Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2022 CMS Web Interface Quick Start Guide

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Table of Contents

Do you already know about MIPS?
If so, skip ahead by clicking on the links in the Table of Contents.

Purpose: This resource provides information about the CMS Web Interface reporting requirements and the CMS Web Interface measures, with a focus on traditional MIPS. (Traditional MIPS is the original framework for collecting and reporting data since the inception of the Quality Payment Program (QPP). This resource doesn't address quality performance category scoring differences for the Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) reporting the CMS Web Interface measures for the APM Performance Pathway (APP).

How to Use This Guide

How to Use This Guide

Table of Contents

The Table of Contents is interactive. Click on a chapter in the table of contents to read that section.

You can also click on the icon on the bottom left to go back to the table of contents.

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 (PHE) 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 (EUC) 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 PHE. The application is now available, along with additional resources.

The Shared Savings Program EUC policy for the quality performance category, which determines shared savings and losses, applies to all Shared Savings Program ACOs for the 2022 performance period.
We consider all Shared Savings Program ACOs to be affected by the COVID-19 PHE and as a result, the Shared Savings Program EUC policy for the quality performance category applies for the 2022 performance period. Shared Savings Program ACOs that are able to report quality data via the APP and meet MIPS data completeness and case minimum requirements will receive an ACO quality performance score based on the higher score of either their ACO's MIPS quality performance score or the 30th percentile of the MIPS quality performance category score. For Shared Savings Program ACOs that are unable to report quality data via the APP and meet the MIPS quality data completeness and case minimum requirements, their ACO quality performance score under the Shared Savings Program will be ~~set~~ equal to the 30th percentile of the MIPS quality performance category score.

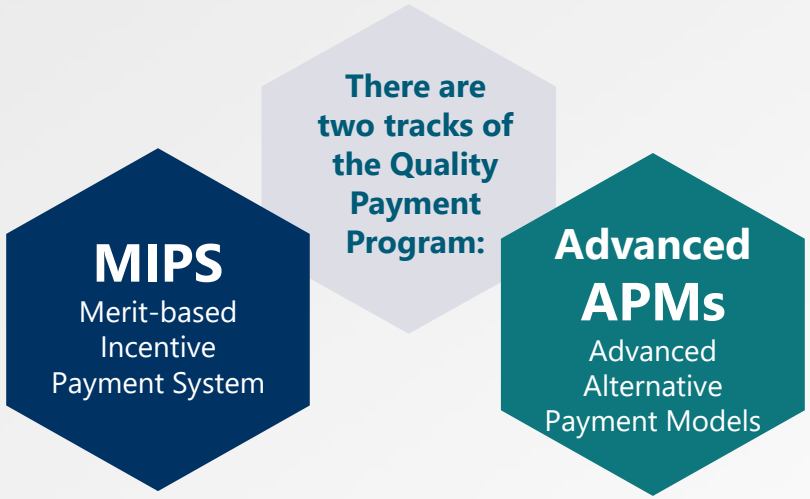
Please note that Shared Savings Program EUC policy for the quality performance category doesn't affect MIPS payment adjustments. However, Shared Savings Program ACO officials can submit a MIPS EUC application on behalf of the MIPS eligible clinicians in the ACO.

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

Quality Payment PROGRAM

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 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 QPP, a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and reward them for improving the quality of patient care and 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 how to participate in MIPS:

- 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 currently finalized 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.
  - Review the 2022 APM Performance Pathway (APP) Toolkit (ZIP). This toolkit will include several resources such as the 2022 APP Quick Start Guide and the 2022 APP Scoring Guide. There will also be information specifically for Shared Savings Program ACOs.
- **To learn more about MVPs:**
  - Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website

What is the CMS Web Interface?

The CMS Web Interface is a secure, internet-based application within the QPP website that allows you to submit data for a specified set of 10 quality measures. This collection and submission type is available to registered groups, virtual groups and APM Entities with 25 or more eligible clinicians reporting through traditional MIPS.

Registration isn't required for Shared Savings Program ACOs reporting on the CMS Web Interface measures as part of the reporting requirements under the APP.

What's New with the CMS Web Interface in 2022?

The CMS Web Interface will **sunset** as a collection and submission type under traditional MIPS at the end of the 2022 performance period. This will be the **last performance period** the CMS Web Interface will be available for quality measure reporting for groups, virtual groups and APM Entities reporting traditional MIPS. The CMS Web Interface will continue to be an option for Shared Savings Program ACOs reporting via the APP through the 2024 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 starting with the 2023 performance period. Please review the following resources to help in your transition: CMS Web Interface Transition Guide (PDF), CMS Web Interface Transition Guide: Getting Started with eCQM Reporting (PDF), and CMS Web Interface Transition Guide: Getting Started with MIPS CQM Reporting (PDF).

Reporting via the CMS Web Interface

Reporting via the CMS Web Interface

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How Does the CMS Web Interface Reporting Work?

There are 4 basic steps to the reporting of CMS Web Interface measures.

1. You registered your organization (only applicable to groups, virtual groups, or APM Entities reporting via traditional MIPS) for the CMS Web Interface between April 1, 2022 and June 30, 2022. **Registration closed at 8 p.m. ET on June 30, 2022.**

Note: Shared Savings Program ACOs are automatically registered for the CMS Web Interface for the 2022 performance period.

2. We use your claims data to identify a sample of your eligible Medicare Part A and B patients that potentially qualify for each CMS Web Interface measure.
3. We pre-populate the CMS Web Interface with the patients sampled for each measure and rank them in numeric order for you to complete.
4. You report each measure for the first 248 consecutively ranked patients identified from the sample (or 100% of the assigned patients if there are fewer than 248 patients assigned to a measure).

When possible, we provide an oversample of patients for each measure (when there are more than 248 patients), to account for cases where data may not be able to be reported for certain patients.

> **NOTE:** We'll use the term "organization" throughout this resource to mean a group, virtual group, or APM Entity reporting through the CMS Web Interface.

Reporting via the CMS Web Interface

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Who Can Report through the CMS Web Interface for Traditional MIPS?

Groups, identified by a single Taxpayer Identification Number (TIN), with 25 or more clinicians (including at least one MIPS eligible clinician) that have reassigned their Medicare billing rights to the TIN.

Virtual groups (approved for the 2022 performance period) with 25 or more clinicians.

APM Entities with 25 or more clinicians (including at least one MIPS eligible clinician).

Note: Only Shared Savings Program ACOs have the option to report through the CMS Web Interface to meet APP quality reporting requirements.

If the CMS Web Interface measures don't apply to your patient population, or if you don't have at least 12 months of data for your Medicare patients, the CMS Web Interface isn't the appropriate collection or submission type to use to meet the quality performance category requirements. We urge your organization to use a different collection and submission type. For more information on other collection and submission types, please refer to resources on the QPP Resource Library.

Reporting via the CMS Web Interface

Quality Payment PROGRAM

How Does Registration Work?

Organizations that were interested in reporting quality data for the 2022 performance period via the CMS Web Interface through traditional MIPS must have registered on the QPP website between April 1, 2022, and June 30, 2022, by 8 p.m. ET.

Organizations that used the CMS Web Interface to submit quality data for the 2021 performance period were automatically registered for the 2022 performance period. If your organization no longer intended to report quality data through the CMS Web Interface for the 2022 performance period, the deadline to cancel your registration was June 30, 2022.

If you missed the deadline to cancel your registration, being registered for the CMS Web Interface doesn't prohibit your organization from reporting quality data using a different collection and submission type if you choose to no longer use the CMS Web Interface for meeting the quality performance category requirements.

Shared Savings Program ACOs were automatically registered for the CMS Web Interface for the 2022 performance period. Shared Savings Program ACOs are required to meet reporting requirements under the APP but aren't required to report quality data through the CMS Web Interface. Please review the 2022 APM Performance Pathway (APP) Toolkit for more details.

NOTE: Groups that participate in a Shared Savings Program ACO would only have registered for the CMS Web Interface if they want to report traditional MIPS as a group. The group's participation would be in addition to the ACO's required reporting under the APP.

CMS Web Interface Measures

CMS Web Interface Measures

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What are the 2022 CMS Web Interface Measures?

There are 10 measures required by the CMS Web Interface. The CMS Web Interface measure set for the 2022 performance period is the same as the CMS Web Interface measure set for the 2021 performance period; however, the measures were updated during the annual review cycle and some measures have substantive changes.

Please review the 2022 CMS Web Interface Measure Specifications (ZIP), including the Release Notes and Coding Release Notes. Also, review the supporting documents which can be found on the Quality Payment Program Resource Library or the Explore Measures & Activities tool to make sure your organization can collect and submit data on the 10 CMS Web Interface measures outlined below.

CMS Web Interface Measure ID	Measure Name	Quality ID	Measure Type
CARE-2	Falls: Screening for Future Fall Risk	318	Process
DM-2	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	001	Intermediate Outcome
HTN-2	Hypertension: Controlling High Blood Pressure	236	Intermediate Outcome
MH-1	Depression Remission at Twelve Months	370	Outcome
PREV-5	Breast Cancer Screening	112	Process
PREV-6	Colorectal Cancer Screening	113	Process
PREV-7	Preventive Care and Screening: Influenza Immunization	110	Process
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Process
PREV-12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	134	Process
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	438	Process

CMS Web Interface Measures

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What are the 2022 CMS Web Interface Measures? (Continued)

In both traditional MIPS and the APP, CMS Web Interface measures without a benchmark are excluded from scoring if data completeness requirements are met. **MH-1 and PREV-13 don't have a benchmark for the 2022 performance period (R)** and will be excluded from scoring if data completeness requirements are met.

CMS Web Interface Measure ID	Measure Name	Quality ID	Measure Type
MH-1	Depression Remission at Twelve Months (R)	370	Outcome
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (R)	438	Process

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.

CMS Web Interface Measure ID	Measure Name	Quality ID	Measure Type
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Process
PREV-12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	134	Process

CMS Web Interface Measures

How Does Patient Assignment & Sampling Work?

When you report through the CMS Web Interface, you're reporting data for each measure on a pre-populated sample of your Medicare patients.

Patients are assigned to an organization (group, virtual group, or APM Entity) when the patients were deemed to have the plurality of their Medicare services with that organization (according to claims submitted by the organization in 2022). Patients included in the CMS Web Interface had at least 2 primary care services furnished by your organization between January 1, 2022, and October 31, 2022. As a result of your organization being accountable for the care of these patients, it's expected that your organization will obtain the needed information to complete the requirements for each measure in the CMS Web Interface.

Once assigned to an organization, patients are evaluated for measure-specific eligibility, based on the denominator criteria in each measure's specification. Using data from inpatient, outpatient, and physician claims along with patient demographics, patients are selected for each measure's sample based on meeting the measure's denominator and patient eligibility criteria. Measure denominators are populated with a random sample of eligible patients. When the patient is eligible for multiple measures, they'll be included in multiple measures. Each patient will be assigned a number referred to as the patient's "rank". The "rank" indicates the order in which the patient was sampled into that measure.

All organizations, regardless of size, are required to completely and accurately report on a minimum of the first 248 consecutively ranked Medicare patients for each measure. However, when there are fewer than 248 patients in a measure's sample, the organization is required to report on all patients sampled into the measure.

If your organization doesn't have enough patients in the sample for 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 has been conducted.

CMS Web Interface Measures

What are the Data Completeness and Case Minimum Requirements?

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

- 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 if there are fewer than 248 patients in the measure's sample).
  - **For example:** If your patient sample includes 200 patients, you must report all 200 patients consecutively in the sample to meet data completeness requirements.
- 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.

It's possible that a group, virtual group, or APM Entity (including a Shared Savings Program ACO) may be unable to report performance data on a given patient for a given measure. To account for such cases, an **oversample** is provided when possible, resulting in more than the required 248 consecutively ranked patients in each measure. Any patient ranked above 248 is considered part of the oversample. Your group, virtual group, or APM Entity (including a Shared Savings Program ACO) isn't required to submit data on patients in the oversample, unless you **skip** a patient within the first **248** (minimum range) consecutively ranked patients. In such a case, patients ranked above 248 (the oversample) will move into the minimum range and data will need to be submitted for such patients in order to meet data completeness requirements.

Scoring

How Does Scoring Work?

There are generally 10 points available for each required measure with a benchmark. The table below outlines measure-level scoring information based on the availability of a benchmark, and whether data completeness and case minimum requirements are met.

CMS Web Interface Measure	Points Earned for Each Measure
✓ **Has benchmark** ✓ **Meets data completeness requirement** ✓ **Meets case minimum requirement**	3 – 10 points
✓ **Has benchmark** ✓ **Meets data completeness requirement** ✗ **Doesn't meet case minimum requirement**	N/A – Excluded from scoring (denominator reduced) **NOTE:** This differs from scoring for other collection types.
✓ **Meets data completeness requirement** ✗ **Doesn't have benchmark**	N/A – Excluded from scoring (denominator reduced) **NOTE:** This differs from scoring for other collection types.
✗ **Doesn't meet data completeness requirement**	0 points

Mapping of Performance Rates According to the MIPS Benchmark Deciles

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

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

Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
0.00 - 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 if the data completeness requirement is met.

Measure-Level Scoring for DM-1 (Inverse Measure, Lower Performance Rate indicates Better Performance)

Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
100.00 - 70.01%	3 - 3.9 points	Decile 3
70.00 - 60.01%	4 - 4.9 points	Decile 4
60.00 - 50.01%	5 - 5.9 points	Decile 5
50.00 - 40.01%	6 - 6.9 points	Decile 6
40.00 - 30.01%	7 - 7.9 points	Decile 7
30.00 - 20.01%	8 - 8.9 points	Decile 8
20.00 - 10.01%	9 - 9.9 points	Decile 9
<= 10.00%	10 points	Decile 10

Please note: The tables above 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 Scoring Example

For example, your organization has a performance rate of 79.09% for PREV-5, which means that your organization would earn between 8 and 8.9 achievement points.

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

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

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

$$Achievement\ points = 8 + \frac{(79.09 - 70.00)}{(80.00 - 70.00)}$$

$$\frac{(79.09 - 70.00)}{(80.00 - 70.00)} = 0.909\ldots$$

which is rounded to 0.9

$$\boldsymbol{Achievement\ points = 8.9}$$

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.

How Does Scoring Work? (Continued)

Administrative Claims-Based Measures
There are 3 administrative claims-based measures in the 2022 performance period that will be automatically calculated (using administrative claims) for those that meet the measure's requirements.

- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups Measure:** Calculated for groups, virtual groups, and APM Entities with 16 or more clinicians that meet a case minimum of 200 cases.
- **Hip Arthroplasty and Knee Arthroplasty Complication Measure:** Calculated for individuals, groups, virtual groups, and APM Entities that meet a case minimum of 25 cases.
- **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions for ACOs (MCC) Measure:** Calculated for groups, virtual groups and APM Entities with at least 16 clinicians that meet a case minimum of 18 cases.

NOTE: When scoring measures across collection types, the CMS Web Interface measures can't be scored with collection types other than the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey and/or the administrative claims measures.

Under MIPS, the CMS Web Interface measures are scored in comparison to quality measure benchmarks established under the Shared Savings Program. To view the 2022 benchmarks for the CMS Web Interface measures, please refer to the Performance Year 2022 APM Performance Pathway: Proposed CMS Web Interface Measure Benchmarks for ACOs.

Please review the 2022 APM Performance Pathway (APP) Toolkit for more information about Shared Savings Program ACOs scoring under the APP.

How Does Scoring Work? (Continued)

For the quality performance category in **traditional MIPS**, organizations submitting quality data through the CMS Web Interface and meeting data completeness requirements can earn a range of maximum points:

- **80 points:** CMS Web Interface measures alone
- **90 points:** CMS Web Interface measures **and** the CAHPS for MIPS Survey measure
- **90 points:** CMS Web Interface measures **and** 1 administrative claims measure
- **100 points:** CMS Web Interface measures **and** the CAHPS for MIPS Survey measure **and** 1 administrative claims measure
- **100 points:** CMS Web Interface measures **and** 2 administrative claims measures
- **110 points:** CMS Web Interface measures **and** the CAHPS for MIPS Survey measure **and** 2 administrative claims measures
- **110 points:** CMS Web Interface measures **and** 3 administrative claims measures
- **120 points:** CMS Web Interface measures **and** the CAHPS for MIPS Survey measure **and** 3 administrative claims measures

Please note: The maximum points above 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.

Scoring Example

In the example below, patient sample counts are designed to illustrate different scoring policies and may not reflect realistic scenarios.

CMS Web Interface Measure ID	# of Patients in Sample (including oversample)	# of Consecutively Ranked Patients Reported	Has a Benchmark	Meets Data Completeness	Meets Case Minimum	Total Points Available	Measure Score	Why?
CARE-2	18	18	✓	✓	✗	N/A	N/A	Even though this measure has a benchmark, and the data completeness requirement was met (100% of sample was reported due to fewer than 248 patients included in the sample), it's excluded from scoring because the sample is below case minimum (20).
DM-2	192	192	✓	✓	✓	10	9.0	This measure is scored against its benchmark because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).
HTN-2	302	257	✓	✓	✓	10	8.6	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
MH-1	248	248	✗	✓	✓	N/A	N/A	This measure doesn't have a benchmark and is excluded from scoring because the data completeness requirement was met (248 consecutively ranked patients are reported).
PREV-5	300	248	✓	✓	✓	10	7.8	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-6	57	57	✓	✓	✓	10	9.1	This measure is scored against its benchmark because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).

Scoring Example (Continued)

In the example below, patient sample counts are designed to illustrate different scoring policies and may not reflect realistic scenarios.

CMS Web Interface Measure ID	# of Patients in Sample (including oversample)	# of Consecutively Ranked Patients Reported	Has a Benchmark	Meets Data Completeness	Meets Case Minimum	Total Points Available	Measure Score	Why?
PREV-7	300	300	✓	✓	✓	10	8.7	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-10	250	249	✓	✓	✓	10	7.5	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-12	289	248	✓	✓	✓	10	6.0	This measure is scored against its benchmark because the data completeness requirement was met (the first 248 consecutively ranked patients are reported).
PREV-13	202	202	✗	✓	✓	N/A	N/A	This measure doesn't have a benchmark and is excluded from scoring because the data completeness requirement was met (100% of the sample is reported due to fewer than 248 patients included in the sample).
Totals						70 Points	56.7 points	The total available points reflects the 7 measures in this example that are scored (measures that don't have a benchmark (MH-1 and PREV-13) and don't meet the case minimum requirements (CARE-2) are not scored).

Are Additional or Bonus Points Available?

No. Beginning with the 2022 performance period, there are **no bonus points available** for reporting additional outcome and high priority measures (which includes the CAHPS for MIPS Survey measure) or for measures that meet end-to-end electronic reporting criteria.

Data Submission

For the 2022 performance period, you can report your quality data for the CMS Web Interface measures between January 3, 2023, and March 31, 2023.

You can submit quality data through any of the following methods (or a combination) via the CMS Web Interface:

- Manually entering data for each patient.
- Uploading patient data in the CMS-approved (Excel) template.
- Using the CMS Web Interface API.

Help and Resources

Help and Resources

Quality Payment PROGRAM

Where Can I Get Help?

The following resources are available on the QPP Resource Library:

Contact the Quality Payment Program Service Center at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. ET or by email 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 resources available in the QPP Resource Library.

Help and Resources

Additional Resources

The QPP Resource Library contains fact sheets, specialty guides, technical and user guides, helpful videos, and more. The table will be updated if more resources become available.

Resource	Description
2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)	Provides comprehensive descriptions of the 2022 CMS Web Interface measures and supporting resources.
2022 CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology	This resource can be used as a reference to describe the process for assigning patients to a group or a virtual group participating in MIPS. (This document is coming soon for 2022).
2022 CMS Web Interface User Guide and User Videos	The 2022 CMS Web Interface User Guide and Videos will be available in December 2022. (Please note the 2021 CMS Web Interface User Guide (PDF) and User Demo Videos are currently available for informational/reference purposes only.)
CMS Web Interface Transition Guide (PDF)	Provides information to groups and virtual groups that previously used the CMS Web Interface, in preparation for sunsetting of the CMS Web Interface in traditional MIPS.
CMS Web Interface Transition Guide: Getting Started with eCQM Reporting (PDF)	Outlines the steps that stakeholders should take to prepare for reporting eCQMs under MIPS.
CMS Web Interface Transition Guide: Getting Started with MIPS CQM Reporting (PDF)	Outlines the steps that stakeholders should take to prepare for reporting MIPS CQMs under MIPS.

Version History

Version History

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

Date	Description
9/2/2022	Original Version