Quality Payment PROGRAM

2022 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2024 Payment Adjustment FAQs

Purpose

This document answers key questions (with supporting screenshots) about the MIPS performance feedback experience for practice representatives, MIPS Alternative Payment Model (APM) Entity representatives, individual clinicians, and virtual group representatives.

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

Table of Contents

Each section contains frequently asked questions and supporting screenshots.

Have questions about a particular topic?

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

Fast Facts About Performance Feedback

What Is Performance Feedback?

Performance feedback is a summary of the data you've submitted to us and that we collected on your behalf. Final performance feedback includes:

- Performance category-level scores and weights
- Bonus points
- Measure-level performance data and scores
- Activity-level scores
- Payment adjustment information
- Patient-level reports

Who Can Access Performance Feedback and Payment Adjustment Information?

MIPS Performance Feedback is accessible to clinicians and authorized representatives of practices, virtual groups, and APM Entities (including Shared Savings Program Accountable Care Organizations [ACOs]), whether they reported traditional MIPS or the APM Performance Pathway (APP).

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

Please review Appendix C more information about what you can and can't view in performance feedback based on your access.

How Do I Access Performance Feedback?

- Sign in to the Quality Payment Program website.
- Click "**View PY 2022 Final Performance Feedback**" on the home page or select "Performance Feedback" from the left-hand navigation.
- Select your organization (Practice, APM Entity, Virtual Group).
    - Practice representatives can access both individual and group feedback through the practice organization.

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

COVID-19's Impact on 2022 Performance Feedback

The 2019 Coronavirus (COVID-19) public health emergency continued to impact clinicians across the United States and territories. We recognize, however, that not all practices have been impacted by COVID-19 to the same extent. For the 2022 performance year, we continued 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 public health emergency.
Clinicians with an approved EUC for all 4 categories and didn't submit any data, or who only submitted data in one performance category, will automatically receive a neutral payment adjustment in 2023.
Any performance category for which an individual clinician didn't submit data is weighted at 0% for the 2022 performance year.

Appendix A outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.

We also extended the deadline for our **MIPS EUC Exception application** to March 2, 2023.

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

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

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

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

Accessing Performance Feedback

Before You Begin

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

- More information is available in the QPP Access User Guide (ZIP, 4.1 MB).

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

- **Please update your browser to the latest version of Microsoft Edge or Chrome.**

How Can I Access My/Our MIPS Performance Feedback?

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

Please note that if you're **a Shared Savings Program ACO's** QPP Security Official or QPP Staff User contact in the ACO Management System (ACO-MS), then you can view performance feedback by signing in to the QPP website using your ACO-MS username and password.

- For guidance on how to add the QPP Security Official and QPP Staff User contacts to an ACO in ACO-MS, please refer to the ACO-MS User Access and ACO Contents Tip Sheet.

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

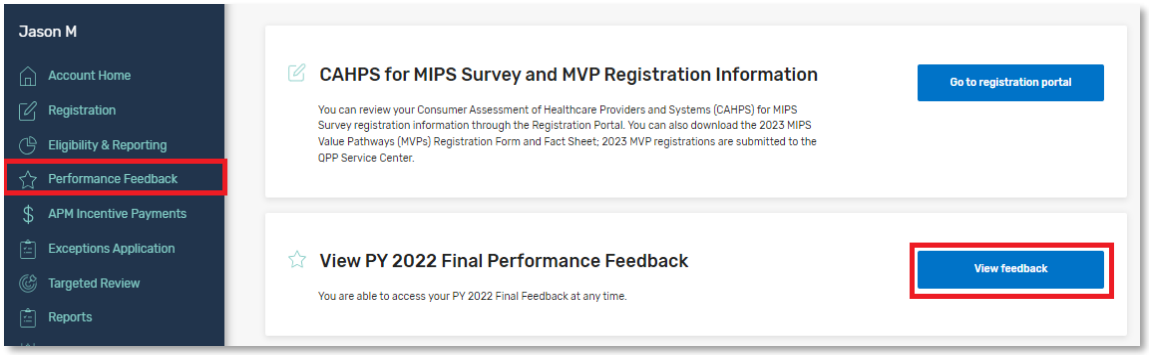
- QPP Access User Guide (ZIP, 4.1 MB)
- How to Create a QPP Account video
- Connect to an Organization: Practice video
- Connect to an Organization: APM Entity video
- Connect to an Organization: Virtual Group video
- Request the Clinician Role video

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

See Appendix C for more information about what you can and can't view in performance feedback based on your credentials.

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

After signing in, select **View Feedback** or **Performance Feedback** in the left-hand navigation pane.



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

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

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

Please review the **Register for a HARP Account** and **Connect as a Clinician** documents in the QPP Access User Guide (ZIP, 4.1 MB).

Can Third Party Intermediaries Access Performance Feedback?

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

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

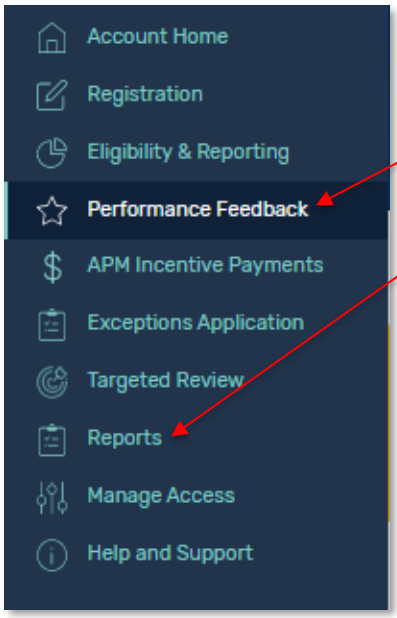
- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims.
- Patient-level reports for administrative claims measures.
- Final score or payment adjustment information.

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

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

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

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



You'll access your 2022 MIPS performance feedback through the **Performance Feedback** tab.

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

- 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Detail Reports.
- Historical CMS Web Interface reports for groups that have reported quality measures through the CMS Web Interface in previous years.
- Historical payment adjustment reports.

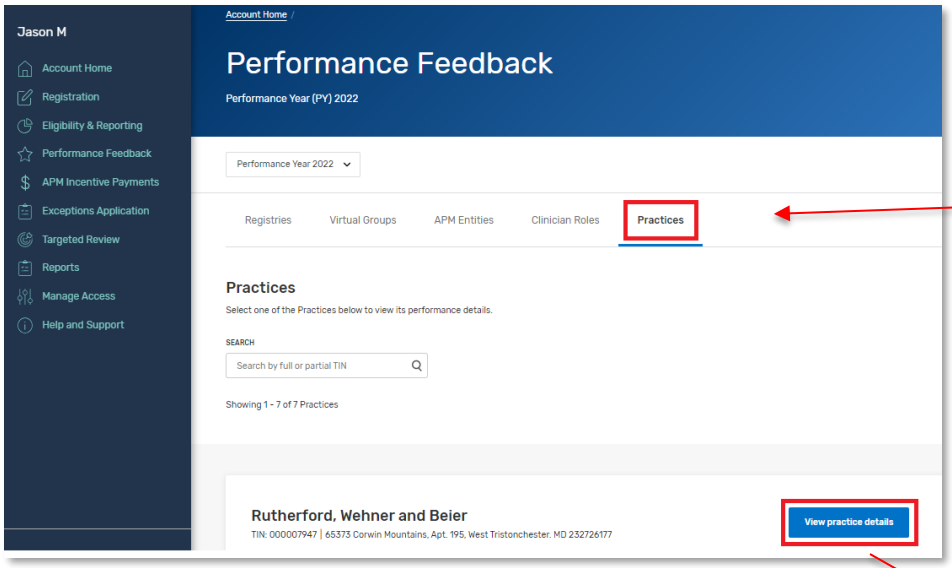
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

Navigating Into Performance Feedback: Practice Representatives

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

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

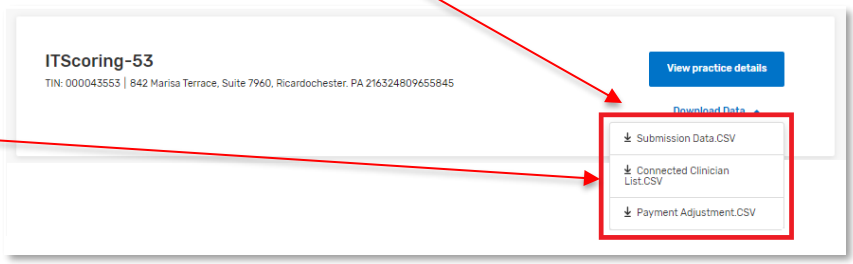
From **Performance Feedback**, select **View Practice Details** to access group- or clinician-level performance feedback.



If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **Practices** tab.

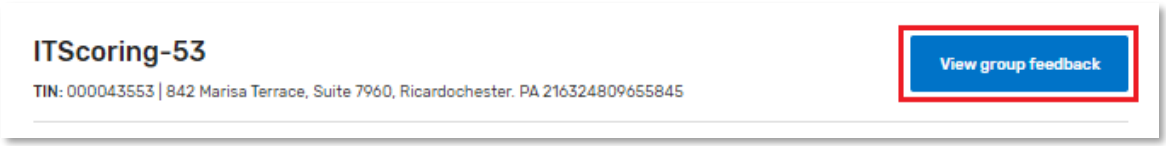
You can also select **Download Data** to access:

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

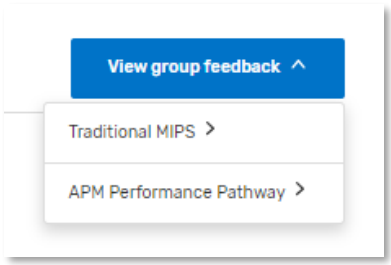


Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

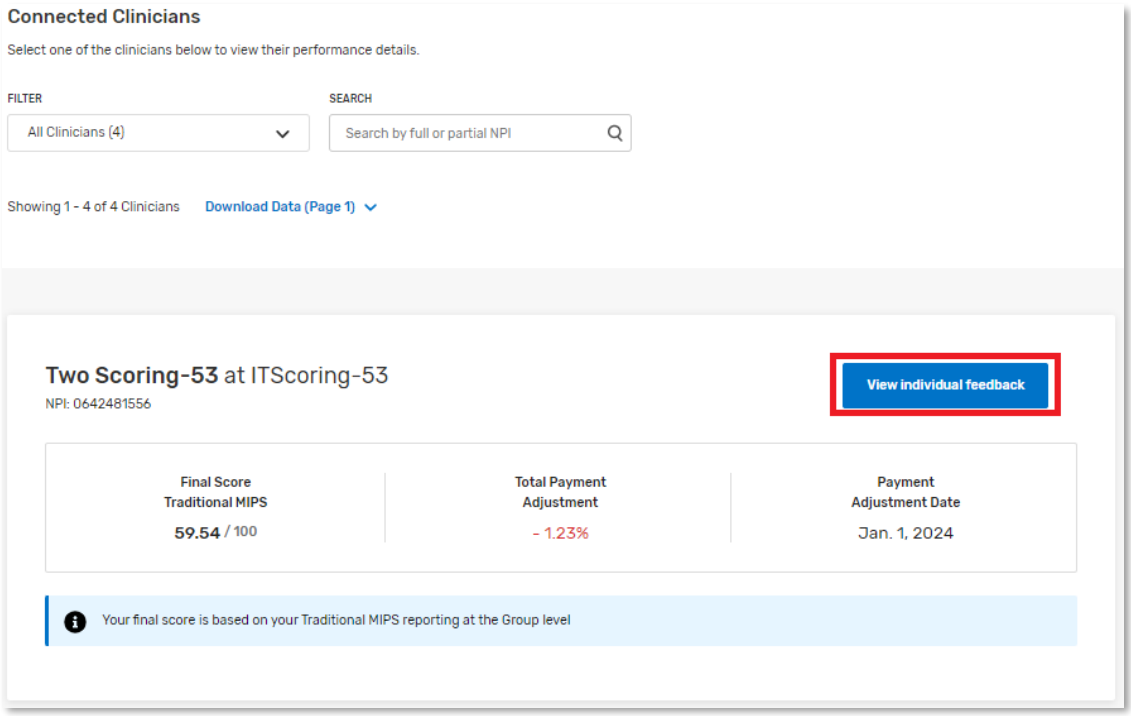
Select **View group feedback** to the right of the practice name to access performance feedback based on **group participation** (aggregated data submitted on behalf of all clinicians in the practice).



Note: If your practice reported via traditional MIPS and/or the APP, you'll have to select which feedback to view.



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



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

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

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

If your practice didn't submit data as a group for the 2022 performance year, you'll see a message indicating that your clinicians only reported as individuals:

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

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

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

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

Connected clinicians are all of the clinicians, identified by the National Provider Identifier (NPI) associated with your practice (TIN) through Medicare Part B claims billed between 10/1/2021 and 9/30/2022, regardless of their individual MIPS eligibility. Your connected clinicians are displayed on the Practice Details page of performance feedback and can also be accessed through the Connected Clinicians List comma-separated values (CSV) download on the main Performance Feedback page.

- Clinicians who started billing claims under your TIN between 10/1/2022 and 12/31/2022 will appear in the Payment Adjustment CSV download.

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

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

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

Representatives of solo practitioners and practices participating in a virtual group must have a Staff User role connected to the virtual group to access the virtual group's performance feedback. These permissions are different than the ones that let you access information specific to your practice. Please review the **Connect to an Organization** document in the QPP Access User Guide (ZIP, 4.1 MB).

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

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

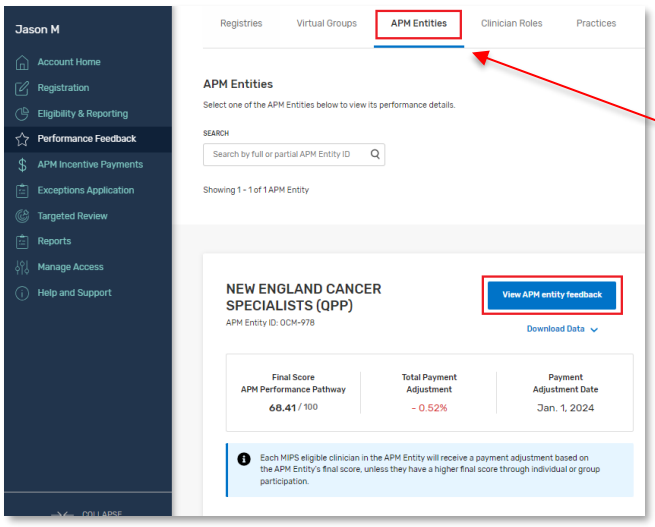
Navigating Into Performance Feedback: APM Entity Representatives

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

The following programs and models can review 2022 MIPS performance feedback, if applicable and available:

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

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



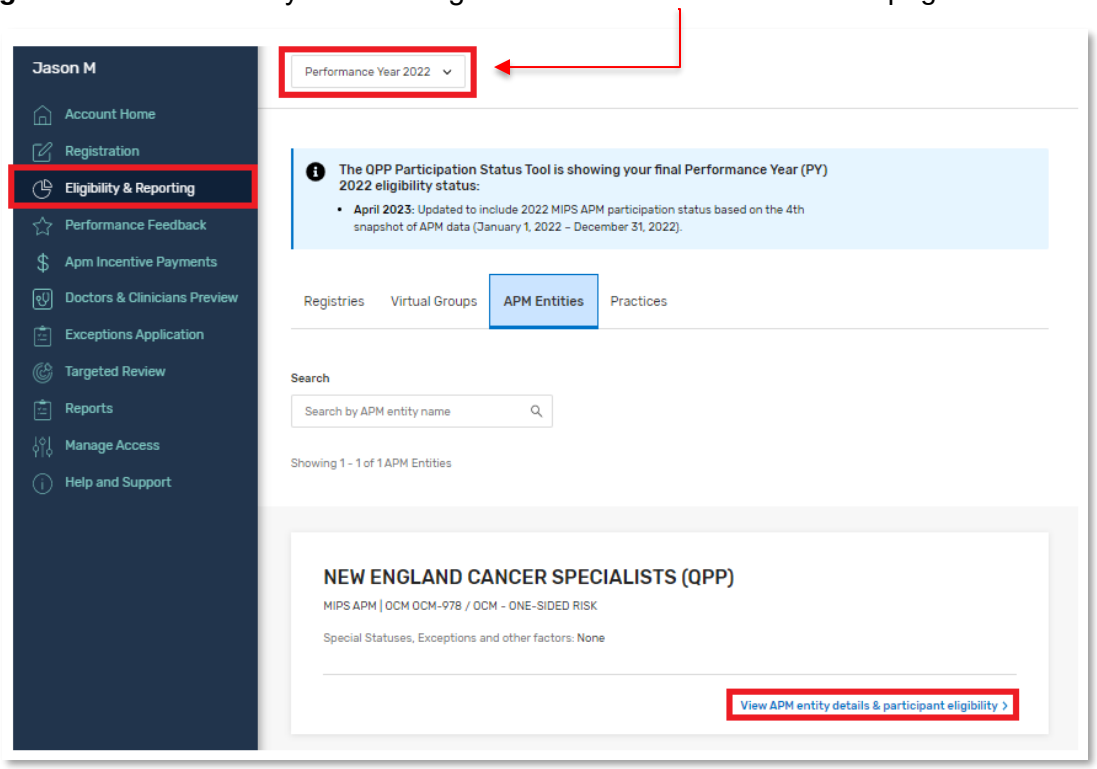
If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **APM Entities** tab.

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

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

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

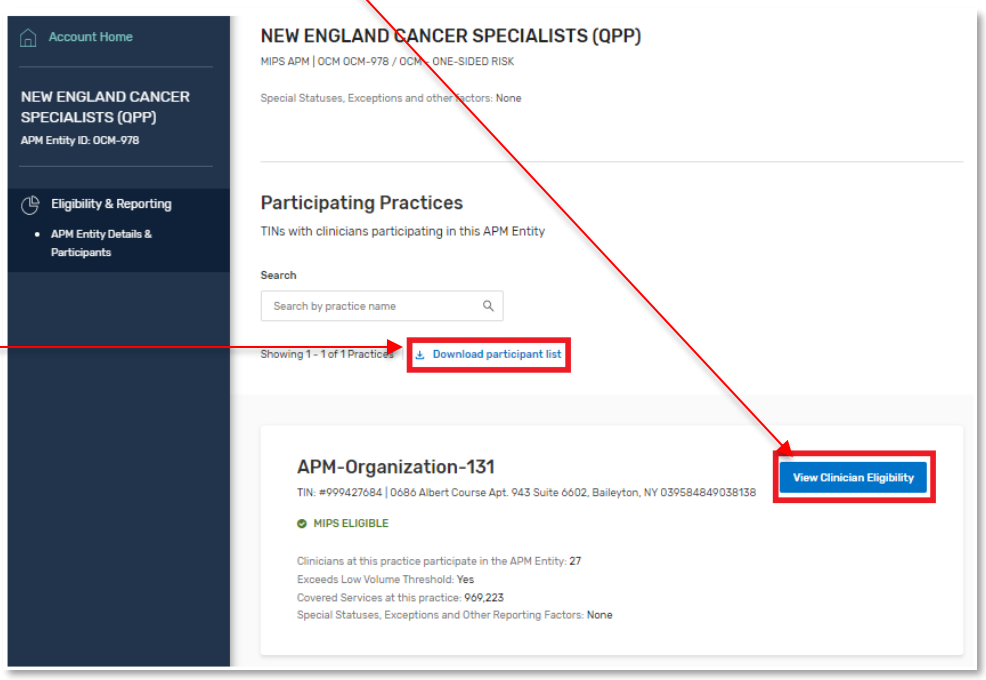
Yes. You can download this list by clicking "**View Participant Eligibility**" from the **Eligibility & Reporting** tab. Make sure that you're looking at the **Performance Year 2022** page.



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

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

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



What Should We Expect to See in Feedback?

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

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

Can Individual Clinicians View Our APM Entity Feedback?

Yes. Individual clinicians in the APM Entity can view their performance feedback from the APM Entity if they have the clinician role **or** if they've been approved as a staff user for the APM Entity.

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

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

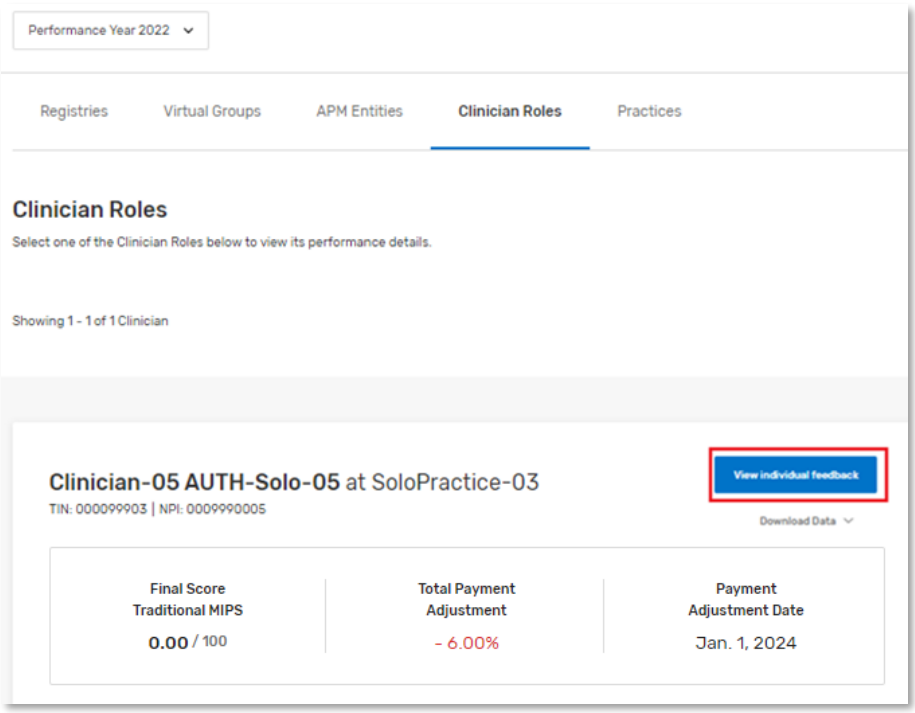
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

Navigating Into Performance Feedback: Individual Clinicians

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

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

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



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

How Do I Identify My Associated Organizations in Performance Feedback?

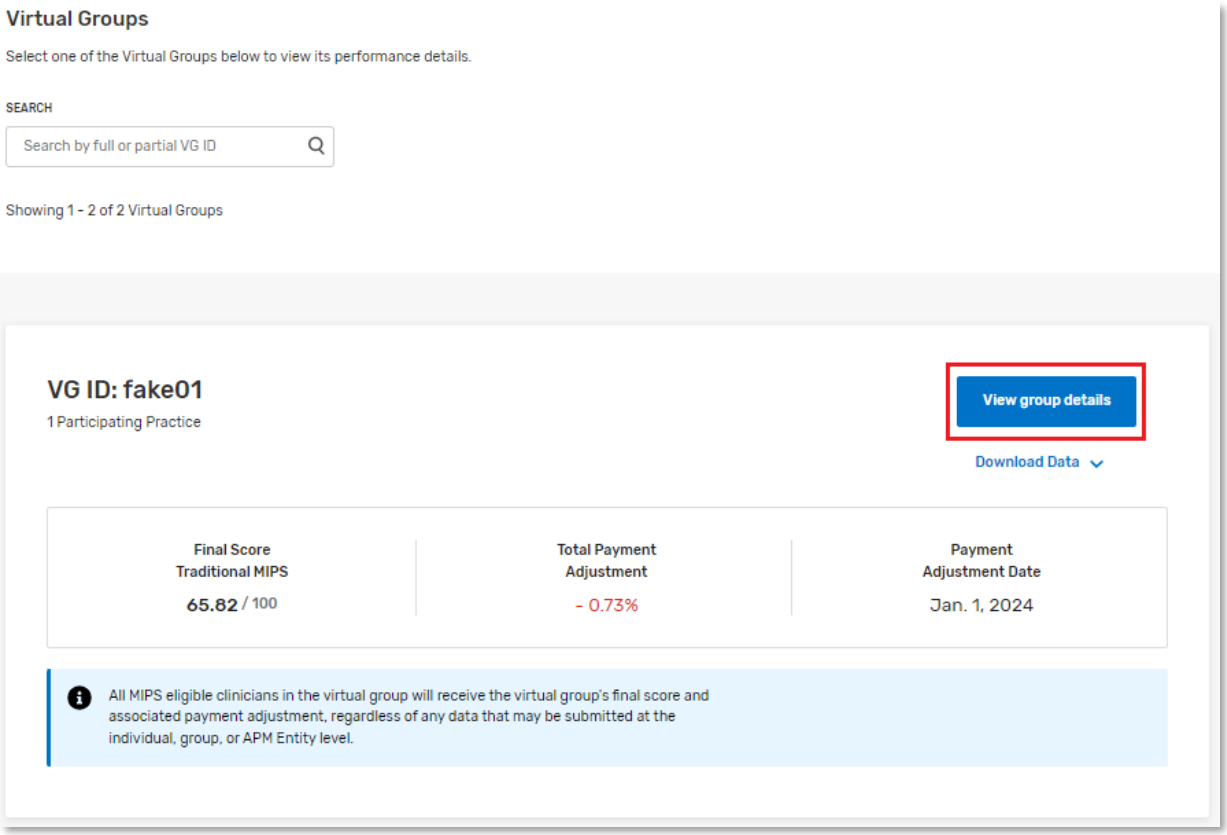
You should see the same associations on the **Performance Feedback** tab as you see for the 2022 performance year in the QPP Participation Status Tool or on the Eligibility & Reporting page when you sign in to the QPP website. Click "**View Individual Feedback**" to preview your final score as well as any individual data you may have submitted.

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

Navigating Into Performance Feedback: Virtual Group Representatives

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

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



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

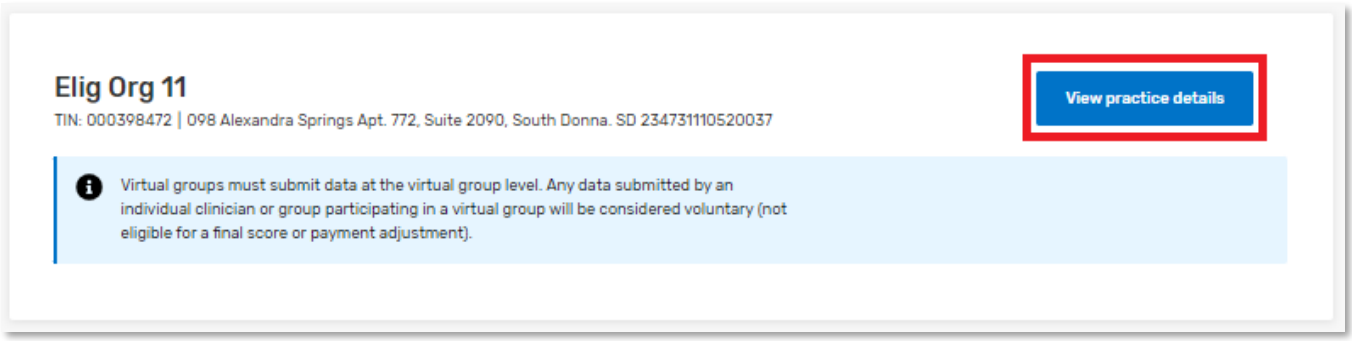
Can the Practices and/or Solo Practitioners Who Participate in Our Virtual Group Access Our Performance Feedback?

Yes, but only if they have an approved Staff User role for your virtual group. This means they're connected to your virtual group organization and requested the Staff User role; these permissions are different than the ones that let them access information specific to their practice. For more information, review the **Connect to an Organization** document in the QPP Access User Guide (ZIP, 4.1 MB).

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

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

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



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

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

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

Overview: Final Score and Payment Adjustment

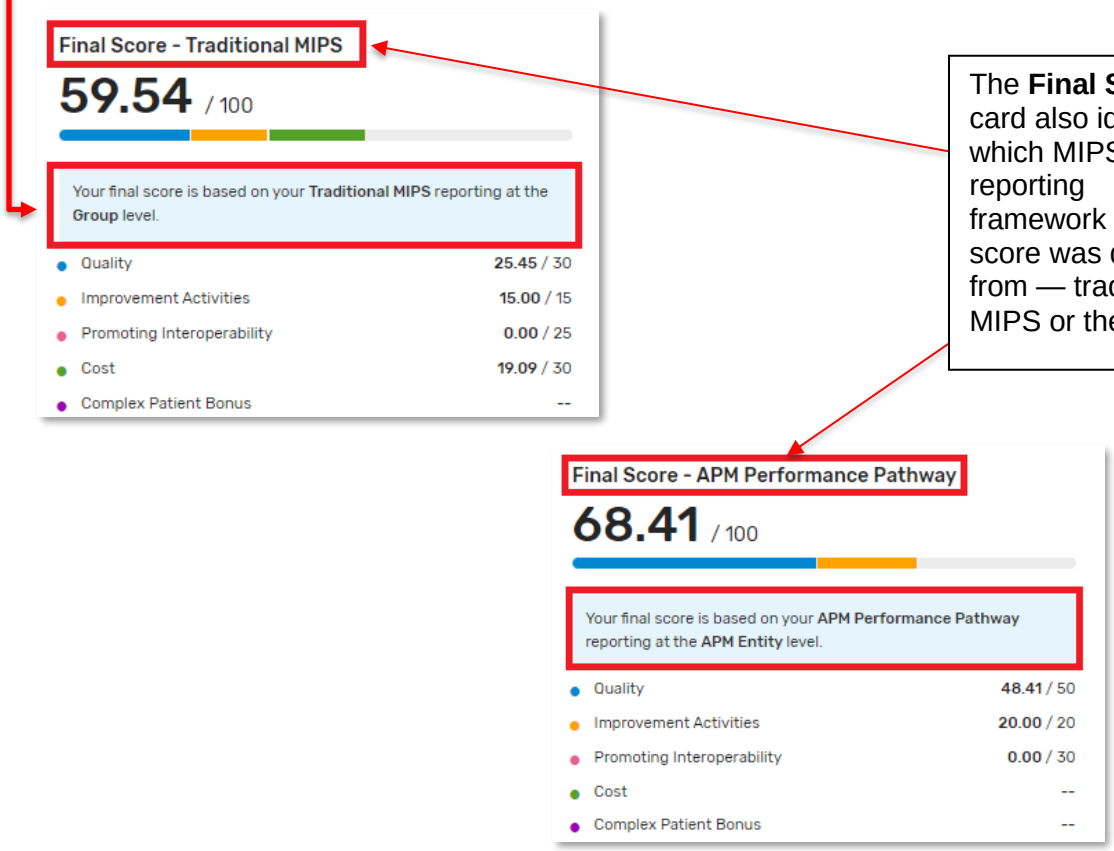
When you navigate into feedback, you'll land on the **Overview** page. From here, you can preview:

- Your final score, which will be based on reporting for traditional MIPS or the APP
- Your score and the weight for each MIPS performance category
- Your payment adjustment(s) information

How Is Our Final Score Determined?

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

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



Who Gets the 2024 MIPS Payment Adjustment(s) that I See in Performance Feedback?

The payment adjustment information is specific to the final score that's being viewed. It's possible for clinicians to have multiple final scores under a single TIN/NPI combination, so we recommend reviewing the Payment Adjustment CSV, which can be downloaded from the main performance feedback page.

When a clinician has multiple final scores that can be attributed to their TIN/NPI combination, we apply the following hierarchy when determining which final score will determine payment adjustments:

Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI is part of a virtual group and reported as an individual, group and/or APM Entity.	Virtual group's final score. (All other reporting is considered voluntary.)
TIN/NPI has a score from individual, group and/or APM Entity reporting.	The highest of the final scores, from either APM Entity, group, or individual reporting.

For group, virtual group and MIPS APM participation, **MIPS eligible clinicians** includes clinicians who didn't exceed the low-volume threshold as individuals but aren't otherwise excluded from MIPS based on their:

- Clinician type/ specialty
- Medicare enrollment date
- Reaching QP thresholds if they're in an Advanced APM

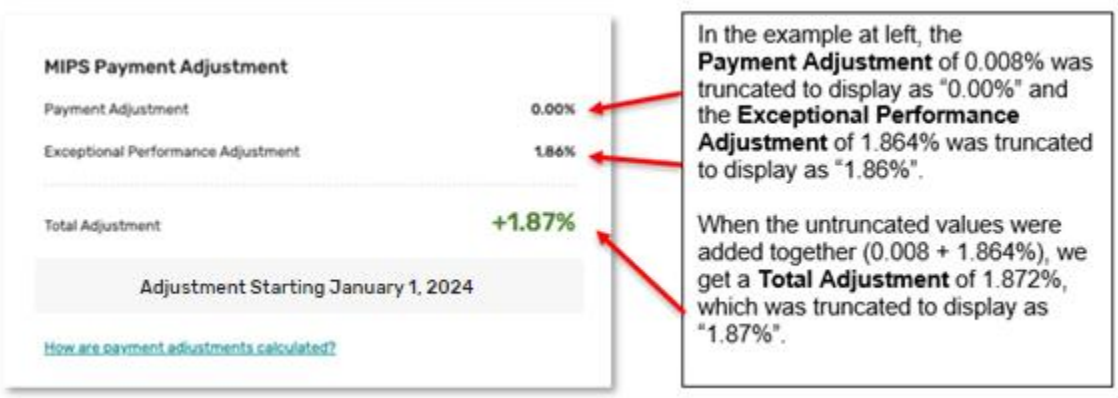
How Does My Payment Adjustment Relate to My Final Score?

Payment adjustments are determined on a sliding scale based on your final score.

Final Score	Payment Adjustment
89.00 – 100.00 points (Additional performance threshold = 89.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) AND • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
75.01 – 88.99 points	• Positive MIPS payment adjustment, greater than 0% (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance

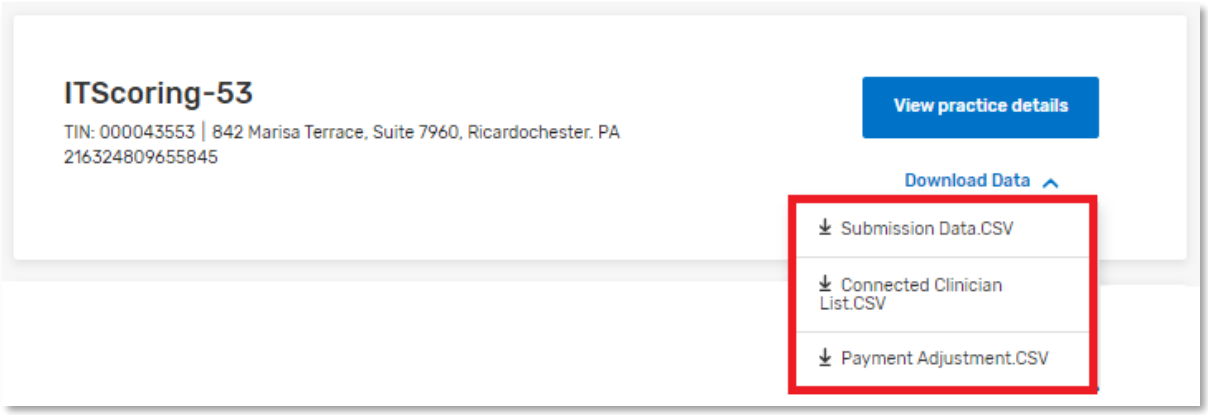
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

75.00 points (Performance threshold = 75.00 points)	Neutral MIPS payment adjustment (0%)
18.76 – 74.99	Negative MIPS payment adjustment, between -9% and 0%, on a linear sliding scale
0 – 18.75 points	Negative MIPS payment adjustment of -9%



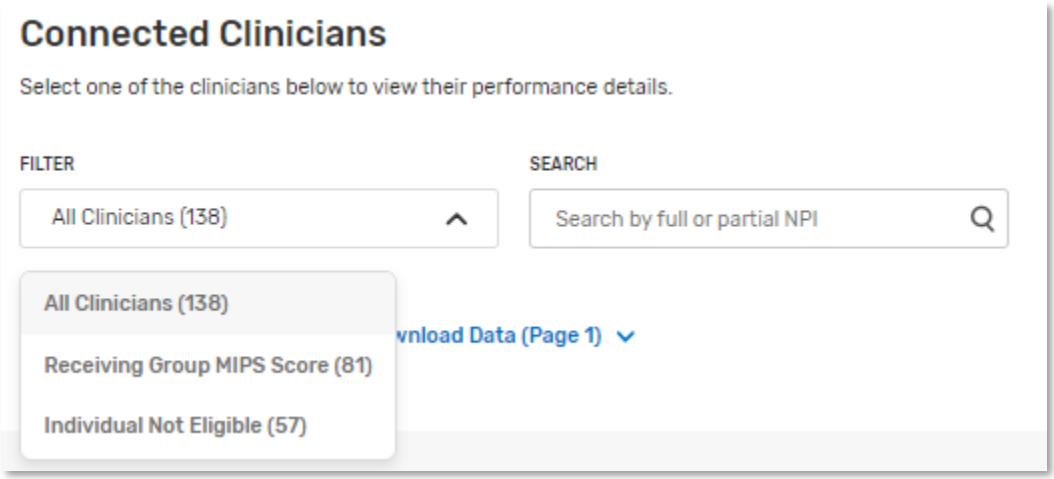
Is There a Way for Me to See a List of the Final Scores and Payment Adjustments for All the MIPS Eligible Clinicians in My Practice (Identified by TIN)?

Yes. From the **Performance Feedback** tab, select **"Payment Adjustment CSV"** from the **Download Data** menu under the **View Practice Details** button.



You can also filter your Connected Clinicians list by final score information once you've clicked **View Practice Details**. The list defaults to showing **All Clinicians**. There are multiple reports you can choose from (not all are shown in the image below).

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



- **Receiving Individual MIPS Score**
  - Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on their individual MIPS reporting.

- **Receiving Group MIPS Score**
  - Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the group's MIPS reporting.

- **Receiving APM Score**
  - Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on individual or group APP reporting.

- **Receiving Group APP Score**
  - Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the group's APP reporting.

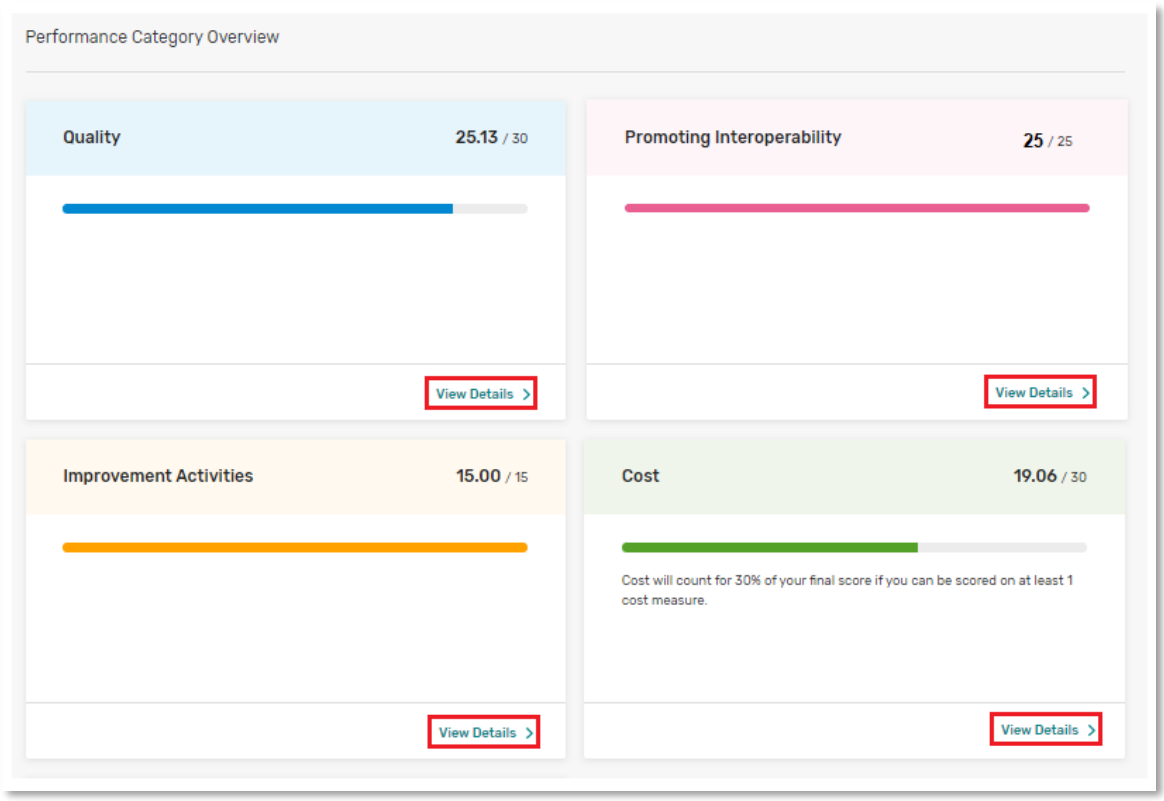
- **Receiving Individual APP Score**
  - Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on their individual APP reporting.

- **Individual Not Eligible**
  - Filters the Connected Clinicians list to show the clinicians who aren't eligible for MIPS reporting.

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

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

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



What Is the Complex Patient Bonus?

The MIPS Complex Patient Bonus aims to protect access to care for vulnerable, medically complex patients by awarding bonus points to the clinicians who care for them. This bonus is comprised of 2 components that are added together to form your score:

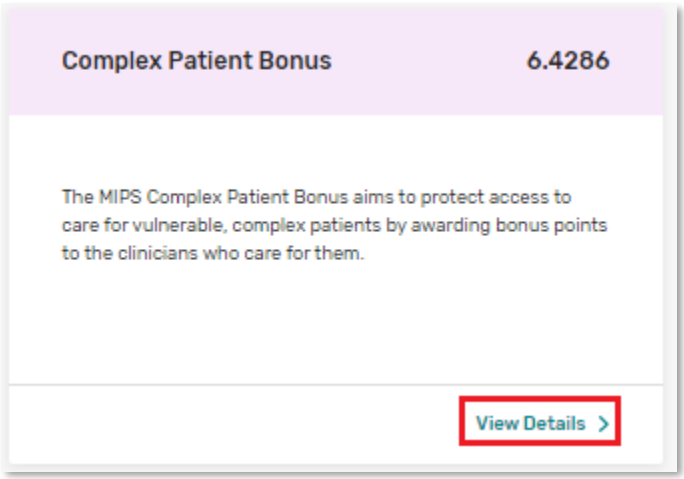
- **Medical Complexity**
  - This component uses the Hierarchical Condition Categories (HCC) Risk Scores of your patient population. These scores are assigned to each Medicare patient based on the severity of their acute or chronic conditions and are an indicator of medical complexity.

- **Social Risk**
  - This component uses the Dual Eligibility Ratio of your patient population. Dual Eligibility is a common indicator of social risk and refers to patients that are eligible for both Medicare and full- or partial-benefits under Medicaid.

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

How Is the Complex Patient Bonus Calculated?

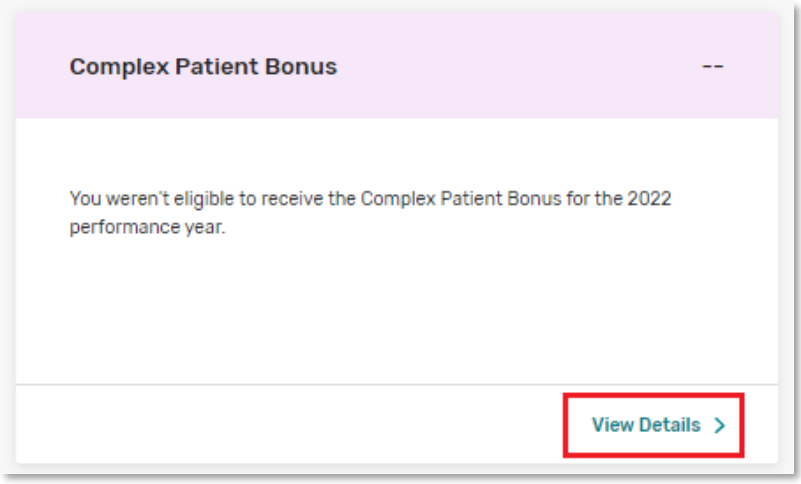
We updated the way we calculate the complex patient bonus beginning with the 2022 performance year. To learn more about these calculations, click **View Details** on the Complex Patient Bonus card.



Why Am I Not Eligible for the Complex Patient Bonus?

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

From the Overview page, you'll see a message indicating that you aren't eligible for this bonus. Click **View Details** to learn more about this calculation and why you aren't eligible.

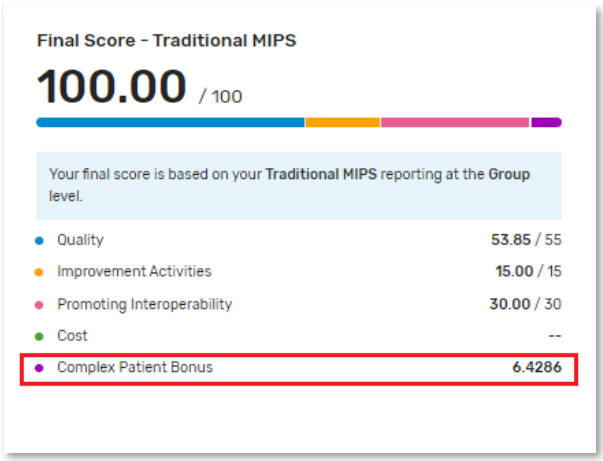


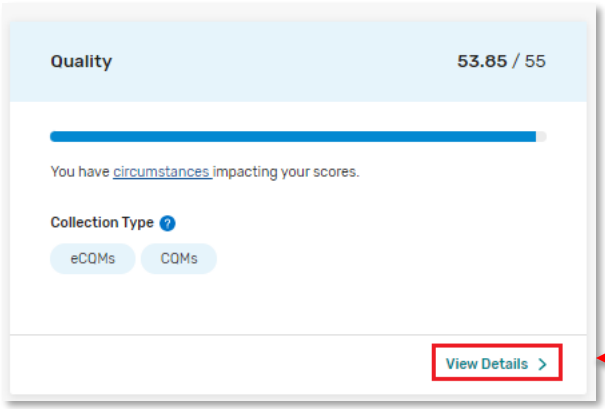
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

Did you know?

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

- Clinicians who weren't eligible for MIPS at the individual level but voluntarily reported as an individual.
- Clinicians who were individually eligible but didn't submit data and are receiving a score equal to the performance threshold because they qualified for the automatic EUC Exception policy.
- Practices that weren't eligible for MIPS at the group level but voluntarily reported as a group.
- Practices that were (1) eligible for MIPS at the group level **and** (2) didn't report as a group **and** (3) had either Administrative Claims Quality Measures or Items and Services data available for informational purposes.





Informational complex patient bonus is displayed here.

If informational administrative claims measures scores are available as well, you'll see an option to "View Details" on the quality card.

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

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

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

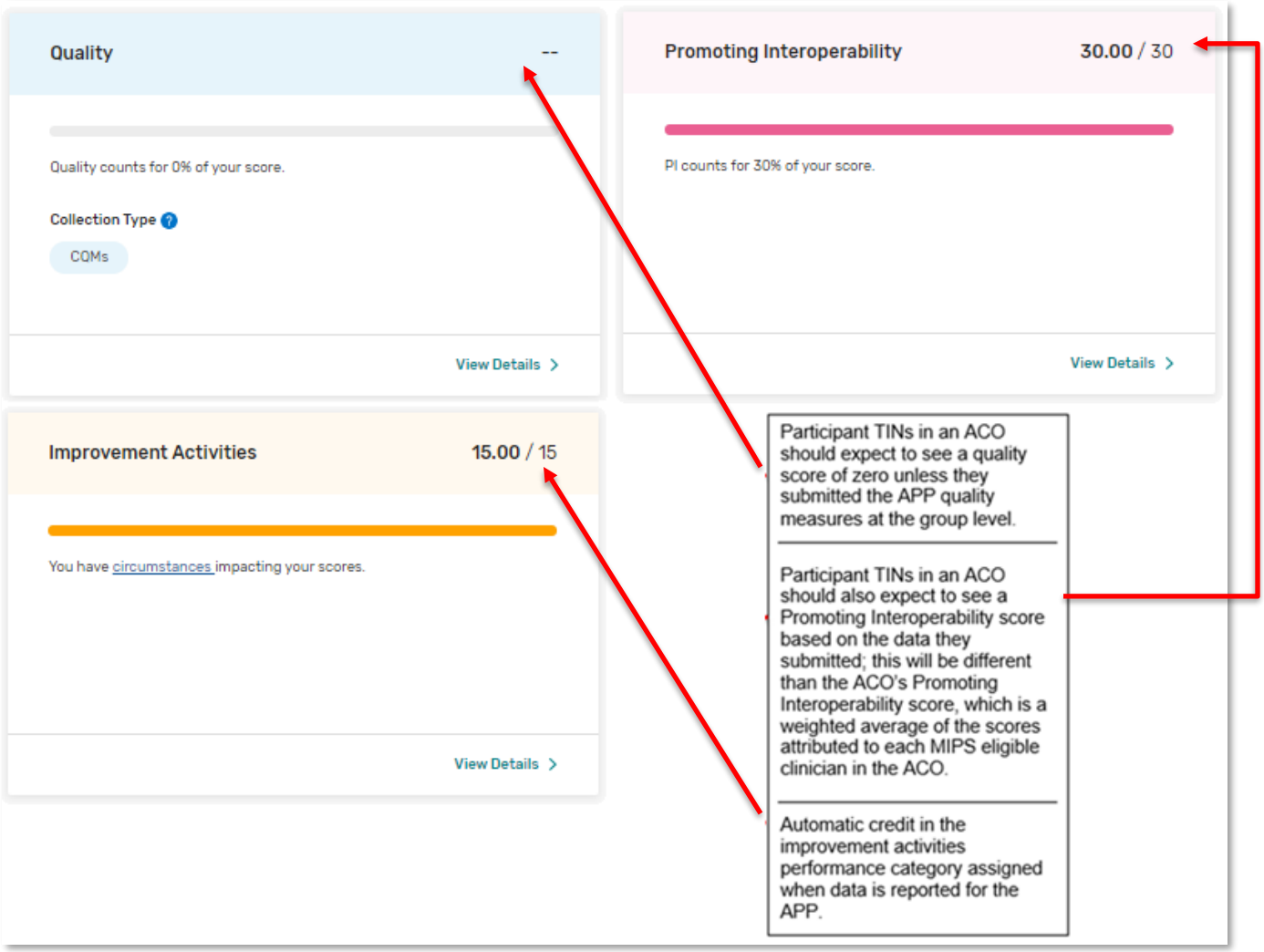
- MIPS eligible clinicians, groups and virtual groups will see "N/A" for every performance category they selected in an approved COVID-19 EUC Exception application, unless data was submitted for that category.
- **Reminder**: Clinicians who participate in an APM — and groups and virtual groups that include these clinicians — qualify for automatic credit in the improvement activities performance category. Submitting data for the quality and/or Promoting Interoperability performance categories triggered this automatic credit and overrode reweighting, making the category eligible for scoring.

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

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

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

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



However, the MIPS eligible clinicians in the ACO will receive the highest final score and associated payment adjustment that could be attributed to their TIN/NPI combination.

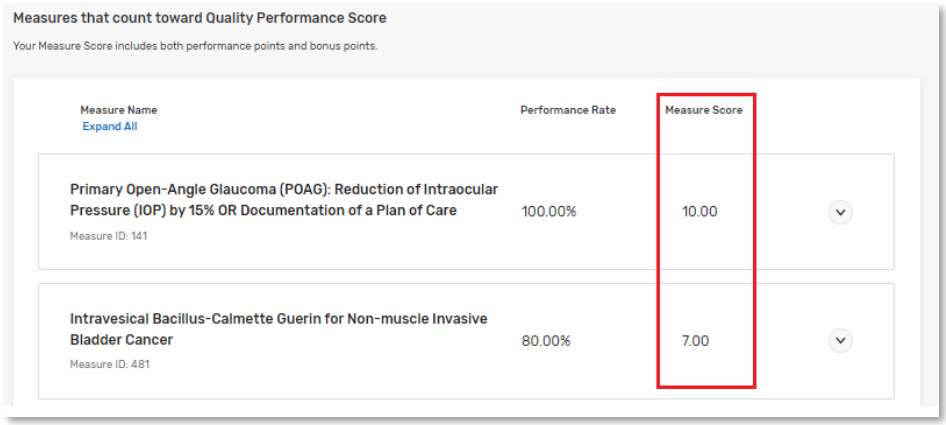
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

Traditional MIPS: Quality

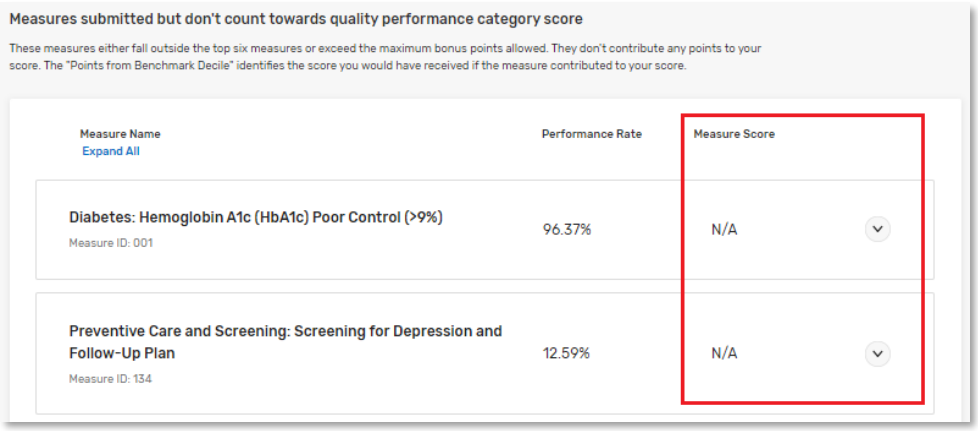
When you navigate into the quality section, you may see quality measures divided in up to 2 groups:

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

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



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



Reminder: 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.

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

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

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

When determining which measures are included in the top 6:

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

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

Example: You submit 7 measures, and your 2 lowest scoring measures (after the outcome measure) were Measure 113: Colorectal Cancer Screening and Measure 425: Photodocumentation of Cecal Intubation, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top 6 because its measure ID (113) has a lower value than the Photodocumentation of Cecal Intubation measure (425)

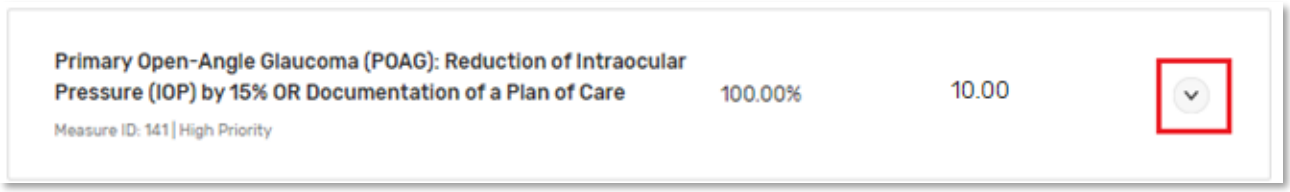
If you submit the same measure through multiple collection types — for example, as a Medicare Part B claims measure and as an electronic clinical quality measure (eCQM) — we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2 versions of the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

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

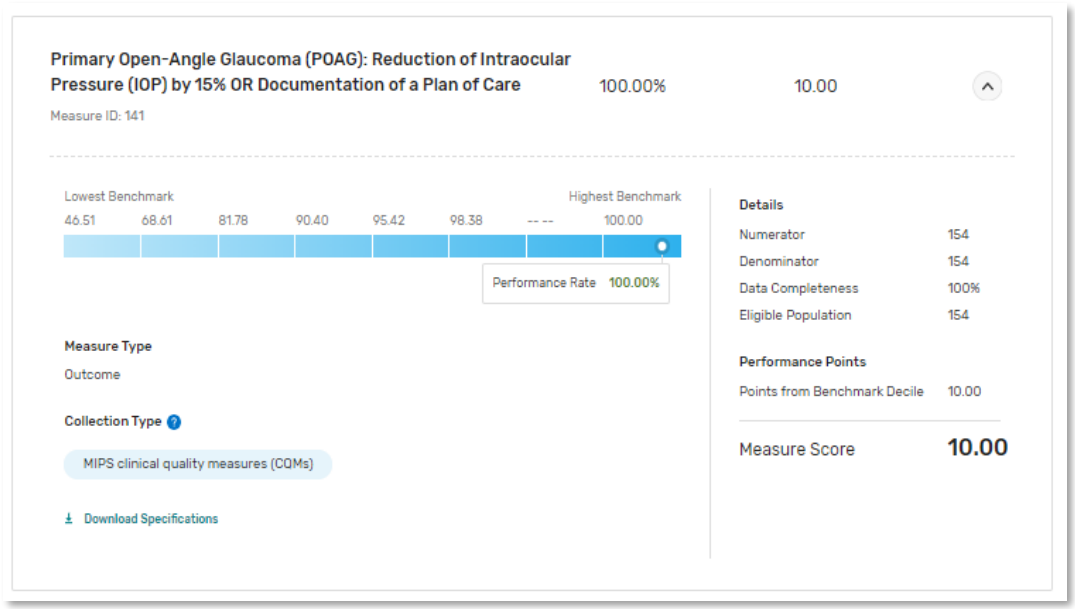
If you reported through the CMS Web Interface, you'll see "—" as the measure score for measures that were excluded from scoring because there's no benchmark, or because you didn't meet the case minimum.

How Can I Access Details About the Measures I Submitted?

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



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



Why Are Measures with Higher Performance Rates Not Counted Towards My Quality Performance Category Score?

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

I Reported 6 Measures. Why Was I Scored on Only 5 of Them?

This occurs if you submitted a measure that was suppressed from scoring. This means the measure wasn't scored and your quality denominator — the maximum number of points available — was reduced by 10 points.

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

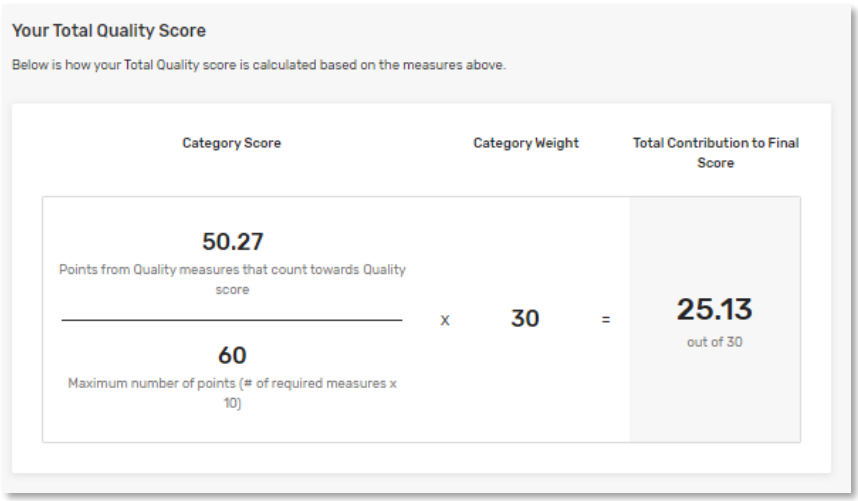
Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

How Do You Calculate My Quality Performance Category Score?

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

We divide the sum of your achievement and bonus points (only for small practices) by the maximum number of points available to you in the quality performance category, and we add that number to your quality improvement score, if applicable.

Finally, we multiply that number by the category weight.



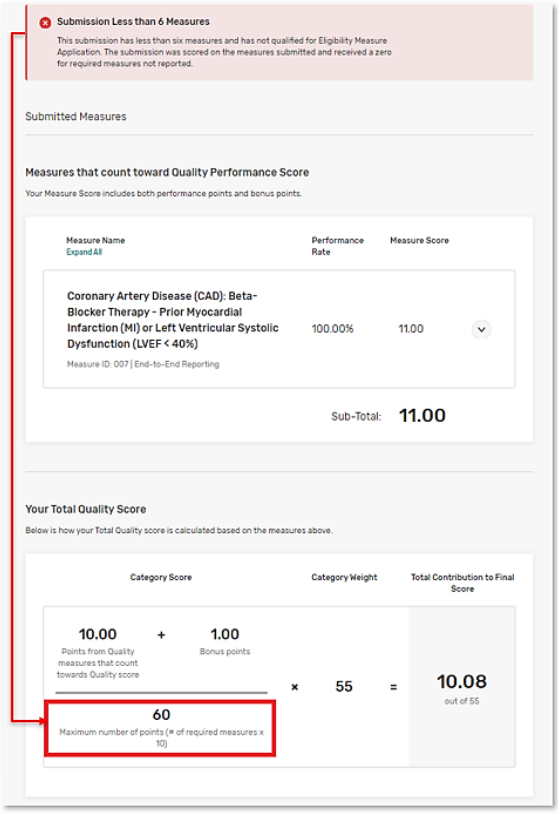
I Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures [CQMs]) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

Clinicians who don't have 6 available quality measures and who report Medicare Part B Claims measures or MIPS CQMs may qualify for the EMA process (PDF, 758 KB). This process checks for unreported, clinically related measures and can result in a denominator reduction in the quality performance category.

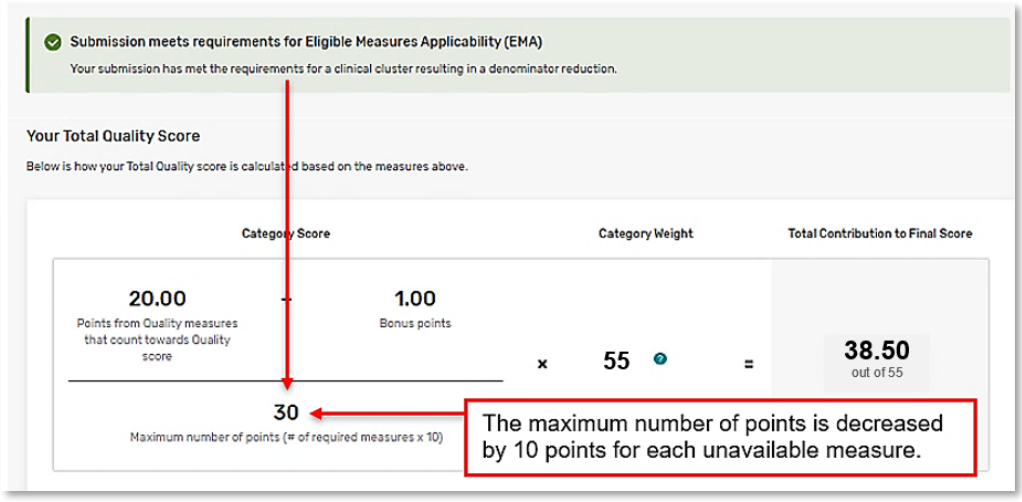
If you submitted fewer than 6 Medicare Part B claims measures or MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA. Denominator reductions are reflected in the **Total Quality Score** calculation section.

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

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



Submission (MIPS CQMs) Qualifies for Denominator Reduction



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

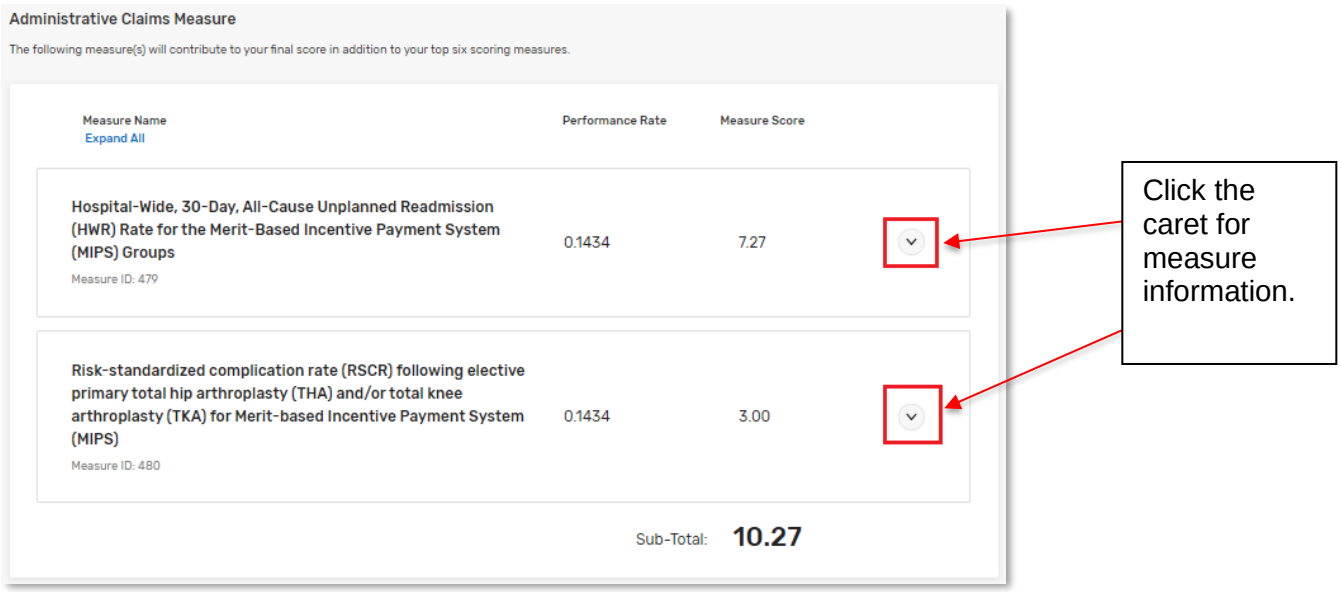
If you submitted all available Medicare Part B claims measures or MIPS CQMs and were still scored out of 60 total possible points (or 70 if you participated as a group and were scored on the All-Cause Unplanned Readmission measure), please contact the QPP Service Center for assistance.

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

Small practices only receive a group level score in the quality performance category from Medicare Part B claims if they also submitted group-level data for another performance category or categories.

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

There are 3 administrative claims quality measures in the 2022 performance year, which will only be displayed in feedback if they could be scored.



- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups.** (This measure replaced the All-Cause Hospital Readmission [ACR] measure.)
    - This measure is automatically calculated for groups, virtual groups, and APM Entities with at least 16 eligible clinicians that meet the case minimum (200 cases).
    - Review the measure specification (ZIP, 2.8 MB).

- **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).**

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

- This measure is automatically calculated for individuals, groups, virtual groups, and APM Entities that meet the case minimum (25 cases).
- Review the measure specification (ZIP, 1.9 MB).

- **Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
  - This measure is automatically calculated for groups, virtual groups, and APM Entities with at least 16 eligible clinicians that meet the case minimum (18 cases).
  - Review the measure specification (ZIP, 25.5 MB).

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

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

What Is Quality Improvement Scoring?

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

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

1. Full participation in the quality category for the current performance period in 1 of the following 3 ways:
   - Submits 6 measures (with at least 1 outcome/high-priority measure).
   - Submits a complete specialty measure set (which may have fewer than 6 measures; submits all measures in the set).
   - Submits all the measures in the CMS Web Interface.

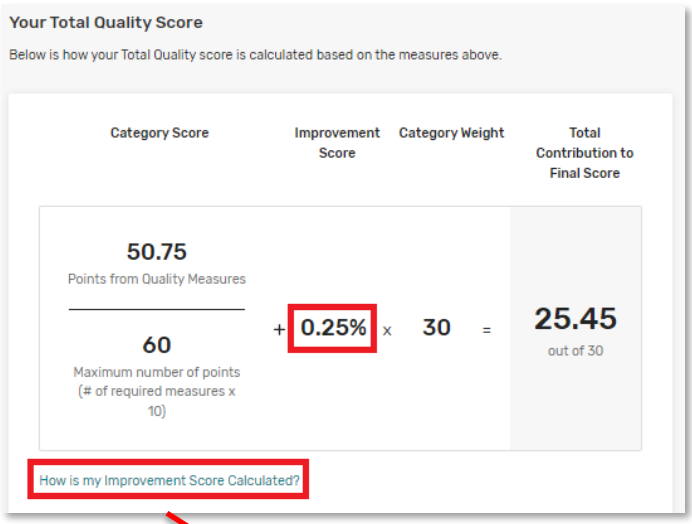
   All submitted measures must meet data completeness requirements.

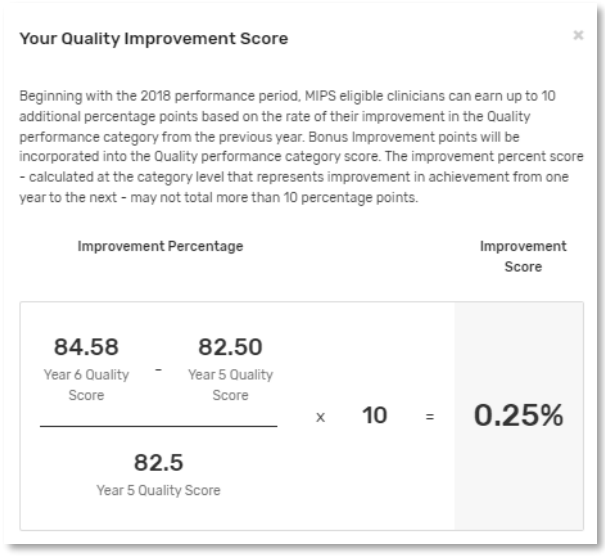
2. Data sufficiency standard is met, meaning data is available and can be compared:
   - There's a quality performance category achievement score (the score earned by measures based on performance, excluding bonus points) for the previous performance period (2021 performance period) and the current performance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

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2021) performance year to the quality performance category achievement score for

the current (2022) performance year. **Measure bonus points aren't included in improvement scoring.**



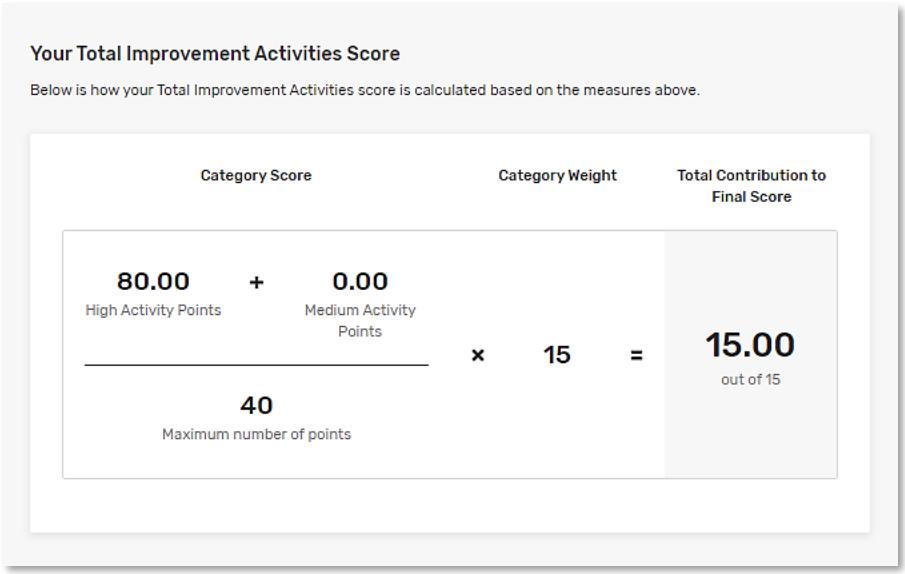


Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

Traditional MIPS: Improvement Activities

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

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



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

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

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

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

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

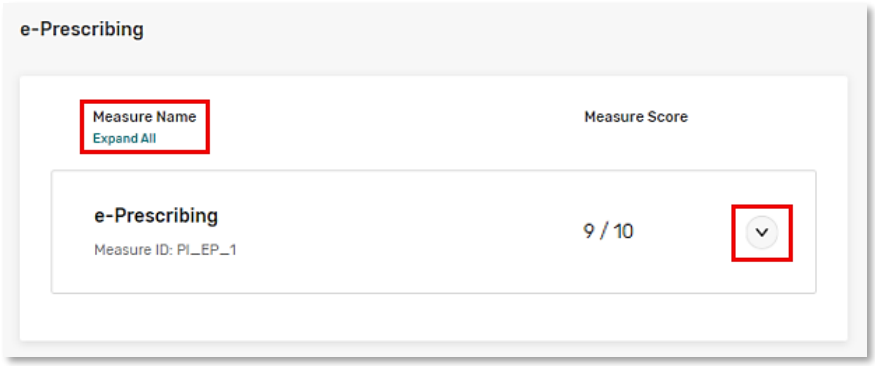
Traditional MIPS: Promoting Interoperability

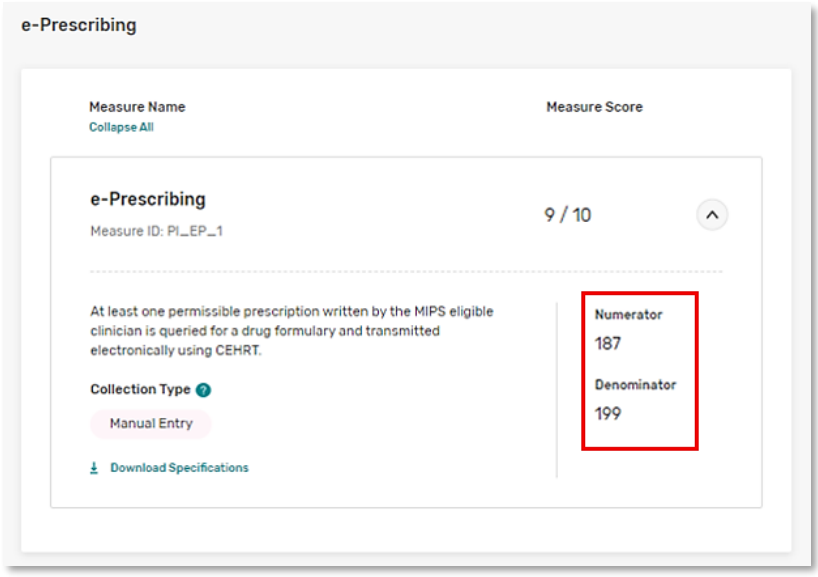
The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed.

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

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

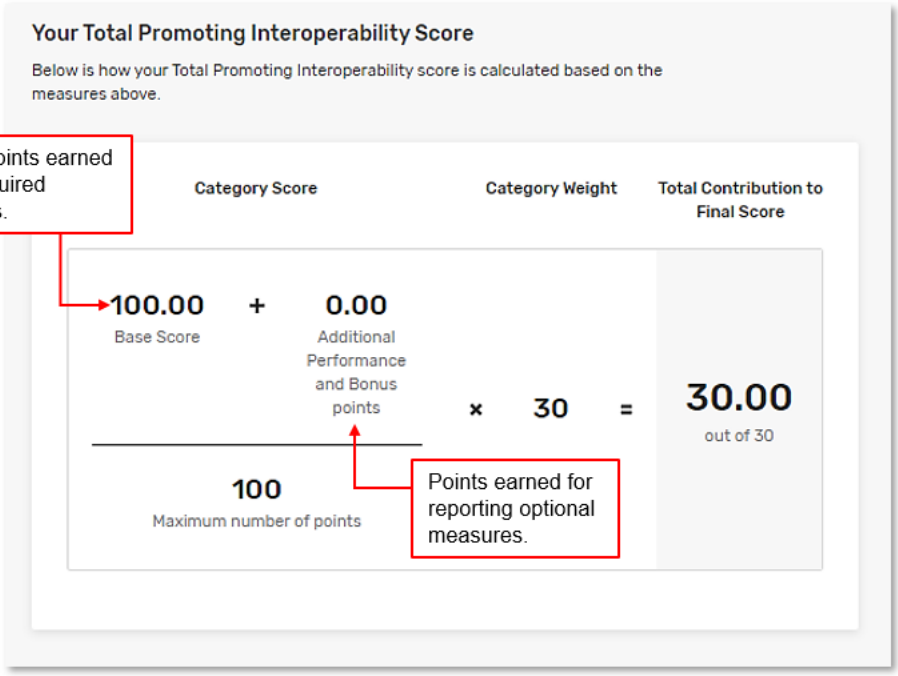
Click the arrow on the right-hand side of the measure information to see numerator/denominator details or click "**Expand All**" below **Measure Name** to see the details of all the measures in that objective.





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

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



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

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

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

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

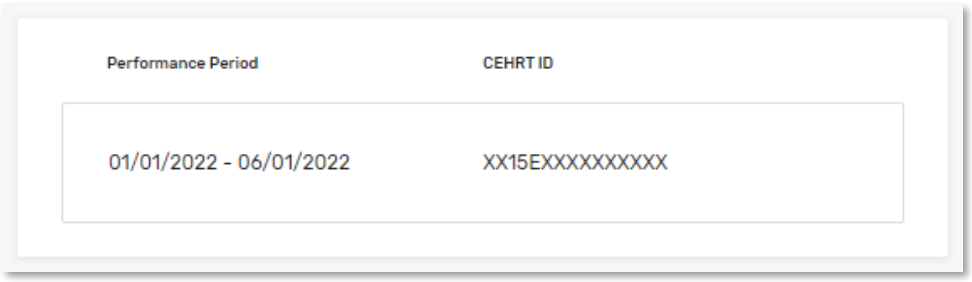
If you reported Promoting Interoperability data through multiple submission types (for example, manual entry and file upload) and there was any conflicting data, you received a score of 0 out of 30 points for the performance category.

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

What Is a CEHRT ID?

The CEHRT identification number (ID) is the CMS Certification ID for your electronic health record (EHR) product(s) proving that they're certified by the Office of the National Coordinator for Health Information Technology (ONC) to the 2015 Edition. 2015 Edition Certified EHR Technology (CEHRT) is required for reporting your MIPS Promoting Interoperability measures and can be found using the Certified Health IT Product List (CHPL) website.

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



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

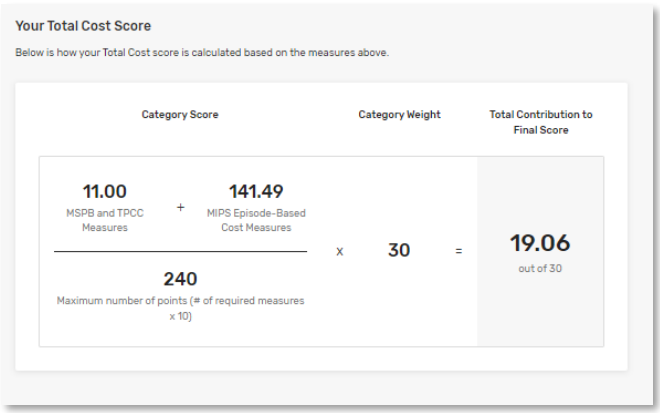
Traditional MIPS: Cost

How is the Cost Performance Category Score Determined?

There's a graphic at the bottom of the Cost page showing how we arrived at the points contributing to your final score.

- We sum the points earned for each of the cost measures you could be scored on and divide that by the maximum number of points available (10 times the number of measures you could be scored on.)
- We then multiply that by 30% performance category weight.

In the example below, the organization could be scored on all 24 cost measures available for scoring in the 2022 performance period. (As a reminder, the Simple Pneumonia with Hospitalization measure was announced as excluded via QPP listserv on 6/12/2023.)



Where Can I Find More Detailed Information about Cost Measures?

We've released patient-level cost measure reports with final performance feedback in August. These reports include details for every cost measure on which you could be scored.

Why Don't I See Any Cost Measure Information?

Only clinicians, groups, and virtual groups who could be scored on at least one measure will see cost measure information in performance feedback.

If you don't see any cost measure details and see a score of "N/A" then your group didn't meet the case minimum for any cost measures and the weight for this performance category was reallocated to another category.

Clinicians, groups, and virtual groups who were approved for reweighting in this performance category can still access measure-level and patient-level feedback if they met the case minimum for at least one cost measure.

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

At a high level, how can I interpret my score (expressed as a dollar value) on a MIPS cost measure?

A cost measure score represents how a clinician performs relative to their peers. This means that a clinician will receive fewer MIPS points on a cost measure if a clinician's average observed (i.e. actual) episode spending is higher than the expected episode spending (predicted through risk adjustment), relative to their peers. Please see the 2023 Traditional MIPS Scoring Guide (PDF, 1,871 KB) for a summary of how the cost measures are scored.

Risk adjustment accounts for factors outside of attributed clinicians' control that influence the cost of care, such as the patient's age or preexisting comorbidities. These factors include comorbidities derived from the CMS Hierarchical Condition Category (HCC) model, plus measure-specific factors that have been tailored to the condition or procedure being assessed by that particular cost measure. The risk adjustment model predicts the cost for a given episode of care ("expected cost") by running a regression, which is then compared to the actual ("observed") costs of an episode to get a ratio (observed/expected). This ratio is averaged across all episodes attributed to a clinician during a performance period and is multiplied by the national observed mean cost to generate a dollar figure for the cost measure score. This score is then translated into points in the cost performance category.

How can I use my 2022 performance year patient-level cost measure reports to address/improve my cost category performance in future performance years?

Cost measures assess costs directly related to treatment choices, as well as the costs of clinically-related adverse outcomes. Clinicians can consider the appropriate use of treatment services, such as office visits, testing and imaging, and medications. Additionally, clinicians can influence the costs of care by providing high-quality care, such as having an appropriate care plan, following clinical guidelines, conducting proactive monitoring, reconciling medications, engaging in care coordination, and providing patient education. These treatment choices can affect the likelihood and severity of costly adverse outcomes, like emergency department visits, hospitalizations and readmissions, post-acute care, and other treatment for complications, which contribute to a clinician's cost performance score.

Clinicians could engage in the following activities/strategies after receiving their patient-level cost measure reports:

- Use the "Hierarchical Conditions Categories (HCC) Percentile Ranking" figure in the TPCC, Medicare Spending per Beneficiary (MSPB) Clinician patient-level reports and the HCC figure in the episode-based cost measure patient-level reports to identify higher and lower risk patients attributed to you. Higher percentile rankings tend to be associated with more serious health conditions, including multiple chronic conditions. These patients may benefit from more intensive care coordination efforts. You may also look for opportunities to help patients at lower risk avoid the need for high-cost services (for example, outpatient emergency services).
- To the extent possible, review attributed patients' clinical history and care decisions to inform future case and condition management.
- Identify patients that could benefit from targeted interventions that could result in avoiding unnecessary and costly services and procedures.

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

What can I do during the current performance year to ensure my MIPS cost measure performance is accurately assessed?

MIPS cost measures are calculated automatically by the Centers for Medicare & Medicaid Services (CMS) using Medicare Parts A, B, and D administrative claims data. As such, it's important to accurately submit Medicare claims. For example, please ensure you fully document your patients' conditions in claims submitted to Medicare so that risk adjustment methodologies adequately capture patients' relative acuity.

You may also review the measure specifications to see which services and costs are included in the measure; this information is available in the 2022 MIPS Cost Measure Codes Lists (ZIP, 10.6 MB) and the 2022 MIPS Cost Measure Information Forms (ZIP, 10.4 MB), which are both available in the QPP Resource Library.

While providers don't directly influence the costs of services paid for by Medicare, they can meaningfully influence the volume and types of services provided to their patients. Please continue to provide your patients the right care in the most appropriate settings.

What is different in the 2022 performance year cost performance category compared with 2019 performance year when it was last scored?

The number of measures in the cost performance category has increased: in PY 2019, there were 8 episode-based cost measures and 2 population-based measures, Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC). In the 2022 performance year there are 23 episode-based cost measures and revised versions of the MSPB and TPCC measures. The cost performance category weight has also changed: it was 15% of the MIPS final score in the 2019 performance year and is now weighted at 30% in the 2022 performance year. Further, both the MSPB Clinician and TPCC measures underwent substantial revisions as part of a prior comprehensive re-evaluation, with the revised measures being implemented for MIPS starting in 2020. As such, it isn't appropriate to draw conclusions about the current MSPB Clinician and TPCC measures based on data from before 2020.

Why did my 2022 performance year episode-based cost measure score increase by a certain amount of dollars compared to my 2019 performance year score for the same measure?

Your cost measure score is shown as a dollar value that reflects the national average observed cost for that measure for that year. This means that it can't be compared across years, as the national average will change each year. Instead, you could compare your observed over expected cost ratio across years to see any changes in whether your episodes were, on average, more or less expensive than what they were predicted to be through risk adjustment. You could also compare the number of MIPS points that you received for a measure across years, as this is calculated based on your position within a performance decile; that is, how you performed relative to your peers.

Additional information on the cost measures can be found in the 2022 MIPS Cost User Guide (PDF, 1,653 KB) in the QPP Resource Library.

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

Why is my PY2022 score on MSPB or TPCC worse (i.e. higher) than it was in calendar year 2019?

Please note that the MSPB Clinician and TPCC measures in 2022 performance year are substantially different from the versions that were calculated in the2019 performance year. As such, any comparison of performance on MSPB Clinician or TPCC from the2019 performance year to the 2022 performance year should take into consideration the extensive changes to specifications. Please see Appendix A in these methodology documents from an earlier year for a table comparing the key specifications changes as a result of comprehensive reevaluation: Revised TPCC Measure Cost Measure Methodology (ZIP, 901 KB) and the Revised MSPB Measure Cost Measure Methodology (ZIP, 2.6 MB). For the methodology used in both measures in the2022 performance year, please refer to the 2022 MIPS Cost Measure Information Forms (ZIP, 10.4 MB).

Can a clinician be scored on an episode-based cost measure if that clinician isn't individually attributed episodes for the measure?

Yes. Due to the nature of MIPS group reporting, it's expected that some specialists may be scored on the episode-based cost measures even if the clinician isn't individually attributed episodes for those measures. Clinicians may be participating in MIPS as part of a group practice that's attributed sufficient episodes under those measures to meet the established case minimum. If a clinician participates in MIPS as part of a large group practice that provides a variety of care, it's reasonable that they may be attributed a measure assessing costs of services that they didn't provide but that someone else from their group did provide. This is similar to group reporting for quality measures, where a clinician may be scored for a quality measure that's outside the specific care they provide.

Questions related to the COST_D_1 (Diabetes) Measure:

Why is an ophthalmologist being scored on the Diabetes measure (COST_D_1)?

The Diabetes measure intends to capture the role of the clinicians managing a patient's diabetes, which can consist of both primary care clinicians and specialists. Therefore, it's expected that some ophthalmologists may be scored on the Diabetes and other episode-based cost measures as part of a group practice, even if the clinician isn't attributed episodes for those measures. By encompassing this range of clinicians, the measure aims to identify the care team based on the care provided. It also reflects input from persons with lived experience of diabetes about the range of clinicians who they saw as being part of their diabetes management team, and as such, encourages care coordination. More information on how clinicians are attributed diabetes episodes can be found in the Chronic Condition Episode-Based Cost Measures Attribution Methodology supplemental documents (ZIP, 1,642 KB) or in the 2022 Measure Information Forms (ZIP, 10.4 MB) ZIP file.

The identification of a care relationship isn't limited by specialty but is instead identified using specific relevant billing codes ("trigger codes") for services and diagnoses specific to diabetes care. These trigger codes were identified and refined over an 18-month period with detailed input from the Clinician Expert Workgroup, and are listed in the "2021-12-08-codes-list-diabetes.xlsx" file available in the 2022

MIPS Cost Measure Codes Lists (ZIP, 10.6 MB) ZIP file (other years are available in the QPP Resource Library as well.)

The trigger codes are used to identify a clinician-patient relationship for diabetes. TINs must bill 2 of these codes to a given patient within 180 days to be attributed a Diabetes episode. TIN-NPIs are attributed the episode if they're part of the attributed TIN and provide 30% or more of the services used for attribution within that episode. For both TINs and TIN-NPIs, there's a 20-episode case minimum to be scored on the Diabetes measure. The measure also requires that a TIN-NPI must have billed at least 2 diabetes-related prescriptions on different days to 2 different patients during the measurement period plus a one-year lookback period. This final check ensures that the measure is accurately capturing the intended clinician role.

You can also find additional information on the construction of the Diabetes measure in the Measure Information Form (PDF, 4.5 MB).

Why doesn't the Diabetes measure (COST_D_1) use specialty exclusions like TPCC to remove specialists who only provide care for diabetes complications, rather than diabetes?

This and other episode-based cost measures are clinically refined and focus on specific conditions or procedures, unlike TPCC, which is an all-cost measure that broadly applies to clinicians with a primary care-type relationship with patients. As such, the Diabetes measure was developed with nuanced trigger, attribution, service assignment, and exclusion rules that are intended to reflect the role of clinicians in providing care for patients with diabetes. This allows the measure to apply to specialists who are providing the type of care intended by the measure without using broad specialty exclusions, since there can be much variation in practice patterns within specialties.

Questions Related to the COST_IOL_1 (Routine Cataract Removal with Intraocular Lens Implantation) Measure:

Can you explain what the Cataract Removal (COST_IOL_1) measure is?

COST_IOL_1 is an episode-based measure that focuses on routine cataract removal procedures with intraocular lens (IOL) implantation. The procedure is identified with the CPT/HCPCS 66984 trigger code. The clinician who bills that code is responsible for the episode of care; in other words, they're attributed the episode.

An episode of care (or "episode") starts 60 days prior to this cataract removal procedure and ends 90 days after it. During this period, all Medicare Part A and B services are evaluated, and only the costs of services that are clinically related to cataract removal are included in the measure. These services include the procedure and related treatment, follow-up care, adverse outcomes (e.g., complications), and other types of care. A full list of assigned services for the measure can be found in the "Service_Assignment" tab of the Measure Codes List file.

The Routine Cataract Removal with IOL Implantation measure is also risk adjusted. Risk adjustment facilitates a more accurate comparison of cost across clinicians by adjusting the total cost of clinically related services for clinical factors that can influence spending, such as a patient's age and comorbidities. Risk adjustment aims to isolate the clinicians' cost variation to just those costs that clinicians can reasonably influence. Accounting for these factors is one way to ensure the validity of cost measures and mitigate potential unintended consequences.

A clinician's cost performance for this measure is evaluated using these episodes for all clinicians with at least 10 episodes. The measure compares the actual (or "observed") costs occurring during each episode to the predicted (or "expected") costs (as estimated through the risk adjustment model). That is, a ratio of observed over expected costs is calculated for each episode attributed to the clinician. The average episode cost ratio is then calculated by taking the average of the observed over expected costs ratio across all of the episodes attributed to a clinician during the performance period (e.g., Calendar Year 2022). A ratio greater than one means that the attributed clinician had more expensive episodes overall than would be expected for the patients and episodes included, and vice versa. The final step is to multiply this ratio with the national observed mean cost to generate a dollar figure for the cost measure score.

You can also find additional information on the construction of the Routine Cataract Removal with IOL Implantation measure in the Measure Information Form and the Measure Codes List file documents available in the QPP Resource Library.

What services are included in the Cataract Removal measure?

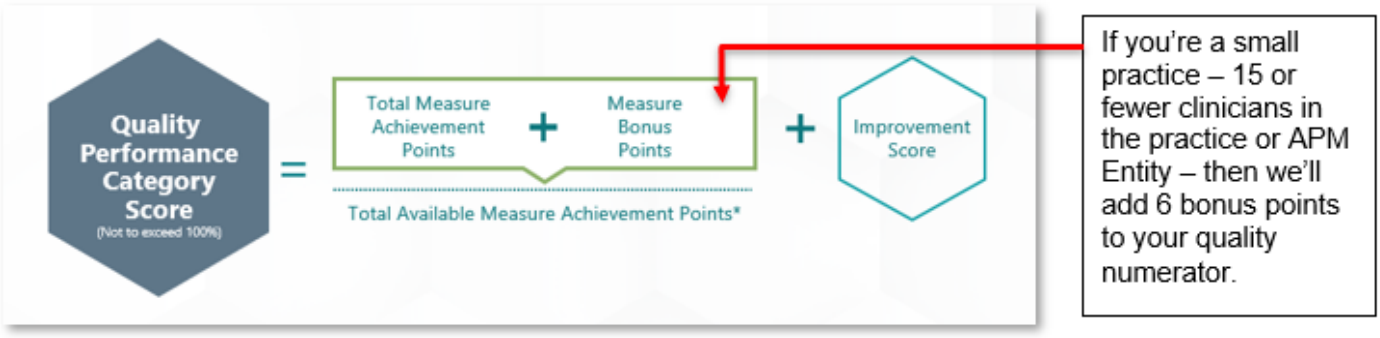
You can find a detailed list of assigned services for the Cataract Removal measure in the "2021-12-08-codes-list-cataract.xlsx" file available in the 2022 MIPS Cost Measure Codes Lists (ZIP, 10.6 MB) ZIP file (other years are available in the QPP Resource Library as well).

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

APM Performance Pathway (APP): Quality

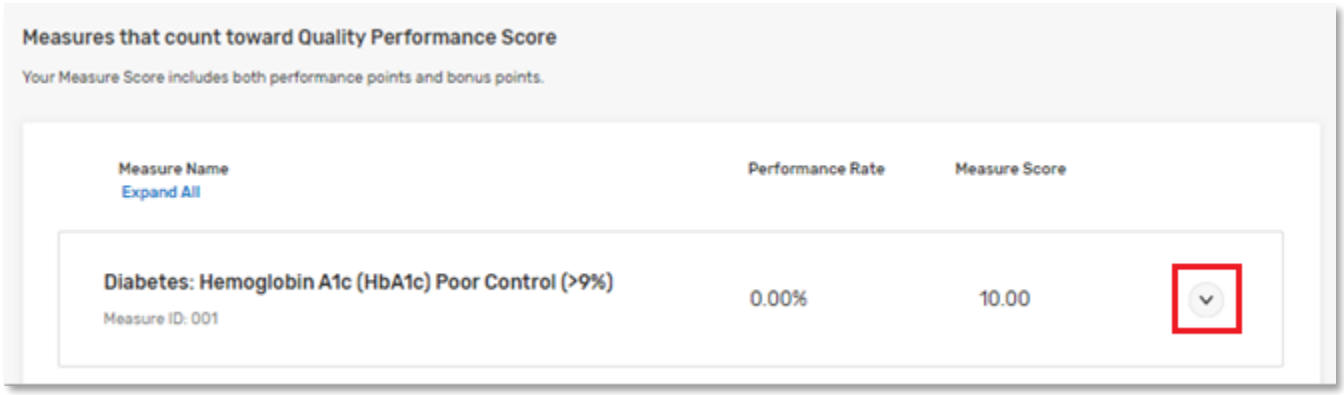
How Was Our Quality Score Calculated?

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

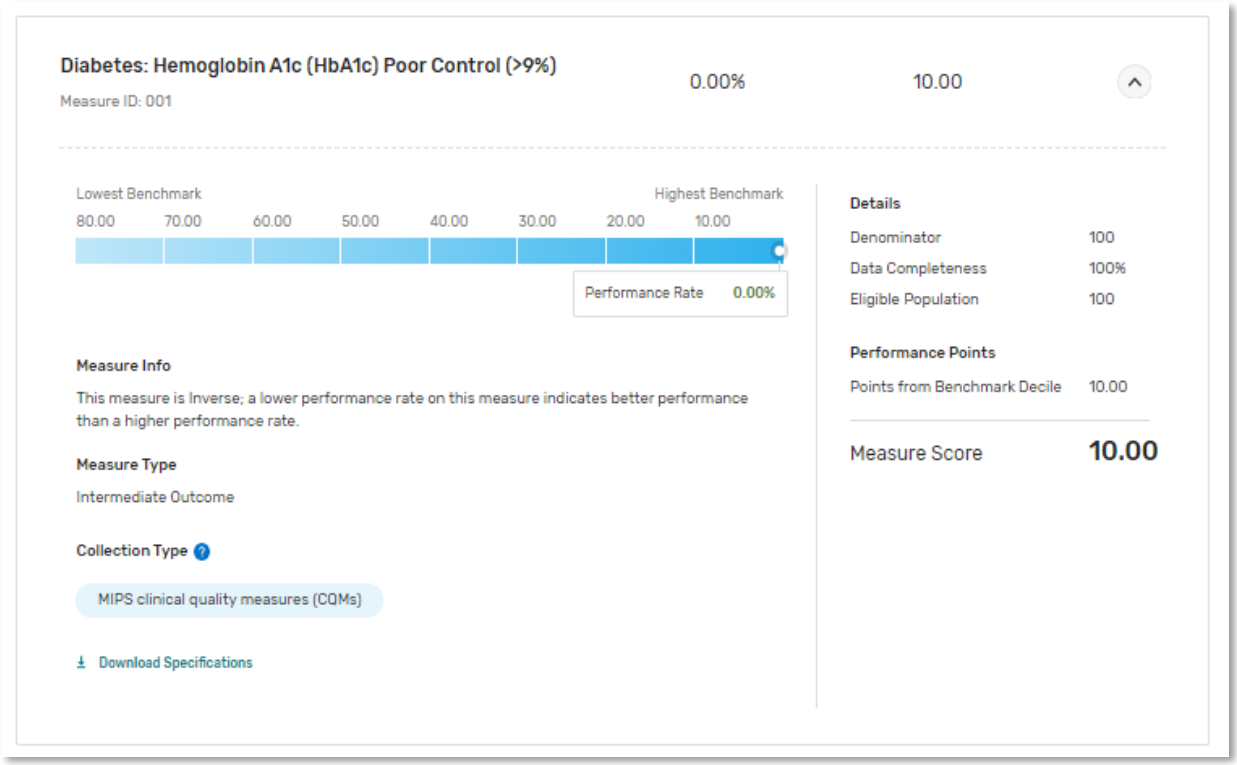


As you scroll down the page, you'll see all of the measures that contributed to your score. Because the APP requires a specific set of measures, you'll see "0.00" points for any measure that was required but unreported.

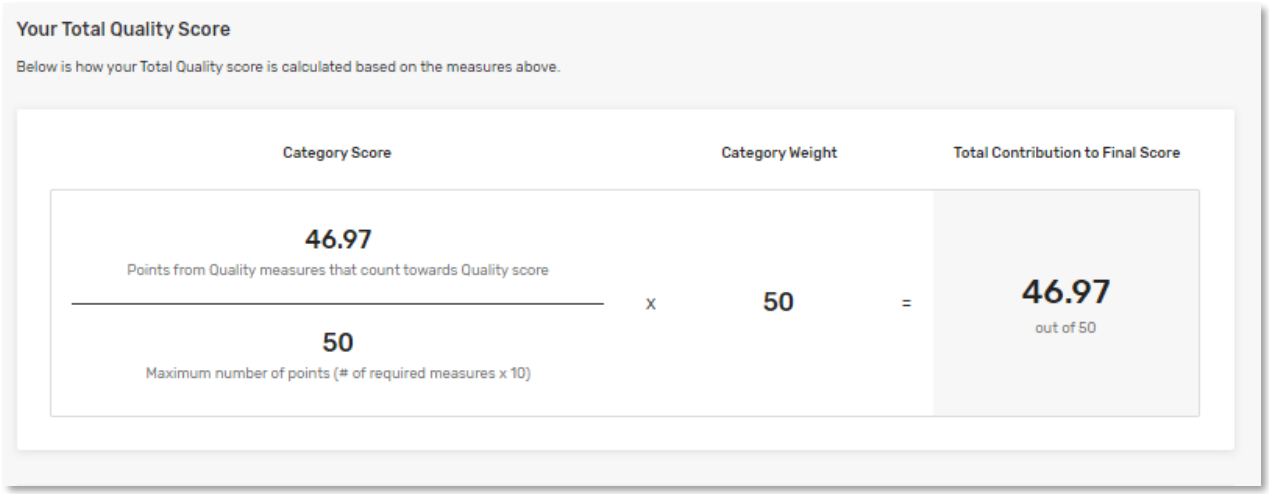
To access measure details, click the caret to the right of the measure score.



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



At the bottom of the page, you'll see the calculation to arrive at your quality score.



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

Why Wasn't I Scored on All the Quality Measures that I Submitted?

As a reminder, 2 of the quality measures required under the APP were suppressed for the eCQM collection type in the 2022 performance period:

- Quality ID 134 / Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Quality ID 236 / Controlling High Blood Pressure

If you submitted either of these measures as an eCQM and met data completeness and case minimum requirements, the measure(s) was excluded from scoring and the maximum number of points available in the quality category was reduced by 10 points (per measure). If you submitted either of these measures as both an eCQM and a MIPS CQM, the measure(s) were excluded from scoring for both collection types.

CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet reporting requirements for such measures.
The following CMS Web Interface measures don't have a benchmark for the 2022 performance year:

- Quality ID 438 / Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- Quality ID 370 / Depression Remission at Twelve Months

In the CY 2023 Medicare Physician Fee Schedule Final Rule, we finalized retroactively setting flat percentage benchmarks to score the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) measure and the Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) measure for the 2022 performance year using our authority under §1871(e)(1)(A) of the Social Security Act.

What Is Quality Improvement Scoring?

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

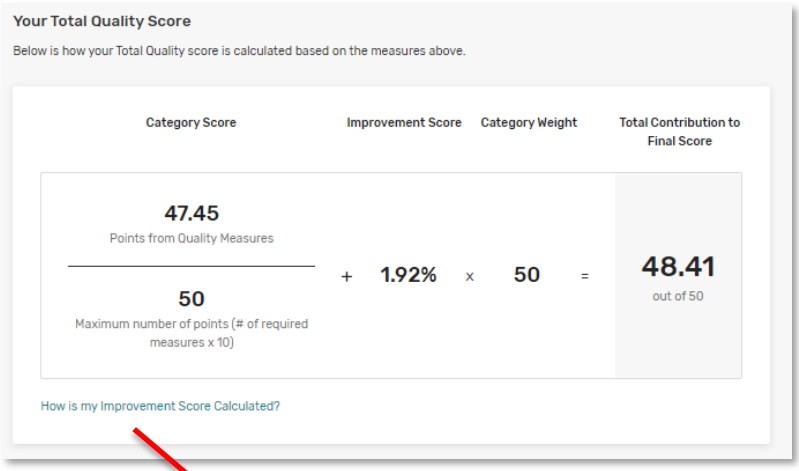
You'll be evaluated for improvement scoring for the 2022 performance year when you:

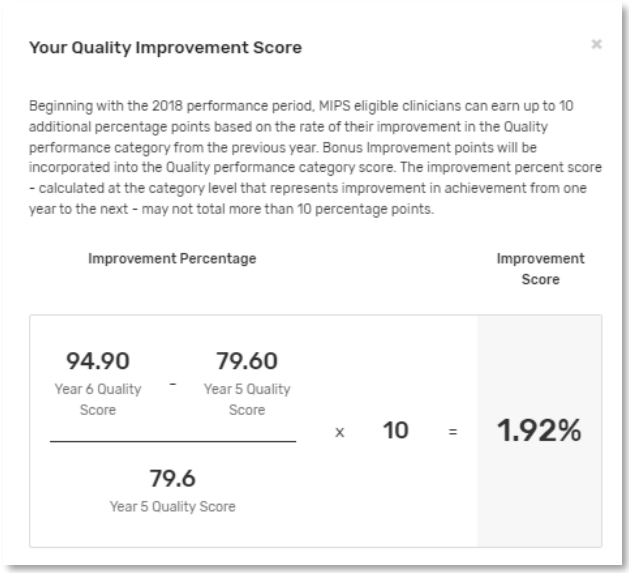
- Meet the quality performance category requirements for the current performance year.
- Have a quality performance category achievement score based on reported measures for the previous (2021) performance year.
- Submit data under the same identifier (such as ACO ID or TIN) for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2021) performance year to the quality performance category achievement score for

the current (2022) performance year. **Measure bonus points aren't included in improvement scoring.**



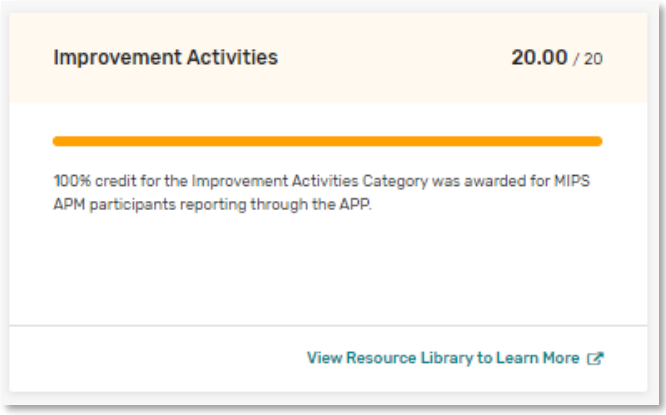


Please note: All screenshots are for illustrative purposes only.
Screenshots don't represent real clinicians, organizations, or payment adjustments.

APM Performance Pathway: Improvement Activities

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

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



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

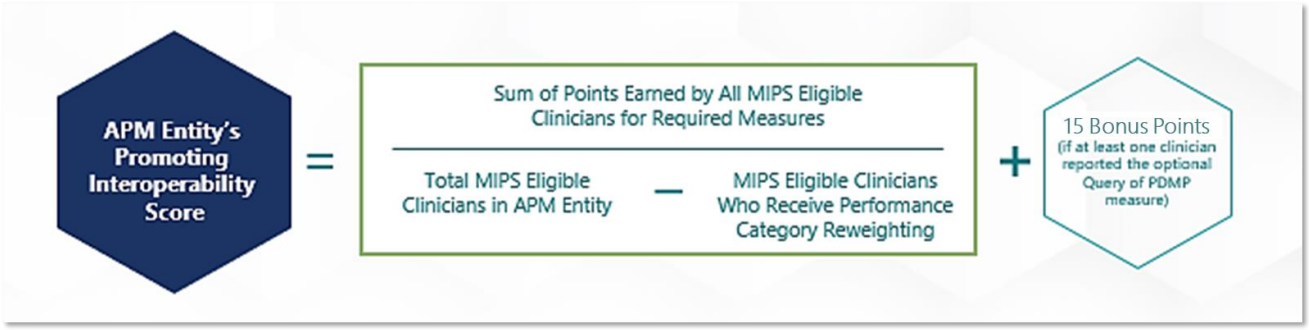
APM Performance Pathway: Promoting Interoperability

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

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

- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting. If you're participating as an APM Entity such as a Shared Savings Program ACO, we'll calculate a score for the APM Entity as a weighted average of the scores received from individual and/or group submissions.

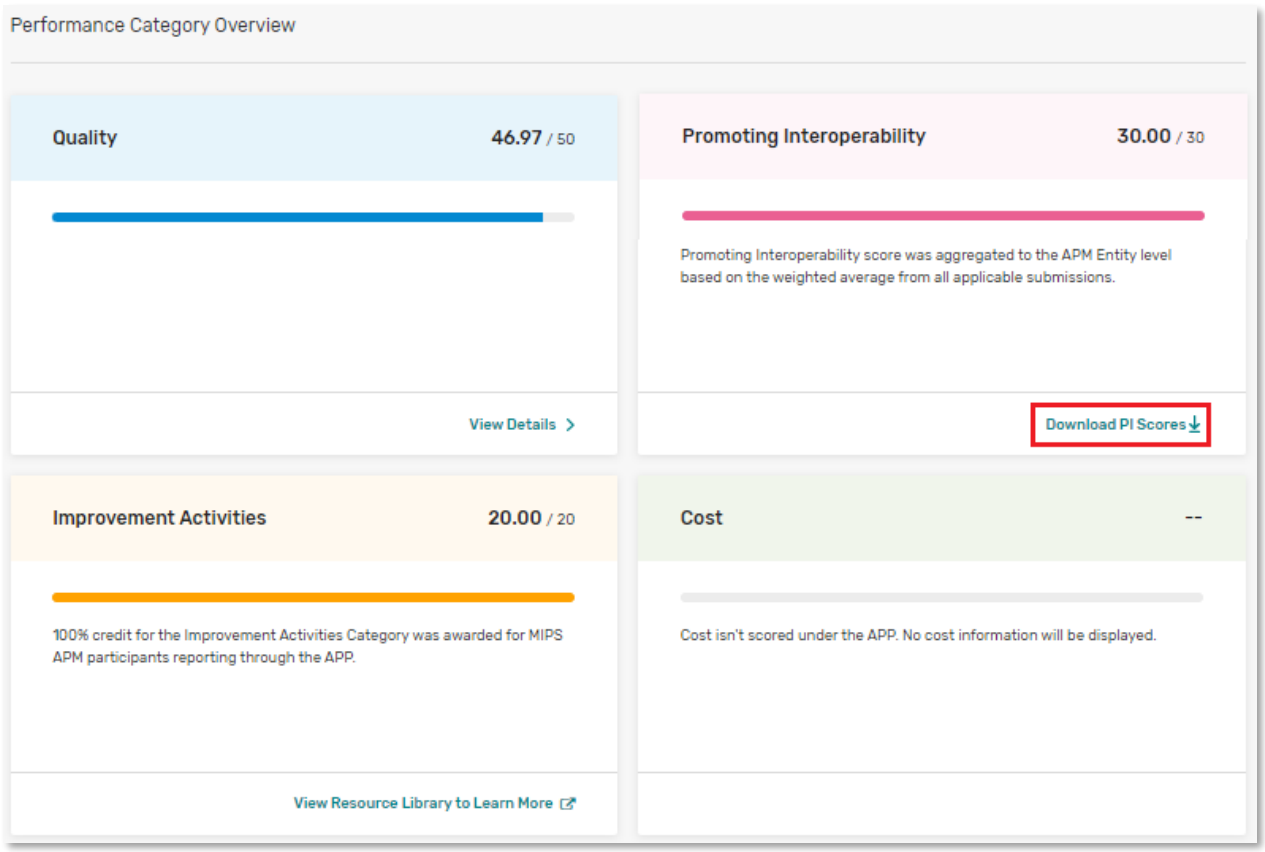
- The APM Entity received up to 15 bonus points if at least one individual or group in the APM Entity reported the optional Query of PDMP measure or any of the optional measures within the Public Health and Clinical Data Exchange objective), but the Promoting Interoperability performance category score can't exceed 100%.



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

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

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



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

Facility-Based Scoring

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

There's no facility-based scoring available in the 2022 MIPS performance year. In the Fiscal Year (FY) 2023 Inpatient Prospective Payment System (IPPS) /Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, the Centers for Medicare & Medicaid (CMS) finalized the suppression of several measures in the Hospital Value-Based Purchasing (VBP) Program for the 2023 fiscal year due to the effect of COVID-19 on measure performance.

As announced through the QPP listserv on 8/5/2022, we believed that calculating a total performance score in the Hospital VBP Program for hospitals using only data from the remaining measures wouldn't result in a fair national comparison. As a result, we didn't calculate a 2023 fiscal year total performance score under the Hospital VBP Program for any hospital.

We use the total performance score from the Hospital VBP Program to calculate facility-based scores for facility-based clinicians and groups in the quality and cost performance categories. The FY 2023 total performance score is what we would use to determine these scores for the 2022 MIPS performance period.

- Because the 2023 fiscal year total performance score from the Hospital VBP Program wasn't available, we couldn't calculate MIPS facility-based scores for the 2022 MIPS performance year.

Items and Services

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

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

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

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

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

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

- **Level I HCPCS Codes**: Codes and descriptors copyrighted by the American Medical Association's (AMA) Current Procedural Terminology (CPT®), fourth edition (CPT-4). These are 5 position numeric codes representing services of physicians, non-physician practitioners, and other suppliers.
- **Level II HCPCS Codes**: Alphanumeric codes consisting of a single alphabetical letter followed by 4 numeric digits. Level II HCPCS codes are used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes and descriptors are maintained and distributed by CMS.[1]

What Is a CPT Code?

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

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

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

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

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

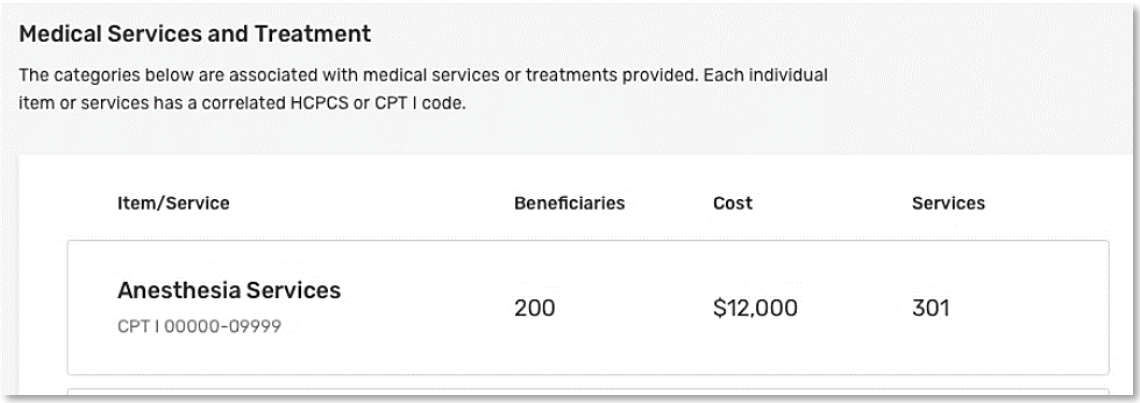
HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS	
00000-09999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital,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

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

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

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

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Types 71 and 72) billed with dates of services between January 1, 2022, and December 31, 2022, and received by CMS within 60 days of December 31, 2022 (a "60-day runout").



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

For individual clinicians, this number includes all unique Part B-enrolled patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the ~~CY~~ 2021 calendar year AND at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the 2022 calendar year.

For groups, this number includes all Part B-enrolled patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the 2022 calendar year AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the 2022 calendar year.

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

The cost reflected in the Items and Services section of performance feedback is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines with dates of service 1/1/-2022-12/31/2022. These numbers are raw allowed charge amounts and aren't payment standardized, risk adjusted, or specialty adjusted.

For individual clinicians, the number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the 2022 calendar year AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any provider during the 2022 calendar year.

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

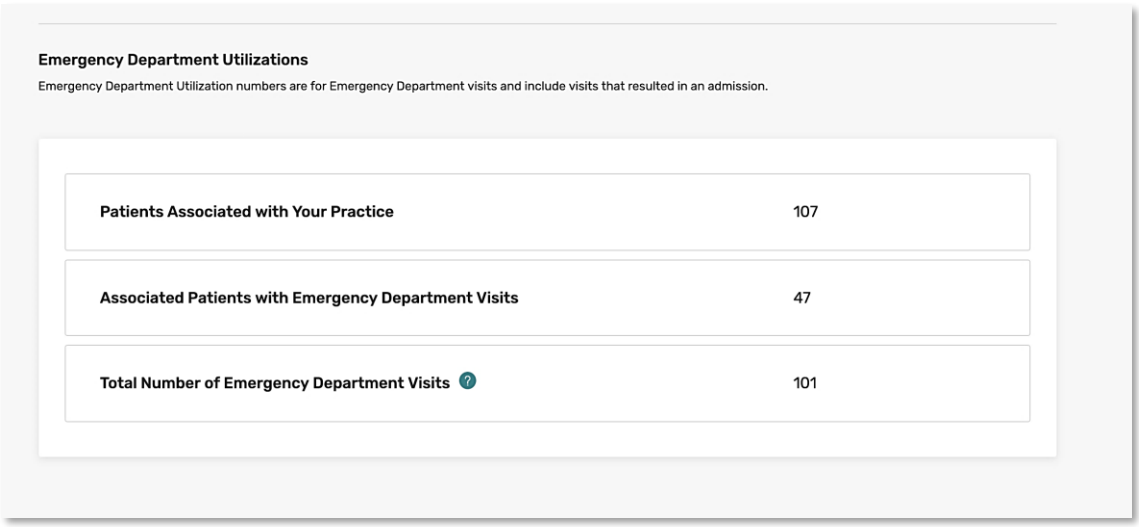
For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the 2022 calendar year AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during the 2022 calendar year.

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

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during the 2022 calendar year AND received at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during the 2022 calendar year.

For groups, this number is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during the 2022 calendar year AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during the 2022 calendar year.

Emergency Department Utilization



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

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

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

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

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

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

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

Step 2: If a patient didn't receive a primary care service from a TIN/NPI classified as a PCP, NP, PA, or CNS during the performance period, then the patient may be assigned to a TIN/NPI in "Step 2." If a patient received more primary care services from a specialist physician's TIN/NPI than from any another clinician's TIN/NPI during the performance period, then the patient is assigned to the specialist physician's TIN/NPI.

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

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

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

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

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

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

This metric reflects the number of attributed patients who also had an ED visit in CY 2022. An ED visit is defined as any CY 2022 claim with a claim line containing any of the following ED revenue center codes: 0450 – 0459 and/or 0981.

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

The figure reflects the actual number of ED visits across all attributed patients in CY 2022.

General Questions

Can I Download Feedback Reports?

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

What If We Find an Error with our Payment Adjustment/Performance Feedback?

If you believe an error has been made in the calculation of your 2024 MIPS payment adjustment, you have until 8 p.m. ET on 10/9/2023 to request a targeted review.

However, we encourage you to contact the QPP Service Center before submitting a targeted review, if possible. You may be experiencing an issue we've already identified as impacting clinicians and groups and are working to address outside of the targeted review process. We can best serve you if you use the Print feature within feedback ("save as PDF") and attach this information to your case.

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday – Friday, 8 a.m. – 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

What's a Targeted Review?

A targeted review is a process through which MIPS eligible clinicians, groups, and MIPS APM participants (individual clinicians, participating groups, and the APM Entity) can request that CMS review the calculation of their MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. For more information on the targeted review process, please review the 2022 Targeted Review User Guide.

We continue to listen to you and make improvements to the system based on your feedback.

There may be slight variation between the information and screenshots in this document and what you see on your screen.

Contact the Quality Payment Program if you have questions about a discrepancy.

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

Where Can I Learn More?

- Quality Payment Program website
- 2022 APM Performance Pathway Toolkit (ZIP, 3.3 MB)

Version History

Date	Change Description
10/16/2023	Added additional FAQs to the Traditional MIPS: Cost section
08/10/2023	Original Posting.

Appendix A: Automatic Extreme and Uncontrollable Circumstances Policy

Performance Category Weights and Payment Adjustment Based on Individual Data Submission

The table below illustrates the 2022 performance category reweighting policies that apply to individual clinicians under the MIPS automatic EUC policy, including those that submit MIPS data as individuals. (This doesn't reflect reweighting for clinicians scored under the APM scoring standard.)

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for 1 Performance Category					
Quality Only	100%	0%	0%	0%	Neutral
Promoting Interoperability Only	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities **and** Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality **and** Improvement Activities **and** Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral

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

Appendix B: Extreme and Uncontrollable Circumstances Exception Application

Performance Category Reweighting Scenarios

The table below identifies the performance category reweighting scenarios applicable to groups and virtual groups with an approved EUC application for the 2022 performance year. (APM Entities could also submit EUC applications but were required to request reweighting in all performance categories.)

Please note that we have updated the table to reflect the 0% reweighting of the cost performance category for everyone in the 2022 performance year.

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

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

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

Reweighting Scenario	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No Quality, No Cost, No Promoting Interoperability	0%	0%	100%	0%	Neutral
No Cost, No Improvement Activities, No Promoting Interoperability	100%	0%	0%	0%	Neutral
Reweight 4 Performance Categories					
All performance categories reweighted to 0%	0%	0%	0%	0%	Neutral

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

Appendix C: Final Score Preview Based on Access

This table provides a snapshot of what you **can** and **can't view** within performance feedback based on your access and organization type.

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

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

With This Access	You CAN	You CAN'T
Clinician Role	✓ View your performance feedback for all and preview final scores applicable to all of your TIN/NPI combinations ✓ View and download payment adjustment data	X View performance feedback for other clinicians
Staff User or Security Official for a **Virtual Group**	✓ View virtual group-level performance feedback ✓ View payment adjustment ✓ Access patient-level reports for administrative claims cost and quality measures	X View performance feedback about data submitted by individuals or practices in your virtual group

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

Appendix D: Quality Measures with Scoring Changes

The following measures have MIPS scoring changes due to changes in clinical guidelines during the 2022 performance period, or because specifications were determined during or after the performance period to have substantive changes.

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

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

Measure 134 / Preventive Care and Screening: Screening for Depression and Follow-Up Plan	eCQM (CMS2v11) MIPS CQM Medicare Part B Claims Measure	Measure was significantly impacted by ICD--10 coding changes. (Note: The CMS Web Interface specification for this measure wasn't determined to be significantly impacted.)	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points. Truncated performance period — those reporting this measure as a MIPS CQM should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission. CMS will truncate the performance period automatically for Medicare Part B claims reporting. If this measure is submitted as both an eCQM and a MIPS CQM, the measure will be excluded from scoring from both collection types.
Measure 236 / Controlling High Blood Pressure	eCQM (CMS165v10) MIPS CQM	eCQM specification was significantly impacted by ICD-10 coding changes. (Note: The other collection types for this measure weren't determined to be significantly impacted.)	This measure will be excluded from scoring if it's submitted as an eCQM, and your quality denominator will be reduced by 10 points. If this measure is submitted as both an eCQM and a MIPS CQM, the measure will be excluded from scoring from both collection types.
Measure 238 / Use of High-Risk Medications in Older Adults	MIPS CQM	Quality Measure Implementation Resulting in Misleading Results: During the annual measure revision process, a second submission criteria was added to this measure. As part of the	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.

		revision, the Quality Data Codes (QDCs) utilized for Performance Met (G9367) and Performance Not Met (G9368) in Submission Criteria 1 were also included as QDCs for Performance Met and Performance Not Met Numerator Options in Submission Criteria 2, which makes it difficult to differentiate which quality action should be attributed to each submission criteria. As a result, when these specific QDCs are submitted, it isn't known to which submission criteria the specific QDCs are applicable or if each quality action was met. Due to this error, it isn't possible to accurately assess numerator compliance. Suppression Rationale: CMS determined that this measure has undergone a significant change that may result in misleading results, due to the inability to accurately delineate the quality action for each submission criteria. Clinicians, groups, and/or virtual groups won't be able to correctly document quality actions in the 2022 performance period and would be unable to identify the applicable numerator option for each submission criteria. (Note: The eCQM specification for this measure wasn't determined to be significantly impacted.)	
Measure 259 / Rate of Endovascular Aneurysm Repair	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of

(EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2)			the performance period (January 1 – September 30, 2022) in their submission.
Measure 281 / Dementia: Cognitive Assessment	eCQM (CMS149v10)	Measure significantly impacted by ICD-10 coding changes	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 282 / Dementia: Functional Status Assessment	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 283 / Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 286 / Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.

Measure 288 / Dementia: Education and Support of Caregivers for Patients with Dementia	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 326 / Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	MIPS CQM	A typographical error was introduced into the measure specifications by the measure steward during the annual measure update. This led to an incorrect denominator exception, which likely will impact reporting and performance of this measure. The denominator exception affected by this typographical error is intended to offer MIPS eligible clinicians/groups a medical reason for not prescribing an FDA-approved oral anticoagulant for denominator eligible patients. Due to this error, the denominator exception now includes a patient population that's already excluded from the denominator of the measure, and no longer allows a medical exception for denominator eligible patients that weren't prescribed an FDA-approved oral anticoagulant.	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 366 / Follow-Up Care for Children Prescribed ADHD Medication (ADD)	eCQM (CMS136v11)	Measure significantly impacted by ICD--10 coding changes	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 383 / Adherence to Antipsychotic	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include

Medications For Individuals with Schizophrenia			data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 415 / Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 416 / Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	MIPS CQM Medicare Part B Claims Measure	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure as a MIPS CQM should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission. CMS will truncate the performance period automatically for Medicare Part B claims reporting.
Measure 465 / Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries	MIPS CQM	Measure significantly impacted by ICD--10 coding changes	Truncated performance period — those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.

Appendix E: Cost Measures with Scoring Changes

The following measures have MIPS scoring changes due to changes in clinical guidelines during the 2022 performance period, or because specifications were determined during or after the performance period to have substantive changes.

Cost Measure ID/Name	Reason for Measure Change	Impact on Scoring, Submission, and Feedback Expectations
COST_SPH_1/ Simple Pneumonia with Hospitalization	The Simple Pneumonia with Hospitalization episode based cost measure was impacted by the introduction of a new diagnosis code for pneumonia. Specifically, an ICD-10 diagnosis code for pneumonia due to COVID-19 (J12.82) came into effect, including additional guidance on reporting these instances as secondary to COVID-19 (U07.1), in January 2021. These coding changes impacted the scope of pneumonia cases captured by this measure.	This measure will be excluded from scoring and won't contribute to the MIPS cost performance category score. This measure won't be included in performance feedback.

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

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

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

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

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

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

Appendix G: Medical Specialists, Surgeons, and Other Physicians Included in the Second Step Attribution (continued)

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

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

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

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

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

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