Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Participating in the Quality Performance Category in the 2022 Performance Year: Traditional MIPS

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

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Purpose: This detailed resource focuses on the quality performance category requirements under the traditional Merit-based Incentive Payment System (MIPS) (original framework for collecting and reporting data since the inception of the Quality Payment Program (QPP)), providing requirements and practical information about quality measure selection, data collection, and submission for the 2022 performance period for individual, group, virtual group, and Alternative Payment Model (APM) Entity reporting. This resource doesn't address quality requirements under the APM Performance Pathway (APP).

How to Use This Guide

How to Use This Guide

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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

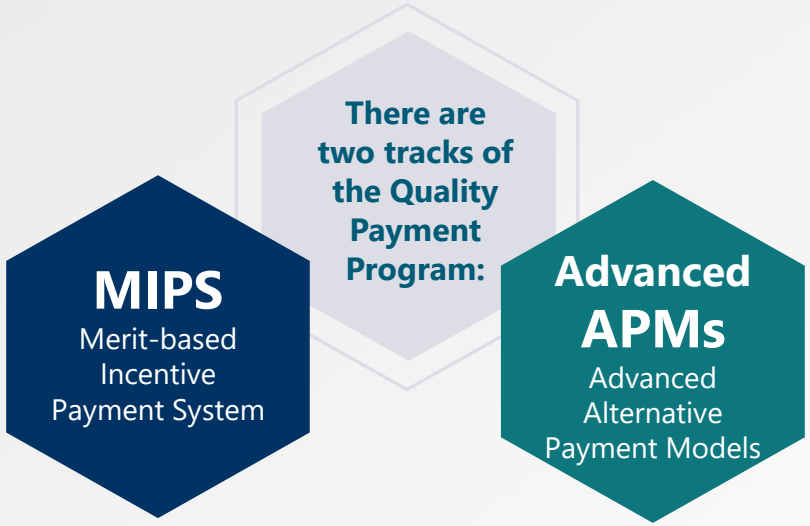
COVID-19 and 2022 Participation

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 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 Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:



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

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

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

What is the 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 established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Through QPP MIPS eligible clinicians are reimbursed for Medicare Part B covered professional services and rewarded for improving the quality of patient care and health outcomes.

Under MIPS, we evaluate your performance across multiple performance categories that lead to improved quality and value in our healthcare 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 webpages on the Quality Payment Program website.
- View the 2022 MIPS Eligibility and Participation Quick Start Guide (PDF).
- Check your current MIPS 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 the 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 CY 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to MIPS Value Pathways section of the QPP website.

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

- **To learn more about the APP:**
  - Visit the APM Performance Pathway webpage on the Quality Payment Program website.
  - View the following:
    - 2021 APM Performance Pathway (APP) Toolkit
- **To learn more about MVPs:**
  - Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website

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

This guide examines the quality performance category under traditional MIPS for the 2022 performance year of the QPP.

For information about the quality performance category under the APP, please refer to the APP Quality Requirements webpage or the 2022 APM Performance Pathway Quick Start Guide (PDF).

Traditional MIPS Performance Category Weights in 2022: Individual, Group, and Virtual Group Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Traditional MIPS Performance Category Weights in 2022: APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
55%	0%	15%	30%

By law, the quality and cost performance categories must be equally weighed at 30% beginning with the 2022 performance period.

What's New with Quality under Traditional MIPS in 2022?

- **The quality performance category weight has decreased from 40% to 30% for individual MIPS eligible clinicians, groups, and virtual groups participating in traditional MIPS.**
    - We are statutorily required to weight the cost and quality performance categories equally beginning with the 2022 performance year, which results in both performance categories having a weight of 30%.
    - The quality performance category will be weighted at 55% for MIPS eligible clinicians participating as an APM Entity.
- **The inventory of measures finalized represents a total of 200 MIPS quality measures, including 1 new administrative claims measure. There are 87 existing MIPS quality measures that have substantive changes; 13 MIPS quality measures that have been removed from the program. For more information on these measures, review the Appendix.**
- **The availability of the CMS Web Interface as a collection and submission type in traditional MIPS is extended through the 2022 performance period and will sunset beginning with the 2023 performance period.**
    - If you have planned or are currently reporting MIPS quality measures through the CMS Web Interface, please prepare to transition to a new collection type, beginning with the 2023 performance period. You can start by reviewing general requirements for other collection types available for the quality performance category in this resource.
- **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.**
- **We'll only calculate a group-level quality score from Medicare Part B claims measures if the practice(s) submits data for another performance category as a group, signaling their intent to participate as a group.**
- **Additional quality scoring flexibilities for measure specification and/or coding changes that occur during the performance period were added for the 2022 performance period.**

What's New with Quality under Traditional MIPS in 2022? (Continued)

Several quality measure scoring policies were finalized for the 2022 and 2023 performance years.

- Beginning in the 2022 performance period, new quality measures ("class 4 measures") that meet data completeness criteria will have a 7-point floor for their first year in the program, and a 5-point floor for their second year in the program.
    - Please note that this policy also applies to Qualified Clinical Data Registry (QCDR) measures, including those introduced in the 2021 performance year; QCDR measures (that meet data completeness) in their second year in the program are subject to the 5-point scoring floor in the 2022 performance year.
    - This policy doesn't apply to administrative claims measures.
- Measures will earn 0 points for the 2022 and the 2023 performance years if data completeness isn't met. Small practices will continue to earn 3 points.
- Measures will earn 3 points in the 2022 performance year but start to earn 0 points in the 2023 performance year if case minimum requirements aren't met. Small practices will continue to earn 3 points.
- Beginning in the 2023 performance year, the 3-point scoring floor for measures with/without a benchmark will be removed.
    - Measures that can be scored against a benchmark will receive 1 – 10 points.
    - Measures without a benchmark will receive 0 points (small practices will continue to earn 3 points.)

Why Focus on Quality?

The quality performance category assesses the quality of care you deliver as demonstrated by your performance on quality measures. Quality measures are tools that help us to:

Measure health care processes, outcomes, and patient care experiences.

Link health outcomes to one or more of the following quality goals for healthcare:

For the **2022 performance year**, the quality performance category:

- Is generally worth 30% of your MIPS final score for MIPS eligible clinicians, groups, and virtual groups participating in traditional MIPS (55% for MIPS eligible clinicians participating as an APM Entity); and
- Has a 12-month reporting period (January 1, 2022 - December 31, 2022).

Quality Measures

For the 2022 performance period, you can choose measures most meaningful to your practice from **200 MIPS quality measures.**

To review the 2022 MIPS quality measures and QCDR measures, visit the Explore Measures & Activities section of the QPP website and the 2022 MIPS Quality Measures List (XML). Once you have found the MIPS quality measures that work for you, you'll need to look at the appropriate measure specifications for the collection type you choose to use.

Below is an overview of the 7 types of quality measures you may report for the quality performance category:

High priority measures aren't an additional measure type, but fall within the following measure types:

- Outcome (includes intermediate outcome and patient-reported outcome-based performance)
- Appropriate Use
- Patient Engagement/Experience
- Patient Safety
- Efficiency Measures
- Care Coordination
- Opioid-related

Quality Measures by Measure Type		
Measure Type	**Measure Type Definition**	**Example**
Process Measures	Process measures show what doctors or other clinicians do to maintain or improve the health of healthy patients or those diagnosed with a given condition or disease. These measures usually specify generally accepted recommendations for clinical practice.	The percentage of patients getting preventive services (such as mammograms or immunizations).
Outcome Measures	Outcome measures show how a health care service or intervention affects patients' health status.	The rate of surgical complications or hospital-acquired infections, such as surgical site infections.
Intermediate Outcome Measures	Intermediate outcome measures assess a factor or short-term result that contributes to an ultimate outcome. Under MIPS, intermediate outcome measures meet the outcome measure criteria.	Reducing a patient's blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.

Quality Measures (Continued)

Quality Measures by Measure Type		
Measure Type	**Measure Type Definition**	**Example**
Patient-Reported Outcome-Based Performance Measures	Patient-reported outcome-based performance measures are derived from outcomes reported by patients and can include any report of a patient's health condition, health behavior, or health care experience. These reports come directly from the patient without interpretation of the patient's response by a clinician. Under MIPS, patient-reported outcome-based performance measures meet the outcome measure criteria.	The percentage of patients who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.
Structure Measures	Structure measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care.	Using electronic support systems such as a continuity of care recall system.
Patient Engagement/Experience Measures	Patient Engagement/Experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys.	Administering the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for MIPS Clinician/Group Survey measure.
Efficiency Measures	Efficiency measures can be used to assess the variability of the cost of health care and to direct efforts to make healthcare more affordable.	Ordering cardiac imaging when it does not meet the appropriate use criteria. Overusing neuroimaging in a target patient population (such as patients with minor blunt head trauma who have no indication for a head CT).

Quality Measures (Continued)

As part of the Meaningful Measures initiative, we continue to incrementally remove process measures that require a limited quality action in order to move toward a streamlined inventory of meaningful and robust quality measures. For this approach, prior to removal, consideration will be given, but not limited to:

In addition, we assess the measure's adoption rate by assessing whether the measure meets case minimum and reporting volumes required for establishing a benchmark after being in the program for 2 consecutive performance years. Removing measures by using this methodology ensures that the MIPS quality measures within the program are truly meaningful and measurable, where quality improvement is sought and measures with low reporting rates for 2 consecutive performance periods may be removed from MIPS.

- Appendix A identifies measures that were finalized for removal from the program, beginning with the 2022 performance period.
- Appendix B identifies measures that were finalized for removal for specific collection types, beginning with the 2022 performance period.

Reporting Requirements

To complete the reporting requirements for the quality performance category, you can:

Report on **at least 6 MIPS quality measures, including at least 1 outcome measure**. If no outcome measures are applicable, you may report another high priority measure.

OR

Report on a defined specialty measure set (if the specialty measure set has less than 6 measures, you'll meet quality reporting requirements if you report all the measures in the specialty set).

OR

Report on **all 10 required CMS Web Interface measures**. This option is available to groups, virtual groups, and APM Entities with 25 or more clinicians that register in advance (April 1, 2022 - June 30, 2022) of the submission period. Registration isn't required for Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) reporting on the CMS Web Interface measures as part of the reporting requirements under the APP.

As finalized in the CY 2022 Physician Fee Schedule Final Rule, the 2022 performance period (data submission beginning in January 2023) will be the **last year** that groups, virtual groups, and APM Entities can report quality measures through the CMS Web Interface via traditional MIPS.

Shared Savings Program ACOs may continue to report using the CMS Web Interface through the 2024 performance period; however, we encourage those who have historically reported MIPS quality measures through the CMS Web Interface to start preparing now for their transition to a new collection type. You can start by reviewing general requirements for other collection types available for the quality performance category in this resource. Additional resources to help you prepare for this transition are now available.

For the quality performance category, all measures must be reported for the 12-month reporting period, January 1, 2022 – December 31, 2022.

NOTE: If you're a specialty group, you're not limited to reporting a defined specialty measure set. You may use the Explore Measures and Activities tool on the QPP website to search for measures relevant to your scope of practice.

Telehealth Guidance

The COVID-19 public health emergency has affected the ability to perform patient-facing encounters; as a result, the use of telehealth capabilities has expanded.

Some quality measures include interactions occurring via telehealth. We encourage MIPS eligible clinicians, groups, virtual groups, and APM Entities to review other aspects of the quality action within the measure specification, including quality actions that cannot be completed by telehealth.

To determine whether the measure includes telehealth within the denominator, you should review the 2022 MIPS quality measure specifications (ZIP). If you have any questions on the ability to include encounters to report for measures that include telehealth capabilities, please contact the QPP Service Center.

For telehealth guidance related to electronic clinical quality measures (eCQMs), please review the Telehealth Guidance for eCQMs for Eligible Professional/Eligible Clinician 2022 Quality Reporting (PDF) document posted on the electronic Clinical Quality Improvement (eCQI) Resource Center for more information.

For CMS Web Interface users, please review the 2022 CMS Web Interface Measure Specifications and Supporting Documentation to determine if telehealth encounters are accepted for a specific measure.

Collection Type

Collection Type refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.

For example: Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%), has different specifications depending on whether you're reporting the measure as an electronic clinical quality measure (eCQM) or as a Medicare Part B claims measure. The data completeness criteria for Measure 001 are different as the eCQM includes all-payer data while the Medicare Part B claims measure is limited to Medicare Part B patients.

Data completeness refers to the volume of performance data reported for the measure's eligible population. To meet data completeness criteria, you must report performance data (performance met, not met, or any denominator exceptions) for at least 70% of the eligible population (denominator).

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

Collection Types

There are 6 collection types, or ways you can collect and submit your quality measures data to CMS.

Electronic Clinical Quality Measures (eCQMs)

MIPS Clinical Quality Measures (MIPS CQMs)

Qualified Clinical Data Registry (QCDR) Measures

Medicare Part B Claims Measures
(Only available to small practices with 15 or fewer clinicians.)

CMS Web Interface Measures
(Only available to Shared Savings Program ACOs reporting via the APP and other pre-registered APM Entities, groups, and virtual groups of 25 or more clinicians reporting via traditional MIPS.)

CAHPS for MIPS Survey Measure
(Only available to pre-registered groups, virtual groups, and APM Entities.)

Collection Types (Continued)

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

- **NEW:** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP).
  - This measure will have a case minimum of 18 cases and will only apply to groups, virtual groups, and APM Entities with at least 16 clinicians.
- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment Program (MIPS) Groups (ZIP).
  - This measure will have a case minimum of 200 cases and will only apply to groups, virtual groups, and APM Entities.
  - This measure replaced the All-Cause Readmission measure in the 2021 performance period.
- Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (ZIP).
  - This measure will have a case minimum of 25 cases and will apply to individuals, groups, virtual groups, and APM Entities.
  - This measure will also have a 3-year performance period (consecutive 36-month timeframe) that will start on October 1, 2019 (3 years prior to the performance year), and end on September 30, 2022 (current performance year) and proceed with a 3-month numerator assessment period.

We'll aggregate quality measures collected through multiple collection types into a single quality performance category score. If you submit the same measure through multiple collection types, the one with the greatest number of achievement points will be selected for scoring. However, the CMS Web Interface measures can't be scored with collection types other than the CAHPS for MIPS Survey measure and/or administrative claims measures.

Collection Types (Continued)

The table below provides additional detail on each collection type, including the types available based on the way you plan to participate and submit data for traditional MIPS: as an individual, group, virtual group, or APM Entity.

Please note that Shared Savings Program ACOs are required to report via the APP. If MIPS eligible clinicians or groups within an ACO choose to report via traditional MIPS in addition to the ACO's required reporting via the APP, they will receive the higher MIPS final score and payment adjustment.

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2022 eCQM Specifications 2022 eCQM Flows (ZIP)	You can report eCQMs if you use technology that meets the 2015 Edition Certified Electronic Health Record Technology (CEHRT) criteria, the 2015 Edition Cures Update criteria, or a combination of both. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities

Collection Types

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Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
MIPS Clinical Quality Measures (MIPS CQMs)	2022 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may choose to work with a Qualified Registry, QCDR, Health IT vendor to support your data collection and submission, or you can submit them yourself. To see the lists of CMS-approved Qualified Registries and QCDRs, visit the QPP Resource Library. MIPS CQMs can be reported in combination with Medicare Part B claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities
Qualified Clinical Data Registry (QCDR) Measures	2022 QCDR Measure Specifications (XML)	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures which are approved during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that are relevant to their practice. You'll need to work with the QCDR (XML) to report these measures on your behalf. QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities

Collection Types

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Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
Medicare Part B Claims Measures	2022 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP) 2022 Part B Claims Reporting Quick Start Guide (PDF)	Individual clinicians reporting Medicare Part B claims measures should include their National Provider Identifier (NPI) and Taxpayer Identification Number (TIN), even when participating as a group, virtual group, or APM Entity. Medicare Part B claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals [clinicians in small practices (15 or fewer clinicians) only] • Groups [small practices (15 or fewer clinicians) only] • Virtual Groups (15 or fewer clinicians in the virtual group) • APM Entities (15 or fewer clinicians in the APM Entity)
CMS Web Interface	2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)	If you want to report through the CMS Web Interface, groups, virtual groups, and APM Entities must register between April 1, 2022, and June 30, 2022. Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare patients identified by CMS for each measure within the application. If your organization doesn't have enough patients assigned to each measure, you may have to choose another way to collect and submit your quality measure data. We'll contact any registered organizations that don't meet patient sampling requirements once assignment and sampling have been conducted. **Reminder:** This is the final year for CMS Web Interface reporting for groups, virtual groups, and APM Entities via traditional MIPS.	• Groups (registered groups with 25 or more clinicians) • Virtual Groups (registered virtual groups with 25 or more clinicians) • APM Entities (ACOs and registered APM Entities with 25 or more clinicians)

Collection Types

Quality Payment PROGRAM

Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
CAHPS for MIPS Survey Measure	The 2022 CAHPS for MIPS Survey Overview Fact Sheet is available on the QPP Resource Library.	Groups, virtual groups and APM Entities can register between April 1, 2022, and June 30, 2022, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience and care within a group, virtual group or APM Entity. This survey must be administered by a CMS-Approved Survey Vendor (PDF). This is a patient engagement/experience survey measure that fulfills the requirement to report at least one high priority measure if no other outcome measure is available. This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.	• Groups (registered groups with 2 or more clinicians) • Virtual Groups (registered virtual groups with 2 or more clinicians) • APM Entities (registered APM Entities with 2 or more clinicians)

TIP: To review the 2022 MIPS quality measures, visit the Explore Measures & Activities section of the Quality Payment Program website and choose the 2022 performance year or the quality measure specifications zip file posted by collection type on the QPP Resource Library.

Not sure where to begin?: Check out the 2022 Quality Quick Start Guide (PDF) for the 5 steps to help you get started with meeting the reporting requirements for the quality performance category.

Collection Types (Continued)

What if I don't have 6 applicable measures, or an applicable outcome/high priority measure?

Start by reviewing the specialty measure sets. You can meet quality reporting requirements by reporting a complete specialty measure set, even if the measure set includes fewer than 6 measures.

If a specialty measure set doesn't apply to you, report all the available measures that are clinically relevant to your practice. CMS will use the Eligible Measure Applicability (EMA) process to review the measure data you submitted to determine if there were any other quality measures you may have been able to report. The EMA process is applied to MIPS eligible clinicians, groups, virtual groups and APM Entities that have reported Medicare Part B claims measures or MIPS CQMs and may result in a denominator reduction for those eligible clinicians that reported all applicable measures meeting data completeness and MIPS program requirements.

More information on the 2022 performance period EMA process and the measures we've identified as clinically related is available on the QPP Resource Library.

Submitting Quality Data

Submitting Quality Data

Quality Payment PROGRAM

Overview

Following the 2022 performance year, we'll assess your performance in the quality performance category based on the quality measure data you submit.

The 2022 performance period data submission period will open **January 3, 2023, and close March 31, 2023**.

Exception: For the Medicare Part B claims submission type (only available to small practices), we receive quality data when denominator eligible claims, that include quality data codes (QDCs) from your selected quality measures, are submitted for payment. Please note that your Medicare Part B claims measure data must be processed by your Medicare Administrative Contractor (MAC) and received by CMS no later than 60 days following the close of the 2022 performance period.

If you transition from one electronic health record (EHR) system to another during the performance period, you'll need to aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month reporting period prior to submitting the data. If your practice uses multiple EHR systems for clinicians billing, as a group, under the same TIN, you'll also need to aggregate data into a single report prior to submitting the data. If a situation arises where data for the full 12 months is unavailable (for example: data aggregation from both systems is not possible), you should submit as much quality data as possible, **but** we want to emphasize that the 12-month performance period and 70% data completeness threshold are applicable regardless of an EHR transition during the performance year. If you're submitting eCQMs, all EHR systems must meet the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

- Preliminary scoring information will be available beginning **January 3, 2023**, once data has been submitted.
- Your final performance feedback will be available in **July 2023**.
- You can review your performance feedback by signing in to the QPP website.

Submitting Quality Data

Overview (Continued)

The following chart outlines your options for submitting quality measure data based on your submission (submitter) and collection types.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When (Submission Period)
You (Individual, Group, Virtual Group, or APM Entity Representative)	**Medicare Part B Claims Measures** (small practices only)	**Through your routine Medicare Part B claims billing practices.**	**Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2023)**
	eCQMs	**Sign in to the QPP website and upload a QRDA III file.**	**January 3 – March 31, 2023**
	MIPS CQMs	**Sign in to the QPP website and upload a QPP JSON file.**	**January 3 – March 31, 2023**
	CMS Web Interface Measures	**Manually enter your data and/or upload a file into the CMS Web Interface or use the CMS Web Interface Application Programming Interface (API).**	**January 3 – March 31, 2023**
Third Party Intermediaries: QCDRs, Qualified Registries, and Health IT Vendors	**eCQMs** **MIPS CQMs** **QCDR Measures**	**Sign in to the QPP website and upload a QRDA III or QPP JSON file or use our QPP Submission API.**	**January 3 – March 31, 2023**
CMS-Approved Survey Vendors	**CAHPS for MIPS Survey Measure**	**Secure method outside of the QPP website.**	**Following data collection (standardized annual timeframe)**

The level at which you participate in MIPS (individual, group, or virtual group) generally applies to all MIPS performance categories. We won't combine data submitted at the individual, group, and/or virtual group level into a single MIPS final score.

Submitting Quality Data (Continued)

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all MIPS performance categories as a group.
- If data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all MIPS performance categories, but your MIPS payment adjustment will be based on the higher score.

Exception: When participating as an APM Entity, the APM Entity will submit data for the quality and improvement activities performance categories at the APM Entity level. However, MIPS eligible clinicians in the APM Entity will submit data for the Promoting Interoperability performance category either at the individual or group level; we'll calculate an average score for the Promoting Interoperability performance category.

NEW: When small practices report Medicare Part B claims measures, we'll only calculate a group-level quality score if the practice submits data for another performance category as a group. Submitting data as a group for the other performance categories signals your intent to participate as a group.

Scoring

Scoring

Quality Payment PROGRAM

Overview

Quality measures submitted for the 2022 performance period will receive between 0 and 10 measure achievement points.

You'll receive:

3-10 points

- Between **3 and 10 achievement points** for measures in their **third year** (or later) based on your performance in comparison to a benchmark if the quality measure meets the data completeness criteria (generally 70%), has a benchmark, and case minimum is sufficient (≥ 20 cases for most measures).
- Beginning with the 2023 performance period, these measures will receive 1 – 10 points.)

7-10 points

- This 7-point scoring floor is only available for new measures in their **first year** of the program.
- Between **7 and 10 achievement points** if the measure can be reliably scored against a benchmark (i.e., a benchmark exists, and the measure meets data completeness and case minimum requirements).
- The quality measure will earn 7 points if the measure meets data completeness but doesn't have a benchmark or meet case minimum.
- 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

- This 5-point scoring floor is only available for new measures in their **second year** of the program**.**
- Between **5 and 10 achievement points** if the measure can be reliably scored against a benchmark (i.e., a benchmark exists, and the measure meets data completeness and case minimum requirements).
- The quality measure will earn 5 points if the measure meets data completeness but doesn't have a benchmark or meet case minimum.
- For the 2022 performance period, this applies to QCDR measures added to the program in the 2022 performance period.

Note: The 7-point and 5-point scoring floor policy doesn't apply to administrative claims measures.

3 points

- **3 achievement points** if your quality measure meets the data completeness criteria, but either 1) doesn't have a benchmark, and/or 2) case minimum is insufficient (≤ 20 cases for most measures).*

0 points

- 0 achievement points if your quality measure doesn't meet data completeness requirements, which varies by collection type.*

* These measure achievement points scoring policies don't apply to CMS Web Interface measures and administrative claims measures.

Topped Out Quality Measures

A process measure is considered topped out if the median performance rate is 95% or higher (non-inverse measure) or is 5% or lower (inverse measure). A non-process measure is considered topped out if the level of variance is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. We identify topped out measures annually through our benchmarking process. Measures that are topped out for 4 consecutive years can be proposed for removal through rulemaking.

A measure is considered extremely topped out if the average performance rate is 98% or higher (non-inverse measure) or is 2% or lower (inverse measure). We would consider this measure for removal in the next rulemaking cycle, regardless of whether it's in the midst of the topped out measure lifecycle. However, we may consider retaining the measure if there are compelling reasons as to why this measure shouldn't be removed (for example, if the removal would impact the number of measures available to a specialist type).

Are all Topped Out Measures capped at 7 points?

No. A measure is capped at 7 points when it's topped out through the same collection type for 2 consecutive years. The 7-point cap is applied in the second year the measure is identified as topped out.

To identify if a measure is topped out or capped at 7 points, refer to the 2022 Quality Benchmarks (ZIP).

A measure may be topped out without being capped at 7 points. A "Y" (for "Yes") in the **Seven Point Cap** column (Column Q) of the benchmark file referenced above indicates the measure is capped at 7 points.

NOTE: QCDR measures are excluded from the topped out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped out during the annual self-nomination process, it may not be approved for the applicable performance period.

Benchmarks

Each MIPS quality measure is assessed against its benchmark to determine how many points the measure earns.

How are the Benchmarks Established?

We establish benchmarks specific to each collection type: QCDR measures, MIPS CQMs, eCQMs, CMS Web Interface measures, the CAHPS for MIPS Survey measure, Medicare Part B claims measures, and the administrative claims measures.

Whenever possible, we use historical data to establish benchmarks. The 2022 historical benchmarks for eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures are based on actual performance data that was submitted to QPP for the 2020 performance period. If a quality measure doesn't have a historical benchmark for any of these collection types, we'll attempt to calculate a benchmark based on data submitted for the 2022 performance period.

Some measures may have certain substantive changes to their specifications from one year to the next such that the historical data cannot be used to establish a benchmark.

For example, Quality ID 065: Appropriate Treatment for Upper Respiratory Infection (URI) (MIPS CQM) required a substantive change in the 2022 performance period. This substantive change no longer allows direct comparison of performance data from previous submissions. In this case, we'll attempt to calculate a benchmark based on data submitted for the 2022 performance period.

NOTE: We'll use flat benchmarks to score Measure 236: Controlling High Blood Pressure for the MIPS CQM and Medicare Part B claims collection types, and Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) for all collection types, as historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient. For Measure 236, we'll use a historical, performance-based benchmark to score the measure for the eCQM collection type.

NEW: We'll attempt to calculate performance period benchmarks for the administrative claims quality measures: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure, Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) measure, and the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups measure for the 2022 performance period.

Benchmarks (Continued)

CMS Web Interface Measures Benchmarks

We use benchmarks from the Shared Savings Program to assess and score the CMS Web Interface measures. These benchmarks are also used for groups, virtual groups, and APM Entities that register to report CMS Web Interface measures for traditional MIPS.

UPDATE: 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).

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.

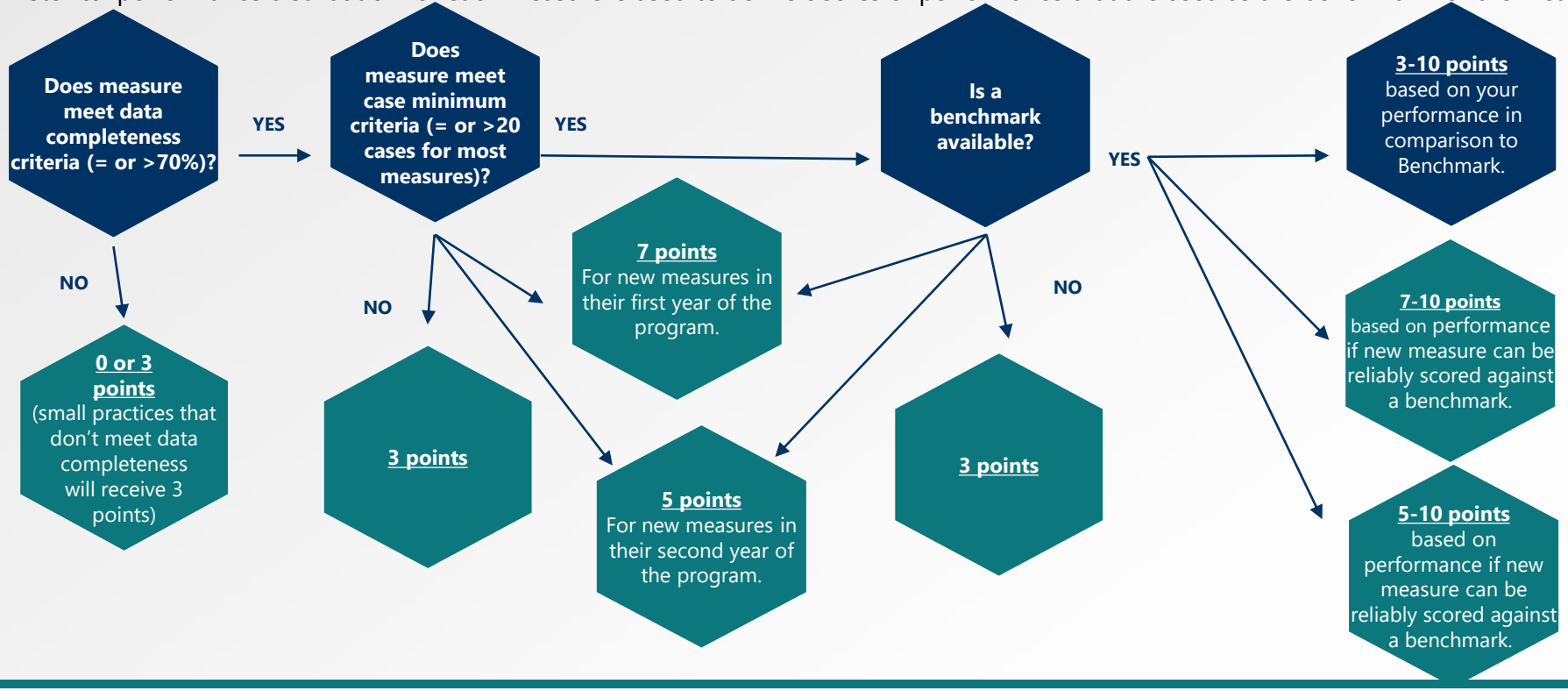
CAHPS for MIPS Survey Benchmarks

We attempt to establish a benchmark for each summary survey measure (SSM) in the CAHPS for MIPS Survey measure. These benchmarks were calculated using historical data from the 2020 performance period. Each SSM with a historical benchmark is awarded 3 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey score will be the average number of points across all scored SSMs. The CAHPS for MIPS Survey benchmarks can be found in the 2022 Quality Benchmarks (ZIP).

Benchmarks (Continued)

How are Benchmarks Converted to Achievement Points?

- Each quality measure with a benchmark is scored using a 10-point scoring system, except for:
  - Measures capped at 7 points because they are in their second consecutive year of being topped out.
  - Measures that don't meet data completeness criteria.
  - Measures that are submitted with an insufficient case volume.
  - New measures in their first and second performance period.
- Historical performance distribution for each measure is used to define deciles of performance that are used as the benchmark for the measure.



Benchmarks (Continued)

- The decile benchmarks are used to assign a measure score between 3 and 10 points.
- We compare your performance on a quality measure to the performance levels in the national deciles.
- The points you earn are based on the decile range that matches your performance rate.
- For measures with inverse performance rates, such as Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

What if I chose a measure that doesn't have an historical benchmark?

- Quality measures that can't be reliably scored against a benchmark, or quality measures without an historical benchmark, will receive 3 measure achievement points (assuming the measure meets data completeness) unless a benchmark can be established with performance period data.
- If the measure doesn't also meet data completeness, it will receive 0 measure achievement points (except for small practices, which will receive 3 measure achievement points).
- The above applies to measures across all collection types except for the CMS Web Interface measures and administrative claims measures. The CMS Web Interface measures that don't have a benchmark aren't included in the scoring calculation if the measure meets data completeness criteria.
- **Did You Know?** Beginning in the 2023 performance period, measures that can't be reliably scored because they don't have a benchmark or meet data completeness or case minimum criteria will receive 0 achievement points, with some exceptions for small practices.

NOTE: There is a 3-point floor for measures that can be reliably scored based on performance for the 2022 performance year. As a result, measures in the lowest deciles can't get less than 3 measure achievement points. (Reliably scored means a national benchmark exists, sufficient case volume has been met, and the data completeness requirement has been met.)

Example 1

The below scoring example shows how to use the 2022 Quality Benchmarks (ZIP) to convert into measure achievement points, assuming that data completeness and case minimum have been met.

Measure 009: Anti-Depressant Medication Management, collected and reported as an eCQM.

Dr. Clark submits data for Measure 009 (eCQM) that results in a performance rate of 79.09% and 5.4 achievement points.

How?

This performance rate falls in Decile 5, which means a measure score of 5.0-5.9 points.

Scoring Example 1
Apply the following formula based on the measure performance and decile range.

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

$$Achievement\ points = 5 + \frac{(79.09-78.07)}{(80.76-78.07)}$$

$$\frac{(79.09-78.07)}{(80.76-78.07)} = 0.379\ldots$$
which is rounded to 0.4

$$\boldsymbol{Achievement\ points = 5.4}$$

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.

Example 2

The below scoring example assumes case minimum and data completeness have been met.

Measure XYZ[1] was collected and reported as a MIPS CQM but errors were found in the finalized measure specification that significantly impacted performance late in the performance year.

Lakeview Associates, a primary care clinic with 17 clinicians, submits 9 consecutive months of data as a group for Measure XYZ (MIPS CQM) that results in a performance rate of 85% and 8 achievement points.

How did Lakeview Associates earn a score after having impact from errors in a measure specification they reported?

Beginning with the 2022 performance year, we've expanded the list of reasons for scoring flexibilities that were established to allow measures that are significantly impacted during the performance period to include errors found in the finalized measure specifications. These errors include but are not limited to changes to the active status of codes, the inadvertent omission of codes, and the inclusion of inactive or inaccurate codes. These errors are in addition to the existing flexibilities of clinical guideline or other coding changes, allowing the measure to still be scored provided there are no concerns with potential patient harm and 9 consecutive months of data available.

If there isn't 9 consecutive months of data available, the measure will be suppressed from scoring. Suppressed measures will earn 0 achievement points (numerator) and reduce the total measure achievement points by 10 (denominator) for each measure submitted that is impacted.

We'll identify measures that are significantly impacted by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) coding changes in the 2022 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released by October 2022 on the QPP Resource Library.

[1] Measures that are significantly impacted by clinical guideline or other coding changes for the 2022 performance year are yet to be determined.

Bonus Points

Beginning in the 2022 performance year, 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

Will the small practice bonus still be applied for the 2022 performance period?

Yes, 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices that submit data on at least one MIPS quality measure.

Improvement Scoring

For the 2022 performance year, you can earn **up to 10 percentage points** based on the rate of your improvement in the quality performance category from the previous performance year.

You'll be evaluated for improvement scoring for the 2022 performance year when you:

- Meet the quality performance category requirements for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure or submit as many measures as were available and applicable or report all 10 measures in the CMS Web Interface; all measures must meet data completeness requirements).
- Have a quality performance category achievement percent score based on reported measures for the previous performance period (2021 performance year).
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

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

NOTE: Facility-based measurement wasn't available for the 2021 performance year and won't be available for the 2022 performance year.

Improvement Scoring (Continued)

How is improvement scoring calculated?

Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2021) performance period to the quality performance category achievement percentage score for the current (2022) performance period.

Scoring Example

The following provides an example of how to calculate the improvement percent score.

For the **2021 performance period**, Dr. Johnson earned 40 measure achievement points and 6 measure bonus points for reporting an additional outcome measure.

For the **2022 performance period,** Dr. Johnson earned 48 measure achievement points.

- 2021 quality performance category achievement percent score = 67%
  - (40/60)
  - Excludes the 6 bonus points
- 2022 quality performance category achievement percent score = 80%
  - (48/60)
- The increase in the quality performance category achievement percent score from the previous (2021) performance period to the current (2022) performance period = 13%
  - (80% - 67%)
- The improvement percent score is 1.9% which will be added to the percent score earned for reported measures.
  - (13%/67%) *10% = 1.9%

Please note that the improvement percent score can't be negative and is capped at 10%.

*Total available measure achievement points = # of required measures x 10

Calculating the Quality Performance Category Percent Score

The quality performance category percent score is a product of the following equation.

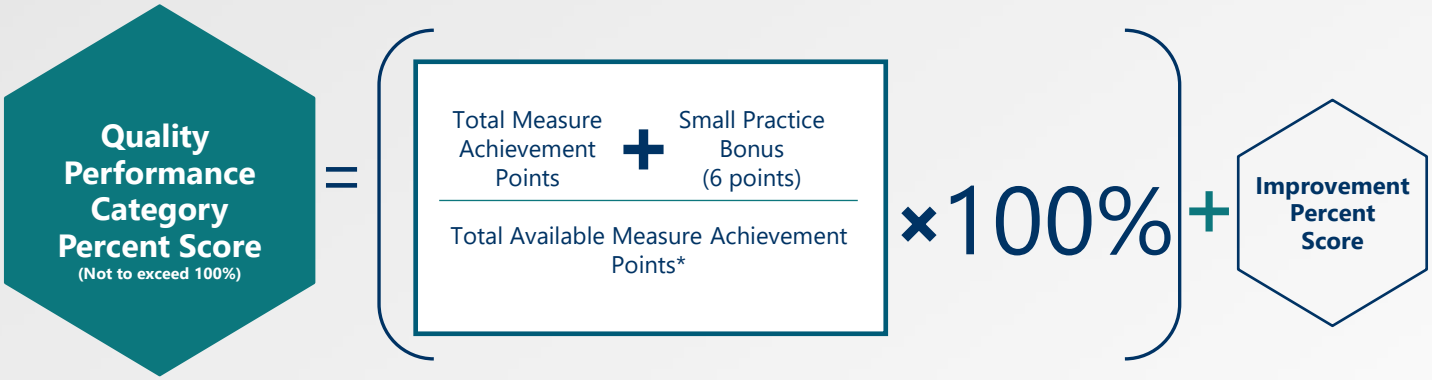
Quality Performance Category Percent Score (Not to exceed 100%) = (Total Measure Achievement Points / Total Available Measure Achievement Points*) × 100% + **Improvement Percent Score**

Example

81.9 Quality Performance Category Percent Score (Not to exceed 100%) = (48 Total Measure Achievement Points / 60 Total Available Measure Achievement Points*) × 100% + **1.9% Improvement Percent Score**

Calculating the Quality Performance Category Percent Score (Continued)

The quality performance category percent score **for small practices** is a product of the following equation.



Your quality performance category percent score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your MIPS final score.

Calculating the Quality Performance Category Percent Score (Continued)

Your quality performance category percent score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your MIPS final score.

Example 1:

The clinician, group or virtual group is scored on all 4 MIPS performance categories.

81.9% x 30% x 100 = 24.57 — Points under the quality performance category contributing to the MIPS final score

Example 2:

The clinician, group, or virtual group cannot be scored on the cost performance category.

81.9% x 55% x 100 = 45.05 — Points under the quality performance category contributing to the MIPS final score

Example 3:

The clinician, group, or virtual group is not scored on the improvement activities performance category, but is scored for the cost performance category.

81.9% x 45% x 100 = 36.89 — Points under the quality performance category contributing to the MIPS final score

Maximum Points Available in the Quality Performance Category

Your quality performance category score is determined by dividing the achievement points that you receive for the measures you submitted by the maximum number of achievement points that you could receive, which will depend on your collection type. The maximum number of points available can vary.

Measure Type	Maximum Points Available
eCQMs, Medicare Part B Claims Measures, MIPS CQMs, and QCDR Measures	Individual – 60 points
	Groups/virtual groups/APM Entities – 60 points if scored on the Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) measure **OR** the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups measure **OR** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure doesn't apply.
	Groups/virtual groups/APM Entities – 70 points if scored on the Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) measure **OR** the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups measure **OR** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure.
	Groups/virtual groups/APM Entities – 80 points if scored on **any combination of two administrative claims measures** (Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) measure, the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups , or the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure).
	Groups/virtual groups/APM Entities – 90 points if scored on **all three administrative claims measures** (Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) measure, the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups measure, and the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure).

Maximum Points Available 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.

Measure Type	Maximum Points Available
CMS Web Interface Measures	Groups/virtual groups/APM Entities – 80 points for CMS Web Interface measures
	Groups/virtual groups/APM Entities – 90 points for CMS Web Interface measures **and** the CAHPS for MIPS Survey measure
	Groups/virtual groups/APM Entities – 90 points for CMS Web Interface measures **and** 1 administrative claims measure
	Groups/virtual groups/APM Entities – 100 points for CMS Web Interface measures **and** CAHPS for MIPS Survey measure **and** 1 administrative claims measure
	Groups/virtual groups/APM Entities – 100 points for CMS Web Interface measures **and** 2 administrative claims measures.
	Groups/virtual groups/APM Entities – 110 points for CMS Web Interface measures **and** CAHPS for MIPS Survey measure **and** 2 administrative claims measure
	Groups/virtual groups/APM Entities – 110 points for CMS Web Interface measures **and** 3 administrative claims measures.
	Groups/virtual groups/APM Entities – 120 points for CMS Web Interface measures **and** CAHPS for MIPS Survey measure **and** 3 administrative claims measures

Facility-Based Measurement Scoring

Facility-based measurement offers certain clinicians and groups that primarily work within an inpatient setting the opportunity to receive MIPS quality and cost performance category scores based on their assigned facility's Hospital Value-Based Purchasing (VBP) Program score instead of receiving scores based on MIPS quality and cost measures.

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).

Reweighting the Quality Performance Category

If you don't submit data for the quality performance category because there are no quality measures available to you or your 2022 Extreme and Uncontrollable Circumstances application is approved, you won't earn any points for the quality performance category, and its performance category weight will be redistributed to other performance categories.

The following example outlines the weight distributions for each performance category when the quality performance category is weighed to 0% for individuals, groups, or virtual groups.

Quality	Cost	Improvement Activities	Promoting Interoperability
			
0% of MIPS Score	30%* of MIPS Score	15% of MIPS Score	55% of MIPS Score

* The example assumes that you/your group/your virtual group can be scored for the cost performance category.

NOTE: 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 or by e-mail at QPP@cms.hhs.gov if you believe there are no MIPS quality measures available to you.

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

Help, Resources, Glossary and Version History

Help, Resources, Glossary and Version History

Quality Payment PROGRAM

Where Can I Get Help?

Contact the Quality Payment Program Service Center at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m.- 8 p.m. ET). 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 QPP Resource Library.

Help, Resources, Glossary and Version History

Quality Payment PROGRAM

Additional Resources

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

- 2022 MIPS Overview Quick Start Guide (PDF)
- 2022 Quality Quick Start Guide (PDF)
- 2022 MIPS Eligibility and Participation Quick Start Guide (PDF)
- 2022 Part B Claims Reporting Quick Start Guide (PDF)
- 2022 Quality Benchmarks (ZIP)
- 2022 MIPS Quality Measures List (XML)
- 2022 Cross-Cutting Quality Measures (ZIP)
- 2022 Qualified Clinical Data Registries (QCDRs) Qualified Posting (XML)
- 2022 Qualified Registries Qualified Posting (XML)
- 2022 QPP Final Rule Resources (ZIP)
- 2022 Self-Nomination Toolkit for QCDRs & Registries (ZIP)
- 2022 QCDR Measure Specifications (XML)
- 2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)
- 2022 Clinical Quality Measure Specifications and Supporting Documents (ZIP)
- 2022 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP)
- 2022 eCQM Measure Specifications (ZIP)
- CMS Web Interface Transition Guide (PDF)
- CMS Web Interface Transition Guide: Getting Started with eCQM Reporting (PDF)
- CMS Web Interface Transition Guide: Getting Started with MIPS CQM Reporting (PDF)

Help, Resources, Glossary and Version History

Quality Payment PROGRAM

Glossary

ACO Accountable Care Organization

APM Alternative Payment Model

APP APM Performance Pathway

CAHPS Consumer Assessment of Healthcare Providers and Systems

CEHRT Certified Electronic Health Record Technology

CMS Centers for Medicare & Medicaid Services

CQM Clinical Quality Measure

EHR Electronic Health Record

eCQM Electronic Clinical Quality Measure

EMA Eligible Measure Applicability

JSON JavaScript Object Notation

MAC Medicare Administrative Coordinator

QPP Quality Payment Program

MACRA Medicare Access and CHIP Reauthorization Act of 2015

MIPS Merit-based Incentive Payment System

MVP MIPS Value Pathway

NPI National Provider Information

PFS Physician Fee Schedule

QDC Quality Data Codes

QP Qualifying APM Participant

QR Qualified Registry

QRDA Quality Reporting Document Archive

SSM Summary Survey Measure

TIN Taxpayer Identification Number

VBP Value-based Purchasing

Help, Resources, Glossary and Version History

Version History

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

Date	Description
09/06/2022	Updated 2022 CMS Web Interface measures benchmark information (slide 36) and Maximum Points Available in the Quality Performance Category (slide 49). Updated to indicate that facility-based scoring won't be available for the 2022 performance year (slide 50).
06/24/2022	Original Posting.

Appendices

APPENDIX A: MIPS Quality Measures Finalized for Removal in the CY 2022 Physician Fee Schedule (PFS) Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
021	Process	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin	MIPS CQM Medicare Part B claims
023	Process	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (when indicated in ALL patients)	MIPS CQM Medicare Part B claims
044	Process	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	MIPS CQM
067	Process	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	MIPS CQM
070	Process	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	MIPS CQM
154	Process	Falls: Risk Assessment	MIPS CQM Medicare Part B claims
195	Process	Radiology: Stenosis Measurement in Carotid Imaging Reports	MIPS CQM Medicare Part B claims
225	Structure	Radiology: Reminder System for Screening Mammograms	MIPS CQM Medicare Part B claims
337	Process	Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier	MIPS CQM
342	Outcome	Pain Brought Under Control within 48 Hours	MIPS CQM
429	Process	Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy	MIPS CQM Medicare Part B claims
434	Outcome	Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair	MIPS CQM
444	Process	Medication Management for People with Asthma	MIPS CQM

APPENDIX B: MIPS Quality Measures Finalized for Removal of Specific Collection Types in the CY 2022 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
014	Process	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	Removed: Medicare Part B claims Retained: MIPS CQM
050	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Removed: Medicare Part B Claims Retained: MIPS CQM
093	Process	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Removed: Medicare Part B claims Retained: MIPS CQM
182	Process	Functional Outcome Assessment	Removed: Medicare Part B claims Retained: MIPS CQM
254	Process	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	Removed: Medicare Part B claims Retained: MIPS CQM
326	Process	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Removed: Medicare Part B claims Retained: MIPS CQM
014	Process	Photodocumentation of Cecal Intubation	Removed: Medicare Part B claims Retained: MIPS CQM

APPENDIX C: MIPS Quality Measures Finalized for Addition in the CY 2022 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
481	Process	Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer	eCQM
482	Intermediate Outcome	Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate	MIPS CQM
483	Patient-Reported Outcome-Based Performance Measure	Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)	MIPS CQM
484	Outcome	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims