

# Merit-based Incentive Payment System (MIPS)

2022 Alternative Payment Model  
(APM) Performance Pathway (APP)  
Data Submission User Guide



Quality Payment  
PROGRAM

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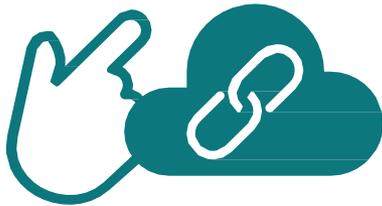


# How to Use this Guide

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# How to Use This Guide



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

## 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.

## Hyperlinks

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

# Getting Started

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# Getting Started

## Before You Begin



### IMPORTANT

The APP is an optional MIPS reporting and scoring pathway for MIPS APM participants; however, it is required for all Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs).

The APP is only available to MIPS eligible clinicians in a MIPS APM.

If your group includes MIPS eligible clinicians who don't participate in a MIPS APM, these clinicians aren't eligible to receive the final score and payment adjustment from the group's APP reporting.

- For these groups, reporting the APP will trigger a final score in traditional MIPS for the clinicians who don't participate in a MIPS APM even if no traditional MIPS data are submitted
- These clinicians – including those who are only eligible at the group level – WILL receive a MIPS payment adjustment.
- These groups will also need to report traditional MIPS on behalf of these clinicians to avoid a negative payment adjustment.

**Note:** This guide doesn't review CMS Web Interface submissions. If you're a Shared Savings Program ACO reporting the APP quality measures via the CMS Web Interface, please review the [2022 CMS Web Interface User Guide](#).



# Getting Started

## Accessing the System

To [sign in to the QPP website](#) and submit Performance Year 2022 data and/or view data submitted on your behalf, you need:

- An account (user ID and password)
- Access to an organization (a role)

If you don't already have an account or access, review the documentation listed below in the [QPP Access User Guide](#) so you can sign in to submit, or view, data.

If you're working with a third party intermediary, **make sure you sign in during the submission period to review data submitted on your behalf.**

You **can't** submit new or corrected data after the submission period closes.

Resource in the Quality Payment Program Access User Guide	Description
Shared Savings Program ACOs_ACO-MS User Access	Information about the process for Shared Savings Program ACOs to get an account and role.  Representatives of Shared Savings Program ACOs who are the ACO's QPP Security Official or QPP Staff User contact in the <a href="#">ACO Management System (ACO-MS)</a> can sign in to the QPP website using their ACO-MS username and password.
QPP Access briefly	An overview of the steps needed to access your organization on the QPP website.
Step 1. Register for a HARP Account	Step-by-step instructions and screenshots for creating a HARP account (completed on the HARP website).
Step 2a. Connect to an Organization	Step-by-step instructions and screenshots for requesting a role for your organization (completed on the QPP website).

### Before You Begin

Make sure you are using the most recent version of your browser:

- Chrome
- Edge

**Note:** Internet Explorer, Safari, and Firefox aren't fully supported by QPP.



# Getting Started

## Sign in to the QPP Website

Go to [the QPP website](#) and click Sign In on the upper right-hand corner.

- Enter your User ID and Password, and click **Sign In**.
- Check **Yes, I agree** next to the Statement of Truth.

Then, you will be prompted to provide a **security code** from your two-factor authentication.

**DISCLAIMER:**  
All screenshots include fictitious patients and organizations. Screenshots were captured from a test environment, so there may be slight variations between the screenshots included in this guide (including dates) and the user interface in the production system

Sign in to QPP

User ID

User ID

Password Show password

Password

[Forgot user ID or password](#)

If you are a representative of a Shared Savings Program ACO and can access the ACO Management System (ACO-MS), then you can sign in to QPP using the same User ID and Password.

**Sign in >**

OR

[Register for QPP](#)



**Agree to This Statement of Truth to Sign In** ✕

I certify to the best of my knowledge that all of the information that will be submitted will be true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

Privacy and security statement:

This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes (1) this computer network, (2) all computers connected to this network, and (3) all devices and storage media attached to this network or to a computer on this

[Cancel](#) [Yes, I agree](#)

# Getting Started

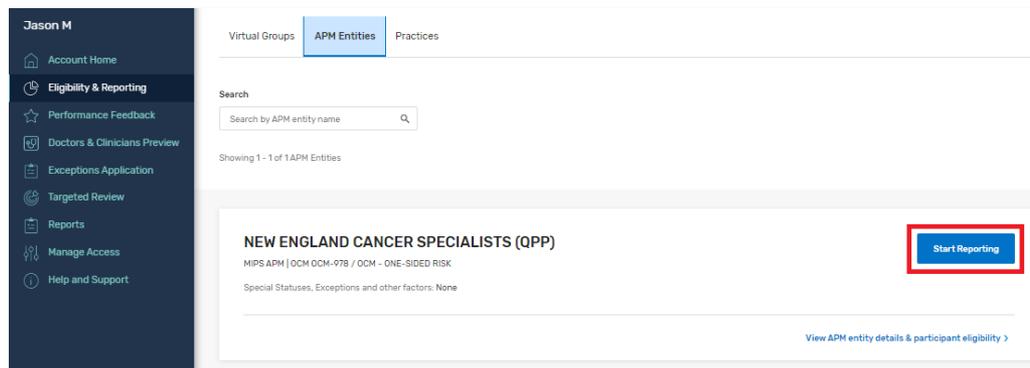
## Sign In to the QPP Website (Continued)

Once signed in, you can click the **Start Reporting** button on the right side of the page, or **Eligibility & Reporting** from the left-hand navigation.



## APM Entities

From the **Eligibility & Reporting** page, click **Start Reporting**

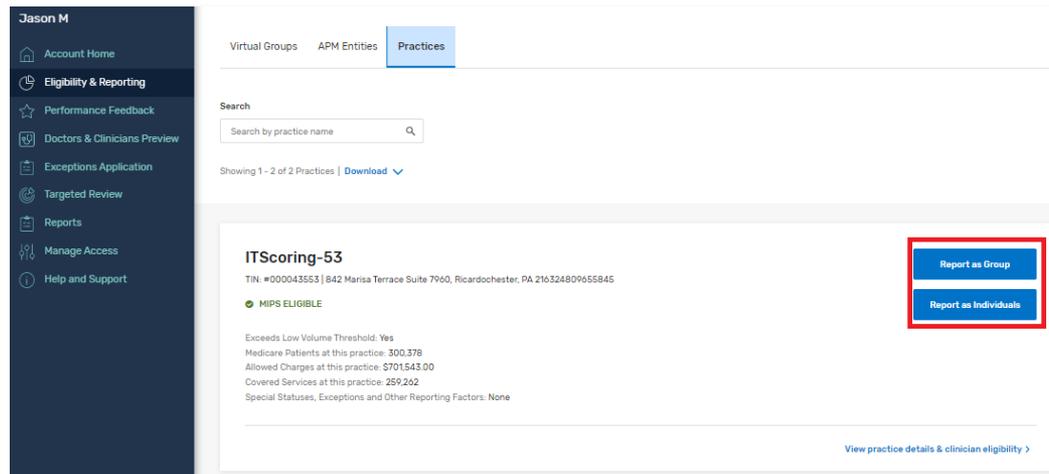


# Getting Started

## Sign In to the QPP Website (Continued)

### Practices

From the **Eligibility & Reporting** page, you'll need to indicate whether you're reporting as a group or as individuals.



### Opt-in Eligible Clinicians and Groups

Opt-in eligible clinicians and groups who wish to report via the APP and receive a MIPS payment adjustment will be prompted to complete an opt-in election before they can submit data. You can't voluntarily report the APP. For more information, review the [2022 Opt-In Election User Guide](#).





# Reporting Option Selection

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# Reporting Option Selection

## Reporting Option Selection

From the **Reporting Options** page, select **Start Reporting** below **APM Performance Pathway (APP)**

Eligibility & Reporting / APM Entity Details & Participants

### Reporting Options

Carey PLC | APM Entity ID: A3859

**Required Reporting**

**APM Performance Pathway (APP)**  
This reporting option is available to all MIPS eligible clinicians participating in a MIPS APM who must report to MIPS.  
[Learn more about the APP. CF](#)

**Optional Reporting**

**Traditional MIPS**  
This reporting option is available to all MIPS eligible clinicians who must report to MIPS.  
[Learn more about Traditional MIPS. CF](#)

This page will identify your required and optional reporting.

**Shared Savings Program ACOs** are required to report the APP quality measure set as part of their participation in the Shared Savings Program.

- Participant TINs in these ACOs (and any individual or group reporting the APP) can select either APP or traditional MIPS when reporting Promoting Interoperability data on behalf of their MIPS eligible clinicians at the individual or group level.

APM Entities participating in the **Primary Care First** models will see their model-specific reporting listed as required.

Other than Shared Savings Program ACOs, APP reporting is optional for APM Entities, groups, and individual clinicians participating in MIPS APMs.



# Reporting Option Selection

## Reporting Option Selection (Continued)

[Eligibility & Reporting](#) / [APM Entity Details & Participants](#) /

### Reporting Options

NEW ENGLAND CANCER SPECIALISTS (QPP) | APM Entity ID: OCM-978

Optional Reporting

**APM Performance Pathway (APP)**

This reporting option is available to all MIPS eligible clinicians participating in a MIPS APM who must report to MIPS.

[Learn more about the APP](#) ↗

**Start Reporting**

**Traditional MIPS**

This reporting option is available to all MIPS eligible clinicians who must report to MIPS.

[Learn more about Traditional MIPS](#) ↗

**Start Reporting**

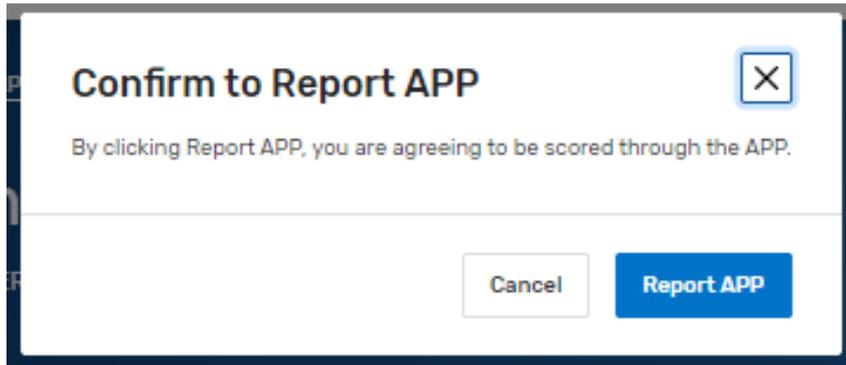
**Reminder:** The APP is only available to MIPS eligible clinicians in a MIPS APM. If your group includes MIPS eligible clinicians who don't participate in a MIPS APM, these clinicians aren't eligible to receive the final score and payment adjustment from the group's APP reporting.



# Reporting Option Selection

## Reporting Option Selection (Continued)

Once you click **Start Reporting**, you'll be asked to confirm your choice.



Once you select Report APP, you will receive a final score under the APP even if no additional data are reported.

Under the APP, APM Entities, groups and individuals automatically receive full credit in the improvement activities performance category which will trigger a MIPS final score and associated MIPS payment adjustment even if no quality or Promoting Interoperability data are submitted.

If you later decide you don't want to report the APP, you can [cancel this selection](#).



# Reporting Overview

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# Reporting Overview

## Reporting Overview

After confirming that you want to report the APP, you'll be directed to the Reporting Overview page where you can:

- Upload a file with your quality and/or Promoting Interoperability data
- Access the CMS Web Interface (Shared Savings Program ACOs only)
- Cancel your APP reporting selection
- Review your preliminary total score in progress
- Review your preliminary performance category scores in progress
- Access the quality and Promoting Interoperability category pages
- Review how your final score will be calculated
- Review information about the additional bonus points you may qualify for (these bonus points aren't available during submission)

**Did you know?** Your file must include the appropriate program name to be counted towards the APP:

When submitting a QPP JSON file, "programName" = "app1"

When submitting a QRDA III file, CMS Program Name =

- "MIPS\_APP1\_APMENTITY" if you're reporting the APP at the APM Entity level (such as a Shared Savings Program ACO)
- "MIPS\_APP1\_GROUP" if you're reporting the APP at the group level
- "MIPS\_APP1\_INDIV" if you're reporting the APP at the individual level



# Reporting Overview

## Preliminary Total Score

You'll find a Preliminary Total Score based on data submitted to date (by you and/or a third party).

- You'll find a Preliminary Total Score of 20 out of 100 points even if no data has been submitted because of the automatic credit in the improvement activities performance category.
- Your Preliminary Total Score will update as new data is submitted.

Eligibility & Reporting / APM Entity Details & Participants / Reporting Options /

APM PERFORMANCE PATHWAY

### Reporting Overview

Monroe-Ferguson | APM Entity ID: A1290

PERFORMANCE YEAR 2022 Print

**Start reporting** Upload File Manage Submissions

You can start reporting by uploading properly formatted QPP 250N and ORCA III files that contain Quality measures, and/or Promoting Interoperability measures, and/or Improvement Activities. You can also scroll down and report for each category separately.

Remember: These files will be calculated immediately and the page below will update with your preliminary scoring information.

All changes are saved automatically.

<b>Preliminary Total Score</b>	• Quality	-- / 50
<b>20.00</b> / 100	• Promoting Interoperability	-- / 30
	• Improvement Activities	20.00 / 20
	• Cost	N/A

Your final score will be available for preview in Summer 2023.

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<b>Preliminary Total Score</b>	• Quality	17.06 / 50
<b>37.06</b> / 100	• Promoting Interoperability	-- / 30
	• Improvement Activities	20.00 / 20
	• Cost	N/A

Your final score will be available for preview in Summer 2023.

Your Preliminary Total Score will change as data is reported.

### **IMPORTANT**

When reporting as an APM Entity, the APM Entity reports quality data, and the MIPS eligible clinicians in the APM Entity report Promoting Interoperability data at the group or individual level.

- The Preliminary Total Score for APM Entities, such as Shared Savings Program ACOs, won't reflect Promoting Interoperability scores based on data submitted by individuals or groups.
- The Preliminary Total Score for a group or individual in the Entity won't reflect quality scores based on data submitted by the APM Entity.

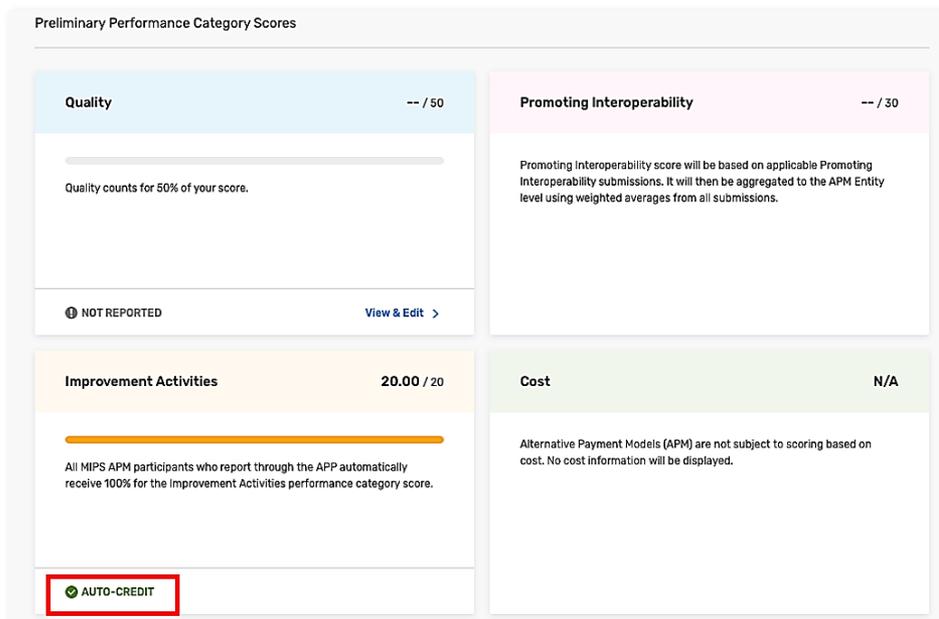


# Reporting Overview

## Preliminary Performance Category Scores

You'll find Preliminary Performance Category Scores based on data submitted to date (by you and/or a third party).

- You'll find a preliminary score of 20 out of 20 points in the improvement activities performance category. (100% credit is automatically awarded.)
- Preliminary scores for the quality and Promoting Interoperability performance categories will update as new data is submitted.



Your Preliminary Performance Category Scores will change as data is reported.

You'll find your automatic full credit in the improvement activities performance category.

### **IMPORTANT:**

When reporting as an APM Entity, the APM Entity reports quality data, and the MIPS eligible clinicians in the APM Entity report Promoting Interoperability data at the group or individual level.

- APM Entities, such as Shared Savings Program ACOs, won't be able to access Promoting Interoperability data or scores during submission.
- Groups and individuals in the Entity won't be able to access quality scores.



# Reporting Overview

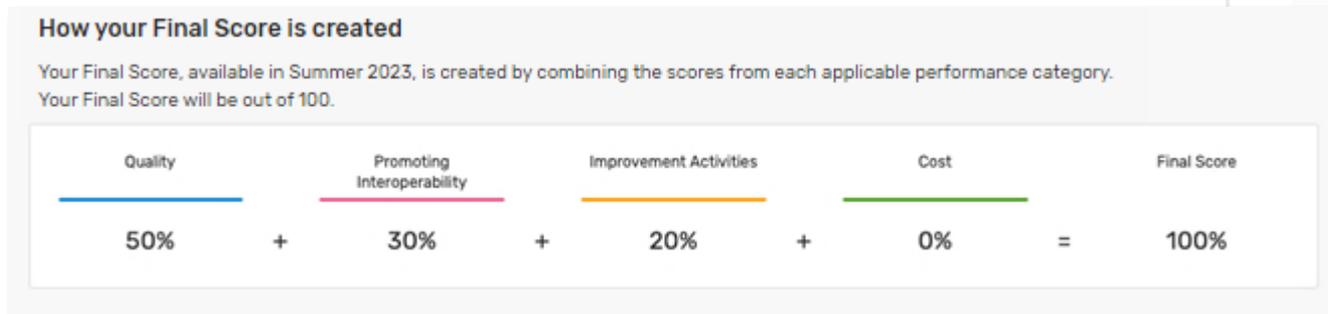
## Additional Bonus Points

Additional Awarded Bonus Points	N/A
<p><b>Complex Patient Bonus:</b></p> <p>The Complex Patient Bonus is based on the level of complexity and risk of a clinician's or practice's patient population seen during the 2022 calendar year.</p> <p><b>Quality Improvement Bonus:</b></p> <p>If you were eligible for the previous performance year and made an eligible Quality submission, you may be eligible for an additional bonus. Once Feedback is available, this will be included as part of your Quality Score.</p> <p><a href="#">Search the Resource Library for more information.</a> </p>	

**REMINDER:**  
 Complex patient bonus points and quality improvement scoring aren't available during submission.  
 If applicable, this information will be added to performance feedback, available in Summer 2023.

## Practices

At the bottom of the Reporting Overview page, you can access the final score calculation.



# Reporting Overview

## Cancel Your APP Reporting Selection

If you've already confirmed that you wish to be scored under the APP and later decide that you don't want to report the APP, you can cancel your selection.

From the Reporting Overview page, click **Manage Submission**.

The screenshot shows the 'Reporting Overview' page for 'NEW ENGLAND CANCER SPECIALISTS (QPP) | APM Entity ID: OCM-978'. At the top, there are navigation links: 'Eligibility & Reporting / APM Entity Details & Participants / Reporting Options /'. Below this, the page title is 'Reporting Overview'. The performance year is set to 'PERFORMANCE YEAR 2022'. There is a 'Print' button. Under the 'Start reporting' section, there is an 'Upload File' button and a 'Manage Submissions' button, which is highlighted with a red rectangular box. A note at the bottom states: 'Remember: These files will be calculated immediately and the page below will update with your preliminary scoring information.'

### **IMPORTANT:**

If you don't cancel your selection, you will receive a MIPS final score of 20 out of 100 points based on your automatic credit in the improvement activities, resulting in a negative payment adjustment for your MIPS eligible clinicians.

Submissions can be cancelled up until the submission deadline 8p.m. ET on March 31, 2023.

### **NOTE:**

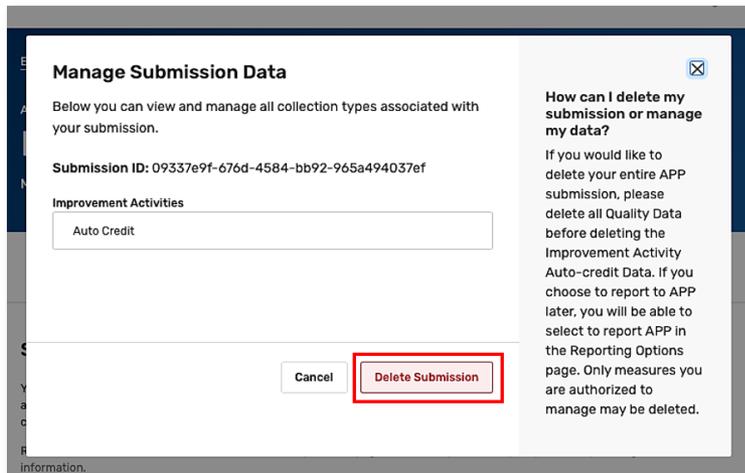
If a Shared Savings Program ACO doesn't report under the APP, they will fail the Shared Savings Program quality standard.



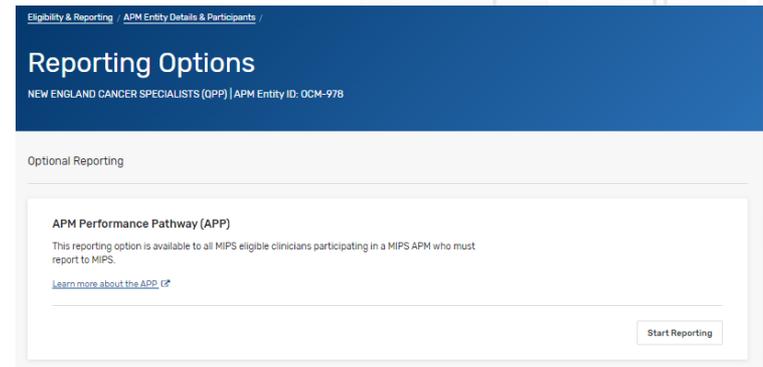
# Reporting Overview

## Cancel Your APP Reporting Selection (Continued)

In the Manage Submission modal, you'll see automatic improvement activities credit and the option to Delete Submission. Click **Delete Submission** to cancel your APP reporting selection. You can also **Cancel** to return to APP reporting.



Once you've deleted your submission, you'll return to the **Reporting Options** page. If you decide later that you'd like to report the APP, you can click **Start Reporting** from this page.





# Submitting and Reviewing Quality Data

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# Submitting and Reviewing Quality Data

## Submitting and Reviewing Quality Data

As a reminder, when reporting the APP as an APM Entity, such as a Shared Savings Program ACO, quality data is reported by the APM Entity.

- [Reporting APP measures as eCQMs/MIPS CQMs](#)
  - If you're a Shared Savings Program ACO reporting the APP measures as eCQMs/MIPS CQMs, please review the [Medicare Shared Savings Program: Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Pathway \(guidance document\)](#).
- [Reporting APP measures through Medicare Part B claims](#) (Option not for available for Shared Savings Program ACOs)
- [Reviewing Previously Submitted Quality Data](#)
- [Frequently Asked Questions](#)

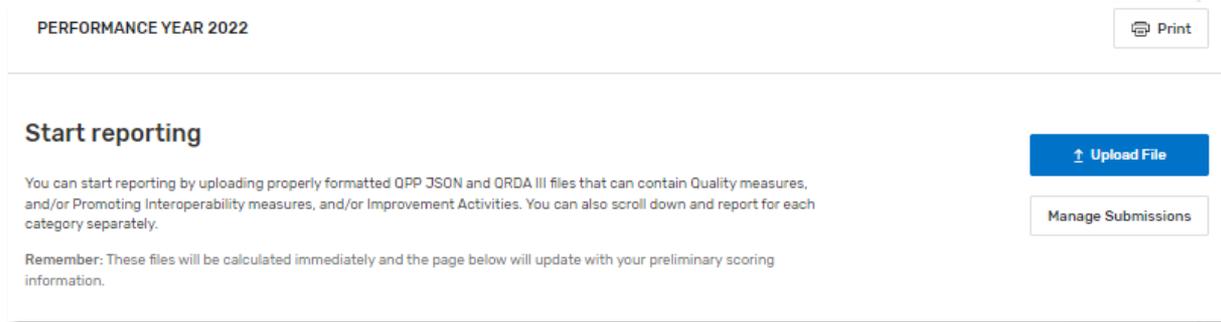
**This guide doesn't review CMS Web Interface submissions.** If you're a Shared Savings Program ACO reporting the APP quality measures via the CMS Web Interface, please review the [2022 CMS Web Interface User Guide](#).



# Submitting and Reviewing Quality Data

## Reporting APP measures as eCQMs/MIPS CQMs

You can upload your QPP JSON or QRDA III file with your eCQMs and/or MIPS CQMs directly from the **Reporting Overview** page by clicking **Upload File**.



Once you've uploaded your file, you will see an indicator of success or error.

✔ **Upload successful**

Your files were successfully uploaded. You can now review your submitted data on the Overview and Category Details pages.

✘ **An Upload Error Occurred**

You have an error in your submission reporting. You can continue to review your submission or [DOWNLOAD REPORT](#)

Download your error report to review the specific errors in your file.

A	B	C	D	E
File N:	Size	Timestamp	Status	Message
MIPS J	6.2 KB	2022-11-01T17:00:	Upload Fa	SV - performanceEnd must be after or the same as the performanceStart date - null
MIPS J	6.2 KB	2022-11-01T17:00:	Upload Fa	SV - performanceEnd must match the submission's performanceYear - null
MIPS J	6.2 KB	2022-11-01T17:00:	Upload Fa	SV - performanceStart must match the submission's performanceYear - null

Once you've successfully uploaded a file, you will see your preliminary quality category score on the Reporting Overview and Quality pages and can access your measure scores the Quality page.

- Skip ahead to the [Quality Page](#) section for more information about the details provided after quality data has been submitted.

# Submitting and Reviewing Quality Data

## Reporting APP measures as eCQMs/MIPS CQMs

### Troubleshooting

If you or a third party successfully uploaded a file with your quality data, but you don't see it reflected on the APP Reporting Overview page, the file probably didn't include the APP program name. Your file must include the correct program name to be counted towards APP reporting.

You may need to reach out to your EHR vendor or third party intermediary for assistance with verifying the program name included in your file and updating (or adding) it as needed.

When submitting a **QPP JSON** file, "programName" = "app1"

Refer to the [QPP Submission MeasurementSets API documentation](#) for more information.

When submitting a **QRDA III** file, "CMS Program Name" =

- "MIPS\_APP1\_APMENTITY" if you're reporting the APP at the APM Entity level (such as a Shared Savings Program ACO)
- "MIPS\_APP1\_GROUP" if you're reporting the APP at the group level
- "MIPS\_APP1\_INDIV" if you're reporting the APP at the individual level

Refer to p. 22 of the 2022 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals (accessible from [this page](#) of the eCQI Resource Center) for more information.



# Submitting and Reviewing Quality Data

## Reporting APP measures through Medicare Part B claims

APM Entities, groups and individual clinicians with the small practice designation have the option of reporting the 3 required APP measures through Medicare Part B claims. We anticipate these measures will be available and displayed on the Quality page by mid-January 2023. Note: This option not for available for Shared Savings Program ACOs

## Review Previously Submitted Data

To review eCQM/MIPS CQM data submitted on your behalf by another member of your organization or a third party intermediary, navigate to the Eligibility & Reporting page, click Start Reporting to get to the Reporting Options page. If data has been submitted, you'll see the option to Edit Submission.

The screenshot displays a web interface for reporting quality data. It is divided into two main sections: 'Required Reporting' and 'Optional Reporting'.

**Required Reporting**

- APM Performance Pathway (APP)**  
Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) are required to submit data to the APP as part of their participation in MSSP.  
[Learn more about the APP](#)
- Last Update**  
03/15/2023 04:05: PM EST
- Edit Submission** (button highlighted with a red box)

**Optional Reporting**

- Traditional MIPS**  
If you report through traditional MIPS, the MIPS Eligible Clinicians in the ACO will receive the highest available score for the purposes of MIPS.  
[Learn more about Traditional MIPS](#)
- Start Reporting** (button)



# Submitting and Reviewing Quality Data

## Review Previously Submitted Data (Continued)

Click **Edit Submission** to get to the Reporting Overview page. To see the details of the measure data reported on your behalf, click **View & Edit** on the quality card, or click **Quality** in the left-hand navigation.

**Quality** 17.06 / 50

Quality counts for 50% of your score.

Collection Type ?

CQMs

✓ SUBMITTED View & Edit >

Account Home

**Michiana Accountable Care Organization, LLC (QPP)**  
APM Entity ID: A9369

Eligibility & Reporting  
APM Entity Details & Participants  
Reporting Options

APM Performance Pathway  
• APM Reporting Overview  
Quality

# Submitting and Reviewing Quality Data

## Quality Page

From the **Quality** page, you can access your preliminary quality score and view preliminary performance and scoring information for each measure submitted.

**APP Quality Score**

Beginning in PY 2019, clinicians and groups can report measures from multiple collection types for a single Quality score, with the exception of CMS web interface measures.

The Total Preliminary Score does not reflect CMS Web Interface submission data. If you only submit CMS Web Interface measures, you will see a Total Preliminary Score of 0.00/50 during the submission period until all measures are completed.

Upload File   Manage Data

Total Preliminary Score

**17.06** / 50

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Submitted Measures

**Measures that count toward Quality Performance Score**

Your Measure Score includes both performance points and bonus points.

Measure Name <a href="#">Expand All</a>	Performance Rate	Measure Score	
<b>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</b> <small>Measure ID: 001</small>	26.32%	7.88	▼
<b>Controlling High Blood Pressure</b> <small>Measure ID: 236   High Priority</small>	26.64%	5.66	▼
<b>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</b> <small>Measure ID: 134</small>	26.64%	3.52	▼
<b>Sub-Total:</b>		<b>17.06</b>	

### IMPORTANT

Please note that your preliminary score will only reflect the 3 APP measures (Quality IDs 001, 134, and 236) that are submitted during the submission period.

Once performance feedback is available in Summer 2023, your quality score will be updated to reflect achievement points earned for the administrative claims measures and CAHPS for MIPS Survey measure.



# Submitting and Reviewing Quality Data

## Quality Page (Continued)

Click the caret (“>”) to the right of the measure score to expand the measure details and access more performance information.

**Controlling High Blood Pressure**

Measure ID: 236

2.06%

3.00

▼

**Controlling High Blood Pressure**

Measure ID: 236

2.06%

3.00

▲

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Lowest Benchmark: 51.76    56.81    60.67    64.11    67.52    71.11    75.54    Highest Benchmark: >=81.43

Performance Rate **2.06%**

**Measure Info**  
This measure has scored below the lowest decile and received the minimum three points; however, the score will not display in the decile range above.

**Measure Type**  
Intermediate Outcome

**Collection Type** ⓘ  
Electronic clinical quality measures (eCOMs)

[Download Specifications](#)

**Details**

Numerator	11
Denominator	533
Data Completeness	100%
Eligible Population	533
<b>Performance Points</b>	
Points from Benchmark Decile	3.00
<hr/>	
<b>Measure Score</b>	<b>3.00</b>



# Submitting and Reviewing Quality Data

## Quality Page (Continued)

You will also see the administrative claims measure(s) and CAHPS for MIPS Survey measure listed, showing a measure score of "--". Your score for these measures will be added to performance feedback in Summer 2023.

Additional Measures that may count toward Quality Performance Score

**i** The performance rate and measure score for the following measures will be added to your overall submission after the submission period closes, if applicable. You don't need to take any action on these measures during the submission period.

**Administrative Claims**  
Administrative Claims is required for the APM Performance Pathway.

Measure Name	Performance Rate	Measure Score
<b>Hospital-Wide, 30-Day All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups</b> <small>Measure ID: 479</small>	--	--
<b>Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs</b>	--	--

**CAHPS for MIPS Survey**  
The CAHPS for MIPS Survey is a required measure for the APM Performance Pathway

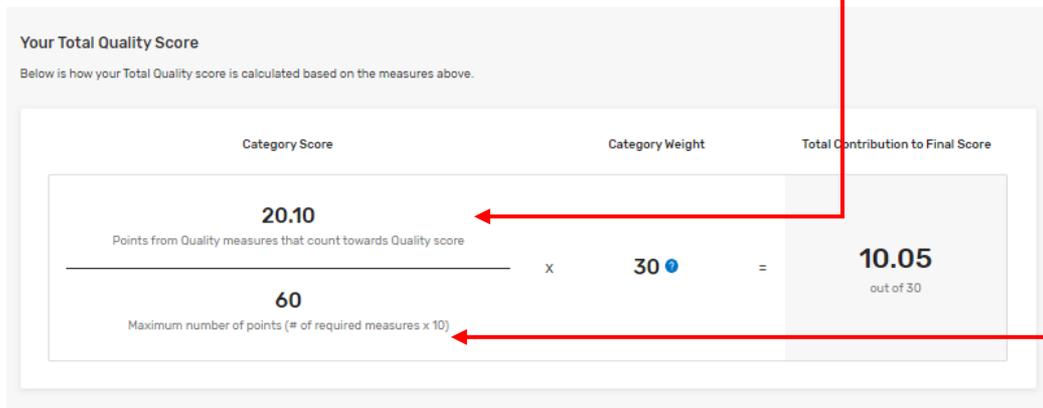
Measure Name	Performance Rate	Measure Score
<b>CAHPS for MIPS Survey</b> <small>Measure ID: 321</small>	--	--



# Submitting and Reviewing Quality Data

## Quality Page (Continued)

Finally, you can view how we've calculated your preliminary quality score



The **numerator** includes the achievement earned for the 3 submitted measures.

The **denominator** includes the maximum points available for **all** measures required by the APP, including those that haven't been score yet.

**Did you know?**

We updated the Multiple Chronic Conditions measure for the 2022 performance year. The Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions is available to all APM Entities, groups and clinicians reporting the APP that meet the case minimum.



# Submitting and Reviewing Quality Data

## Frequently Asked Questions

### What happens if a Shared Savings Program ACO reports both the 10 CMS Web Interface measures and the 3 eQMs/MIPS CQMs?

- If an ACO reports both APP measure sets, we'll use whichever measure set results in a higher score when calculating your quality performance category score – either the 10 CMS Web Interface measures OR the 3 eQMs/MIPS CQMs.

### Do Participant TINs in a Shared Savings Program ACO need to report quality measures?

- No, quality measures will be reported by the ACO. As a reminder, Participant TINs won't see any quality measure data or scores reported by the ACO when they sign in to report Promoting Interoperability data on behalf of their MIPS eligible clinicians.

### When will administrative claims measures and CAHPS for MIPS Survey measure results be available?

- This information will be included as part of your performance feedback that will be available in Summer 2023.

### What happens if we submit the same quality measure through multiple collection types?

- We'll only include achievement points from one collection type for a single measure in your quality performance category score.
- Let's review an example:
  - You report the controlling high blood pressure measure (Quality ID 236) as an eQm and MIPS CQM.
  - You earn 6.1 achievement points for the measure through the eQm collection type.
  - You earn 7.5 achievements points for the measure through the MIPS CQM collection type.
- The MIPS CQM version of measure 236 will be counted towards your quality performance category score because it resulted in more achievement points.
- The eQm version of the measure won't contribute to your quality performance category score.





# Submitting and Reviewing Promoting Interoperability Data

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# Submitting and Reviewing Promoting Interoperability Data

## Submitting and Reviewing Promoting Interoperability Data

When reporting the APP as an APM Entity, such as a Shared Savings Program ACO, Promoting Interoperability data is reported for the MIPS eligible clinicians in the APM Entity and submitted at the individual or group level.

- [File Upload](#)
- [Manual Entry \(Attestation\)](#)
- [Reviewing Previously Submitted Data](#)



# Submitting and Reviewing Promoting Interoperability Data

## File Upload

You can upload a QRDA III or QPP JSON file with your Promoting Interoperability data on the [Reporting Overview](#) page.

**Did you know?** Your file must include the appropriate program name to be counted towards the APP:

When submitting a QPP JSON file, "programName" = "app1"

When submitting a QRDA III file, CMS Program Name =

- "MIPS\_APP1\_APMENTITY" if you're reporting the APP at the APM Entity level (such as a Shared Savings Program ACO)
- "MIPS\_APP1\_GROUP" if you're reporting the APP at the group level
- "MIPS\_APP1\_INDIV" if you're reporting the APP at the individual level

## Manual Entry (Attestation)

You can also attest to your Promoting Interoperability data by manually entering numerators, denominators, and yes/no values as appropriate to the measure.

Click **Create Manual Entry** on the **Reporting Overview**, and then again on the **Promoting Interoperability** page.

The screenshot displays two side-by-side panels from a web application. The left panel, titled 'Promoting Interoperability', shows a progress bar at '-- / 25' and a 'NOT REPORTED' status with a 'Create Manual Entry' button highlighted in red. The right panel, titled 'PERFORMANCE YEAR 2022', shows a 'MIPS Promoting Interoperability Score' section with a 'Total Preliminary Score' of '-- / 25' and a 'Create Manual Entry' button highlighted in red. Below this, a message states 'No Promoting Interoperability measures have been submitted for this profile.' with another 'Create Manual Entry' button highlighted in red.



# Submitting and Reviewing Promoting Interoperability Data

## Manual Entry (Attestation) (Continued)

If your Promoting Interoperability performance category is currently weighted at 0%, you will be prompted to confirm that you wish to proceed (click **Yes, I Agree** then **Continue**).

If you click **Continue** and enter any data, including performance period dates, you will be scored in this performance category.

**Your current category weights**

The information below is subject to change based on availability of contributing factors. For clinicians that have a reweight associated, the Promoting Interoperability weight will be transferred to the Quality category.

Quality		Promoting Interoperability		Improvement Activities		Cost
75%	+	0%	+	25%	+	0%

You are not required to report this category and any data entered will result in a discard of the current reweight. By entering data, this will discard any reweighting currently being applied for this category. This will change your current weight of 0% for this category back to 25%. You will be scored on data submitted. **This action cannot be undone.** Are you sure you wish to proceed?

YES, I AGREE.

**CANCEL** **CONTINUE**

As you provide required information on the Manual Entry page, more fields will appear. For example, once you enter your performance period, the CEHRT ID field will appear. You must provide all required information (including measure data) before you can receive a preliminary score for this performance category.

# Submitting and Reviewing Promoting Interoperability Data

## Enter Your Performance period

PERFORMANCE YEAR 2022 Print

[< Back to Promoting Interoperability](#) **0 / 6** **Manual Entry Objectives Completed** Delete  
All 6 required objectives must be completed in order to receive a score

**i** You will receive a score for your manual entry once **all 6 required Promoting Interoperability objectives** have been completed.

### Manually Enter Your Measures

To begin manually entering your measures, select a performance period. All Promoting Interoperability objectives must be completed before your manual entry can be applied towards your total QPP Promoting Interoperability score.

Performance Period

**Start Date**   **to** **End Date**  



# Submitting and Reviewing Promoting Interoperability Data

Enter your CMS EHR Certification ID (“CEHRT ID”)

The screenshot shows a web form with the following sections:

- Performance Period**: A large empty text input field.
- Start Date**: A date input field containing "01/01/2022" with a calendar icon to its right.
- End Date**: A date input field containing "12/31/2022" with a calendar icon to its right.
- CEHRT ID**: A section with a label "CEHRT ID" and a text input field containing the placeholder text "Enter CEHRT ID". A red arrow points from this field to the explanatory text box below.

For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 26-29 of the [CHPL Public User Guide](#).

A **valid** CMS EHR Certification ID for 2015 Edition CEHRT (including Cures Update criteria) will include **"15E"**.

A CMS EHR Certification ID generated for a combination of 2014 and 2015 Edition CEHRT will include **"15H"** and **will be rejected**.

# Submitting and Reviewing Promoting Interoperability Data

## Complete Required Attestation Statements and Measures

You must select **Yes** for the 3 required attestations before you can begin entering your measure data. As you move through the required information, you will see an indicator as each requirement is **completed**, but you won't see a preliminary score until all requirements are complete.

**Attestation Statements**

**ONC Direct Review Attestation**  
Measure ID: PL\_ONCDIR\_1

I attest that I - (1) Acknowledge the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

Completed

To manually report a measure, you will need to either select **Yes** or enter the **numerator/denominator** value, according to the measure. You can also claim an exclusion if you qualify.

**Security Risk Analysis**

**Security Risk Analysis**  
Measure ID: PL\_PPHI\_1

Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

Completed



# Submitting and Reviewing Promoting Interoperability Data

## Complete Required Attestation Statements and Measures (Continued)

**e-Prescribing**

**e-Prescribing**  
Measure ID: PI\_EP\_1

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

**Measure Exclusion:** Check the box to be excluded from the required e-Prescribing measure. At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

Numerator	Denominator
100	120

Completed

**e-Prescribing**

**e-Prescribing**  
Measure ID: PI\_EP\_1

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

**Measure Exclusion:** Check the box to be excluded from the required e-Prescribing measure. At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

Numerator	Denominator
0	0

Completed



# Submitting and Reviewing Promoting Interoperability Data

## Health Information Exchange Objective

There are 2 options for meeting the Health Information Exchange (HIE) objective:

### Option 1:

- Support Electronic Referral Loops by Sending Health Information
- Support Electronic Referral Loops by Receiving and Reconciling Health Information

### Option 2:

- Health Information Exchange: Bi-Directional Exchange

**Health Information Exchange**

**Support Electronic Referral Loops By Sending Health Information** Numerator: 100 Denominator: 100  
Measure ID: PL\_HIE\_1  
For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider - (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.  
MEASURE SPECIFICATIONS  
[Download Specifications](#)  
 Measure Exclusion: Check the box to be excluded from the required Support Electronic Referral Loops By Sending Health Information measure. Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. Completed

**Support Electronic Referral Loops By Receiving and Reconciling Health Information** Numerator: 100 Denominator: 100  
Measure ID: PL\_HIE\_4  
For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.  
MEASURE SPECIFICATIONS  
[Download Specifications](#)  
 Measure Exclusion: Check the box to be excluded from the required Support Electronic Referral Loops By Receiving and Reconciling Health Information measure. Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period. Completed

**Health Information Exchange(HIE) Bi-Directional Exchange** Yes No  
Measure ID: PL\_HIE\_5  
The MIPS eligible clinician or group must establish the technical capacity and workflows to engage in bi-directional exchange via an HIE for all patients seen by the eligible clinician and for any patient record stored or maintained in their EHR.  
MEASURE SPECIFICATIONS  
[Download Specifications](#)

Option 1

Option 2



# Submitting and Reviewing Promoting Interoperability Data

## Public Health and Clinical Data Exchange Objective

Beginning in 2022, there are 2 required measures for this objective: Electronic Case Reporting and Immunization Registry Reporting.

**Required Measures**

**Immunization Registry Reporting** Yes No

Measure ID: PI\_PHCDRR\_1  
The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

[Download Specifications](#)

**Measure Exclusion:** Check the box to select the applicable exclusion for the required Immunization Registry Reporting measure.

**Electronic Case Reporting** Yes No

Measure ID: PI\_PHCDRR\_3  
The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.

[Download Specifications](#)

**Measure Exclusion:** Check the box to select the applicable exclusion for the required Electronic Case Reporting measure.



# Submitting and Reviewing Promoting Interoperability Data

## Public Health and Clinical Data Exchange Objective (Continued)

To earn an additional 5 bonus points in this performance category, you can choose to report 1 or more of the remaining, optional measures. There are 5 bonus points available whether you report 1, 2 or all 3 of the optional measures.

**Optional (Bonus) Measures**

**Bonus: Syndromic Surveillance Reporting**

Measure ID: PI\_PHCDRR\_2  
The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

[Download Specifications](#)

**Bonus: Public Health Registry Reporting**

Measure ID: PI\_PHCDRR\_4  
The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.

[Download Specifications](#)

**Bonus: Clinical Data Registry Reporting**

Measure ID: PI\_PHCDRR\_5  
The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

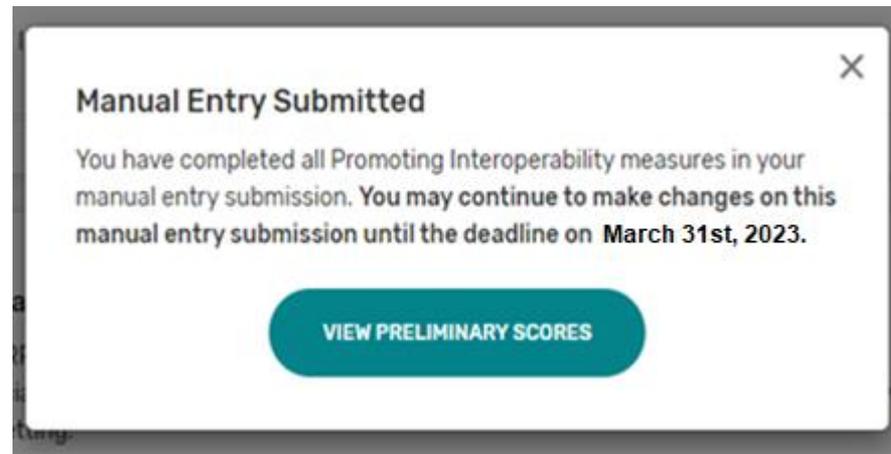
[Download Specifications](#)



# Submitting and Reviewing Promoting Interoperability Data

## Submission Confirmation

Once all required data have been reported, the system will notify you and allow you to view your preliminary scores.



# Submitting and Reviewing Promoting Interoperability Data

## Review Previously Submitted Data

Click View & Edit from the [Reporting Overview](#). You will land on a read-only page, letting you review the preliminary scoring details of your submission.

The screenshot shows a web interface for reviewing Promoting Interoperability data. At the top, it says 'TRADITIONAL MIPS Promoting Interoperability' and provides provider information: 'RegFour 500ne, Doctor of Medicine at Pfeiffer Group', 'NPI: 0087735156 | TIN: 000839403', and '01712 Amy Well Apt. 337, Suite 5150, Douglasburgh, NM 693839346567033'. Below this, it indicates 'PERFORMANCE YEAR 2022' with a 'Print' button. The main section displays the 'MIPS Promoting Interoperability Score' as '25.00 / 25' with a progress bar. A note explains that for performance year 3 and beyond, the QIP policy has been modified to allow clinicians and groups to choose measures from across multiple collection types and submit using the best submission types available. There are 'View Manual Entry' and 'Manage Data' buttons. At the bottom, a table shows the 'Performance Period' as '01/01/2022 - 12/31/2022' and the 'DEHRT ID' as 'XX15EXXXXXXXXXX'.

If you need to update your manually entered data, click **View Manual Entry**.

### Reminders

We recommend using a single submission type (file upload, API, or attestation) for reporting your Promoting Interoperability data.

- **Why? Any conflicting data** for a measure or required attestation submitted through multiple submission types **will result in a score of 0** for the Promoting Interoperability performance category.

This means **you can't create a manual entry to correct inaccurate data reported on your behalf.**

- If you see errors in your data, contact your third party intermediary and ask them to delete the data they've submitted for you.

# Submitting and Reviewing Promoting Interoperability Data

## Review Previously Submitted Data (Continued)

### Troubleshooting

If you or a third party successfully uploaded a file with your Promoting Interoperability data, but you don't see it reflected on the APP Reporting Overview page, the file probably didn't include the APP program name. Your file must include the correct program name to be counted towards APP reporting.

You may need to reach out to your EHR vendor or third party intermediary for assistance with verifying the program name included in your file and updating (or adding) it as needed.

When submitting a **QPP JSON** file, "programName" = "app1"

Refer to the [QPP Submission MeasurementSets API documentation](#) for more information.

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When submitting a **QRDA III** file, "CMS Program Name" =

- "MIPS\_APP1\_GROUP" if you're reporting Promoting Interoperability data for the APP at the group level
- "MIPS\_APP1\_INDIV" if you're reporting Promoting Interoperability data for the APP at the individual level

(Please note that Promoting Interoperability data is reported at the individual and/or group level, even if your APM Entity is reporting the quality measures required by the APP.)

Refer to page 22 of the 2022 QRDA III Implementation Guide (accessible from [this page](#) of the eCQI Resource Center) for more information.



# Submitting and Reviewing Promoting Interoperability Data

## Review Previously Submitted Data (Continued)

If you report Promoting Interoperability data through multiple submission types (ex. Manual entry and file upload) and there is any conflicting data, you will receive a score of 0 out of 25 for the performance category.

### MIPS Promoting Interoperability Score

You'll receive a preliminary score for this performance category after all measures and required information have been reported.

Any conflicting data for a single measure or required attestation submitted through multiple submission methods will result in a score of zero for the Promoting Interoperability performance category.

[Learn more about Promoting Interoperability](#)

View Manual Entry

Manage Data

Total Preliminary Score

-- / 25

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

Measure Name Expand All	Measure Score
e-Prescribing Measure ID: PI...EP_1	9 / 10

Measure Name Expand All	Measure Score
e-Prescribing Measure ID: PI...EP_1	9 / 10
At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.	
Collection Type Manually Enter	Numerator 187
	Denominator 199





# Improvement Activities

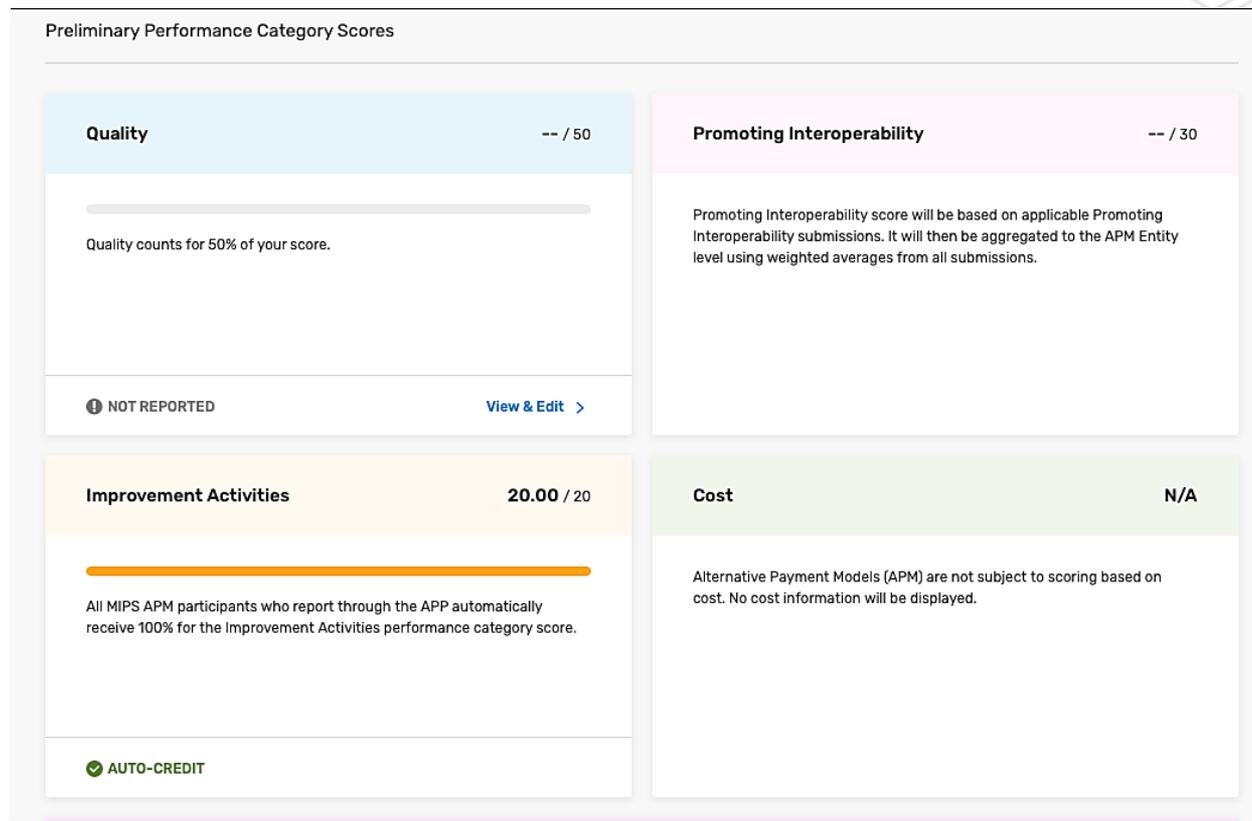
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# Improvement Activities

## Improvement Activities

Individuals, groups and APM Entities reporting the APP automatically receive full credit in the improvement activities performance category. You aren't able to attest to additional improvement activities because you've already earned the maximum points in this performance category.





# Help, Resources and Version History

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# Help and Version History

## Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m.-8 p.m. ET or by e-mail at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).

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

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



# Help, Resources and Version History

## Additional Resources

The [Quality Payment Program Resource Library](#) houses fact sheets, measure specifications, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
<b><u>2022 APP Toolkit</u></b>	Option 2 includes Quality Submission measure documentation for SSP ACOs Only. The included files are: APP Quality Submission Options, APP Quality Measures (Shared Savings Program ACOs Only), APP Quality Measure Specifications.
<b><u>2022 APP Quality Requirements (All Participants)</u></b>	Option 1 contains the measures for Individual, Group, and APM Entity APP Quality Submission. This zip file includes: APP Quality Data Submission Options, APP Quality Measure Set (All Participants), APP Quality Measure Specifications.
<b><u>2022 APP Quality Requirements (SSP ACO)</u></b>	PY 2022 APP Toolkit zip file includes: 2022 APP Toolkit Table of Contents, 2022 APM Performance Pathway for Shared Savings Program Accountable Care Organizations (ACOs) User Guide, 2022 APM Performance Pathway for MIPS APM Participants Fact Sheet, 2022 APM Performance Pathway Infographic, 2022 APM Performance Pathway Quick Start Guide, and 2022 APM Performance Pathway Reporting Scenarios.



# Help and Version History

## Version History

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

Date	Description
01/20/2023	Updated call-out box on slide 7 and updated slide 10 to include a link.
01/03/2023	Original Posting.

