96.74	90	6.8	Compare to benchmark
Measure 111 Pneumococcal Vaccination for Elderly	eCQM	Process	22.21	112	3.0	Compare to benchmark
Measure 111 Pneumococcal Vaccination for Elderly	Medicare Part B Claims	Process	70.56	113	3.3	Compare to benchmark
Measure 113 Colorectal Cancer Screening	MIPS CQM	Process	36.32	13	3.0	Apply 3-point floor because it's below 20 case minimum
Measure 119 Diabetes: Attention for Nephropathy	eCQM	Process	77.19	43	3.7	Compare to benchmark
Measure 110 Preventive Care and Screening: Influenza Immunization	eCQM	Process	0.09	32	3.0	Compare to benchmark; apply 3-point floor due to poor performance
Measure 374 Closing the Referral Loop: Receipt of Specialist Report	eCQM	Process	21.46	40	5.5	Compare to benchmark
Measure 436 Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Medicare Part B Claims	Process	97.25	160	3.4	Compare to benchmark

Appendix A: Scoring Quality Measures (Continued)

4. **Sort and group measures based on achievement.**
   a. First identify the highest scoring outcome measure based on achievement points, then identify the next 5 highest scoring measures based on achievement points.

The following measures contribute achievement points toward the quality performance category score.			
Measures Sorted by Performance	**Collection Type**	**Performance Rate**	**Achievement Points**
1. Outcome/High-priority: **Measure 236**	MIPS CQM	66.74	7.7
2. **Measure 130**	eCQM	96.74	6.8
3. **Measure 374**	eCQM	21.46	5.5
4. **Measure 119**	eCQM	77.19	3.7
5. **Measure 436**	Medicare Part B Claims	97.25	3.4
6. **Measure 111**	Medicare Part B Claims	70.56	3.3

b. Identify measures that won't contribute any points to the quality performance category score.

The following measure don't contribute achievement points toward the quality performance category score.				
Measures Sorted by Performance	**Collection Type**	**Performance Rate**	**Achievement Points**	**Comment**
Measure 113	MIPS CQM	36.32	3.0	Not one of the top 6 scored measures
Measure 111	eCQM	22.21	3.0	Not one of the top 6 scored measures
Measure 110	eCQM	0.09	3.0	Not one of the top 6 scored measures

Appendix B: Reweighting the Performance Categories

Table 1. Performance Category Weight Redistribution (Excluding Small Practices)

Table 1 outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

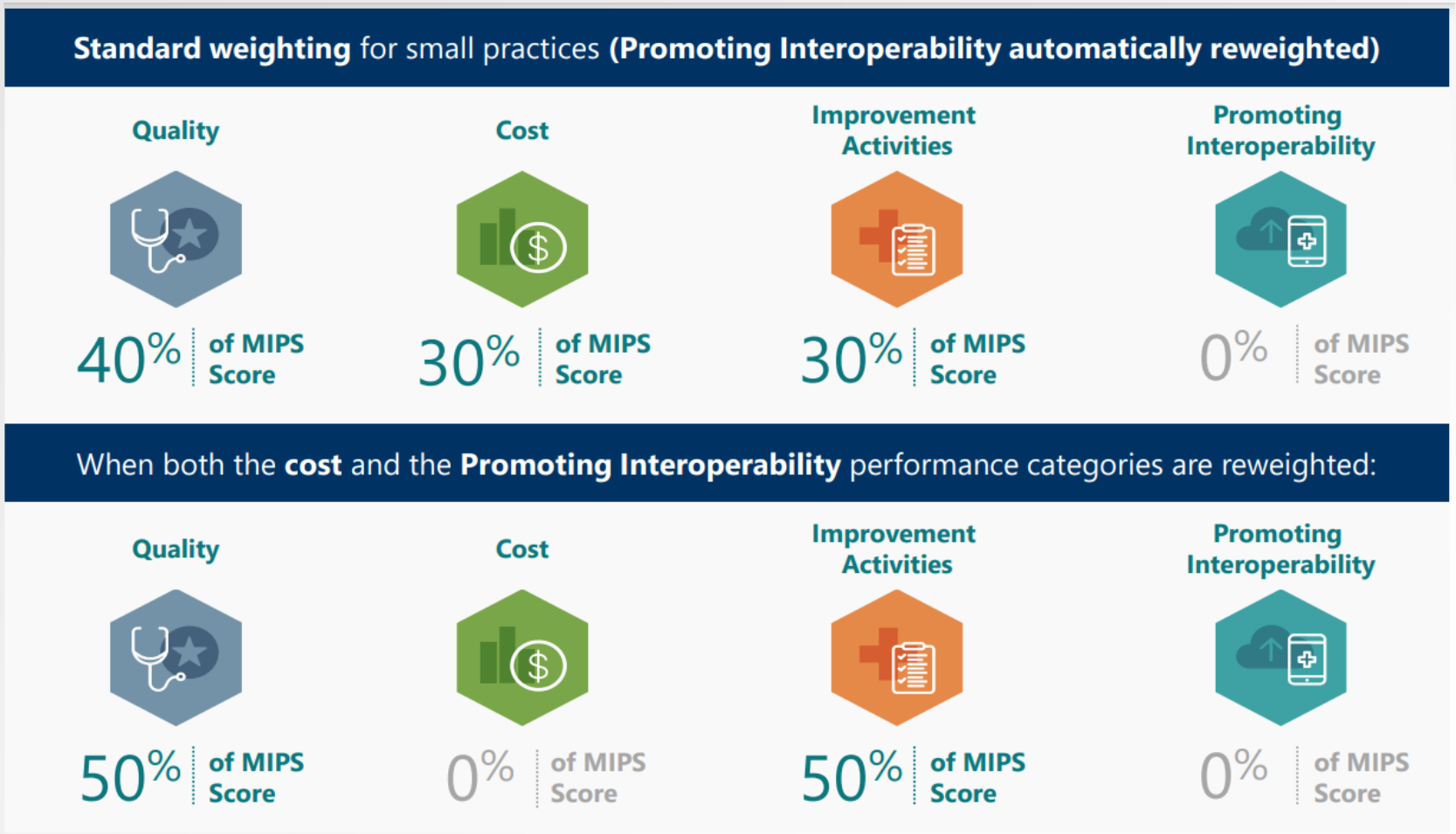
Performance Category Redistribution for the 2022 Performance Year/2024 MIPS Payment Year				
Reweighting Scenario	**Quality**	**Cost**	**Improvement Activities (IA)**	**Promoting Interoperability (PI)**
No Reweighting Needed				
General weighting for all 4 performance categories	**30%**	**30%**	**15%**	**25%**
Reweighting 1 Performance Category				
No Cost: *Cost → Quality and PI*	55%	0%	15%	30%
No Promoting Interoperability: *PI → Quality*	55%	30%	15%	0%
No Quality: *Quality → PI*	0%	30%	15%	55%
No Improvement Activities: *IA → Quality*	45%	30%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability *Cost and PI → Quality*	85%	0%	15%	0%
No Cost and No Quality *Cost and Quality → PI*	0%	0%	15%	85%
No Cost and No Improvement Activities *Cost and IA → Quality and PI*	70%	0%	0%	30%
No Promoting Interoperability and No Quality *PI and Quality → Cost and IA*	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities *PI and IA → Quality*	70%	30%	0%	0%
No Quality and No Improvement Activities *Quality and IA → PI*	0%	30%	0%	70%

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

Appendix B: Reweighting the Performance Categories

Table 2. Performance Category Weight Redistribution (Small Practices)

Table 2 reviews the performance category redistribution policies that apply to small practices in performance year 2022.



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Appendix B: Reweighting the Performance Categories

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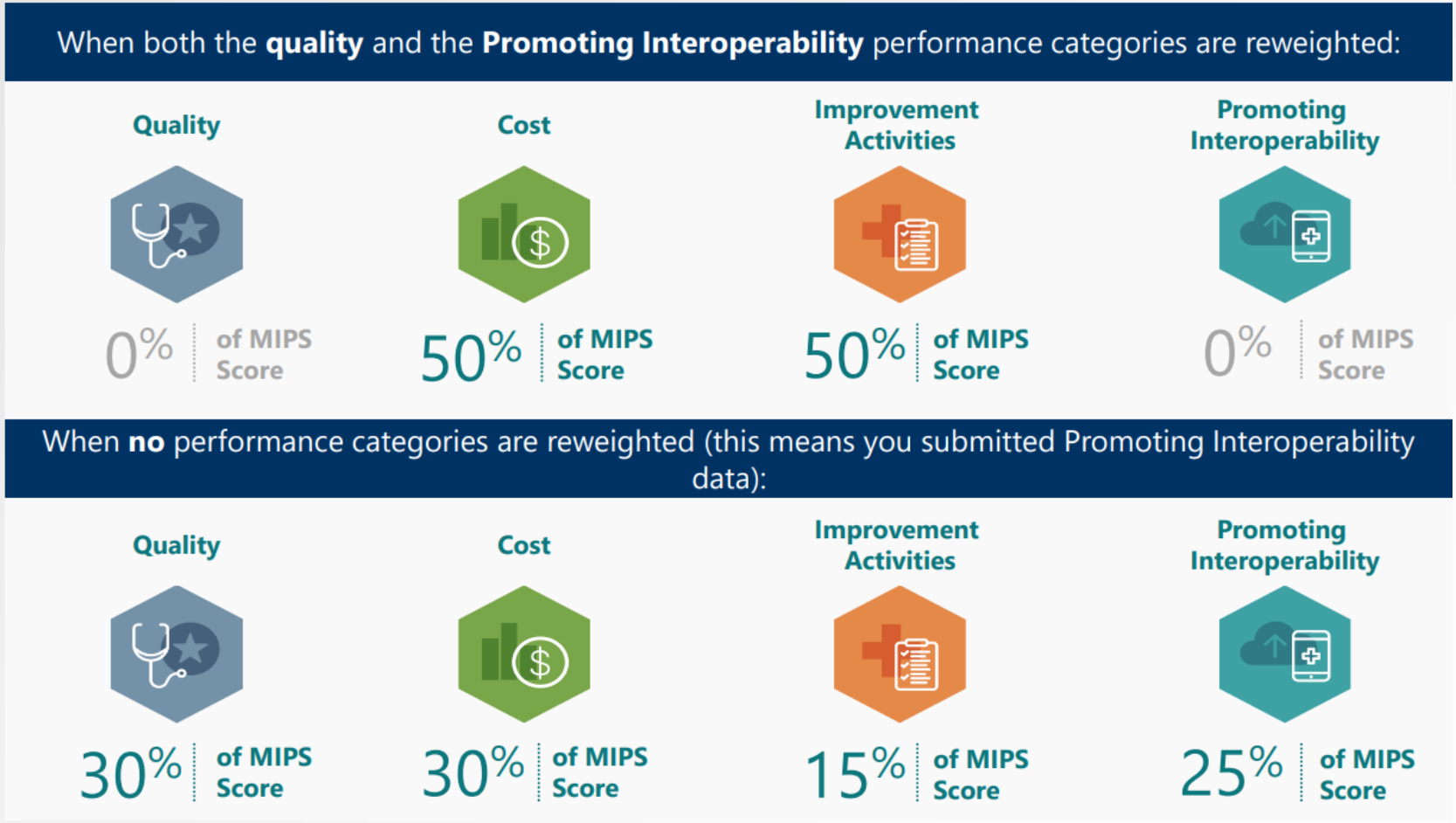

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you will receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix C: 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: Option 1 • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure • Option 2 • 10 points to the HIE Bi-Directional Exchange measure
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)		N/A	N/A
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	…the 20 points are redistributed to the Provide Patients Electronic Access to the Health Information
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	…the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	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 the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting		Yes	…the 10 points are still available in this objective if you **claim one exclusion** and submit a 'yes' attestation for the other required measure in the objective. …the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you **claim two exclusions**.
	Bonus (optional): • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		N/A	N/A

Appendix D: Quality Measures with MIPS Scoring or Submission Changes

This table identifies measures affected by specification or coding issues, clinical guideline changes during the 2022 performance period, or specifications determined during or after the performance period to have substantive changes. This list will be updated if additional measures are identified for suppression or truncation in the 2022 performance period.

02/02/2023: Updated based on MIPS quality measures impacted by International Classification of Diseases, Tenth Revision (ICD-10) updates effective October 1, 2022. (MIPS CQM and Medicare Part B claims measures were truncated and eCQMs were suppressed.) Download this fact sheet for more information. We've also added new suppressed measure scoring examples on pages 25 through 27 of this guide.

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 005/ Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	eCQM (CMS135v10)	eCQM specification was significantly impacted by ICD-10 coding changes. (Note: The MIPS CQM specification for this measure wasn't determined to be significantly impacted.)	Suppressed	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points.
Measure 006/ Coronary Artery Disease (CAD): Antiplatelet Therapy	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 113/ Colorectal Cancer Screening	eCQM (CMS130v10)	eCQM specification was significantly impacted by ICD-10 coding changes. (Note: The other collection types for this measure weren't determined to be significantly impacted.)	Suppressed	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 134/ Preventive Care and Screening: Screening for Depression and Follow-Up Plan	eCQM (CMS2v11) MIPS CQM Medicare Part B Claims Measure	Measure was significantly impacted by ICD-10 coding changes. (Note: The CMS Web Interface specification for this measure wasn't determined to be significantly impacted.)	Suppressed (eCQM) Truncated (MIPS CQM, Part B Claims)	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points. Truncated performance period – those reporting this measure as a MIPS CQM should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission. CMS will truncate the performance period automatically for Medicare Part B claims reporting.
Measure 236/ Controlling High Blood Pressure	eCQM (CMS165v10)	eCQM specification was significantly impacted by ICD-10 coding changes. (Note: The other collection types for this measure weren't determined to be significantly impacted.)	Suppressed	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 238/ Use of High-Risk Medications in Older Adults	MIPS CQM	During the annual revision process, a second submission criteria was added to this measure. However, the same Quality Data Codes (QDCs) were utilized as "performance not met" numerator options for both submission criteria 1 and submission criteria 2, while the quality actions assessed are different. Therefore, when these QDCs are submitted it isn't known which submission criteria they are applicable to and if each quality action was met. Due to this error, it isn't possible to accurately assess numerator compliance. (Note: The eCQM specification for this measure wasn't determined to be significantly impacted.)	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 239/ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	eCQM (CMS155v10)	Measure was significantly impacted by ICD-10 coding changes.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 259/ Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2)	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 281/ Dementia: Cognitive Assessment	eCQM (CMS149v10)	Measure was significantly impacted by ICD-10 coding changes.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 282/ Dementia: Functional Status Assessment	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 283/ Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 286/ Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 288/ Dementia: Education and Support of Caregivers for Patients with Dementia	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 326/ Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	MIPS CQM	A typographical error was introduced into the measure specifications by the measure steward during the annual measure update. This led to an incorrect denominator exception, which will likely impact reporting and performance of this measure. The denominator exception impacted by this typographical error is intended to offer MIPS eligible clinicians/groups a medical reason for not prescribing an FDA-approved oral anticoagulant for denominator eligible patients. Due to this error, the denominator exception now includes a patient population that's already excluded from the denominator of the measure, and no longer allows a medical exception for denominator eligible patients that weren't prescribed an FDA-approved oral anticoagulant.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 366/ Follow-Up Care for Children Prescribed ADHD Medication (ADD)	eCQM (CMS136v11)	Measure was significantly impacted by ICD-10 coding changes.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 383/ Adherence to Antipsychotic Medications For Individuals with Schizophrenia	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 415/ Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 416/ Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	MIPS CQM Medicare Part B Claims Measure	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure as a MIPS CQM should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission. CMS will truncate the performance period automatically for Medicare Part B claims reporting.

Appendix D: Quality Measures with MIPS Scoring or Submission Changes (Continued)

Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 465/ Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.