Merit-based Incentive Payment System (MIPS)

2022 Data Submission User Guide

Quality Payment
PROGRAM

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How to Use this Guide

How to Use This Guide

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

Table of Contents

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

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

Hyperlinks

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

Quality Payment
PROGRAM

Getting Started

Getting Started

Accessing the System

In order to sign in to the QPP website and submit Performance Year 2022 data and/or view data submitted on your behalf, you need:

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

Make sure you sign in during the submission period to review data submitted on your behalf.

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

If you don't already have an account or access, review the following documentation in the QPP Access User Guide so you can sign in to submit, or view, data:

Once you sign in, you can select **Start Reporting** on the main page or **Eligibility & Reporting** from the left-hand navigation bar.

DISCLAIMER:

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

Before You Begin

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

- Chrome
- Edge

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

Getting Started

Quality Payment PROGRAM

Organization Type

From here, you'll see the organizations you have permission to access. Most users will only have access to one organization type:

- **Registry** (includes Qualified Registries and QCDRs) or
- **Practice** (individual and/or group reporting, all performance categories) or

Learn how to connect to an organization as a practice.

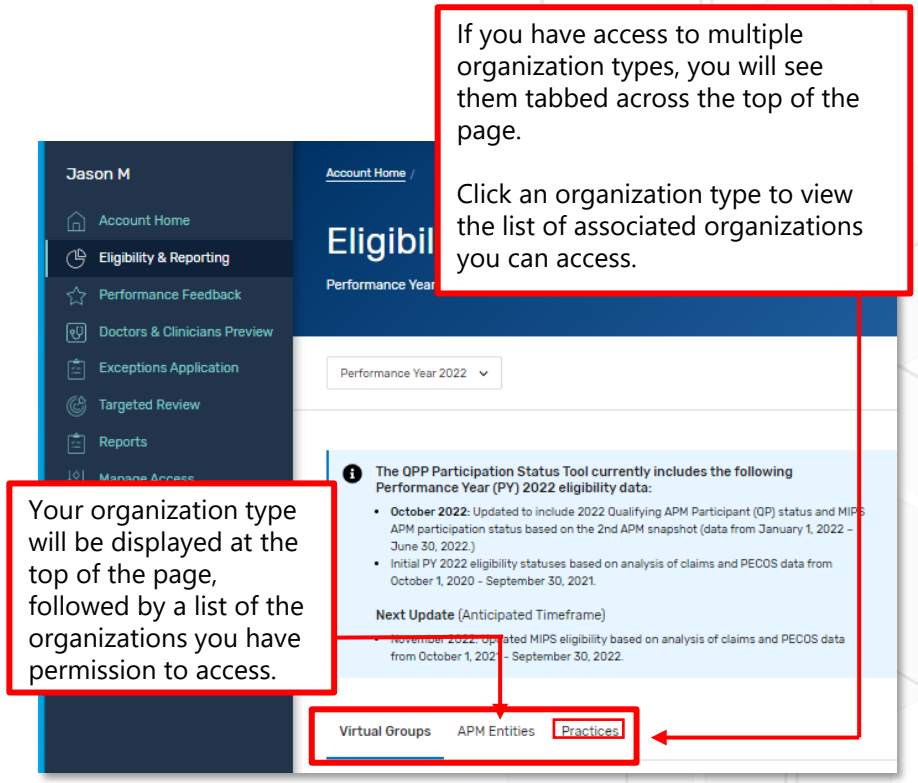
- **APM Entity** (APM Entity-level quality and improvement activities performance categories data submission) or

Learn how to connect to an organization as an APM Entity.

- **Virtual Group** (virtual group reporting, all performance categories)

Helpful Hint

Click the links, or jump to Appendix B, to review what users associated with each organization type can and can't do and view during the submission period.



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Understanding What Information is Available by Organization Type

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Overview

This section reviews the information that can be accessed and viewed by users with the staff user or security official roles for different organization types – registries, practices, APM Entities, and virtual groups.

This section also reviews which performance data can be submitted for APM Entities versus the practices that include clinicians in the Entity.

Skip ahead to:

- Practice Representatives
- APM Entity Representatives
- Virtual Group Representatives

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Registry Representatives

This section includes information for users with a Staff User or Security Official role for a **Registry organization** – Qualified Registry or QCDR – identified by Taxpayer Identification Number (TIN).

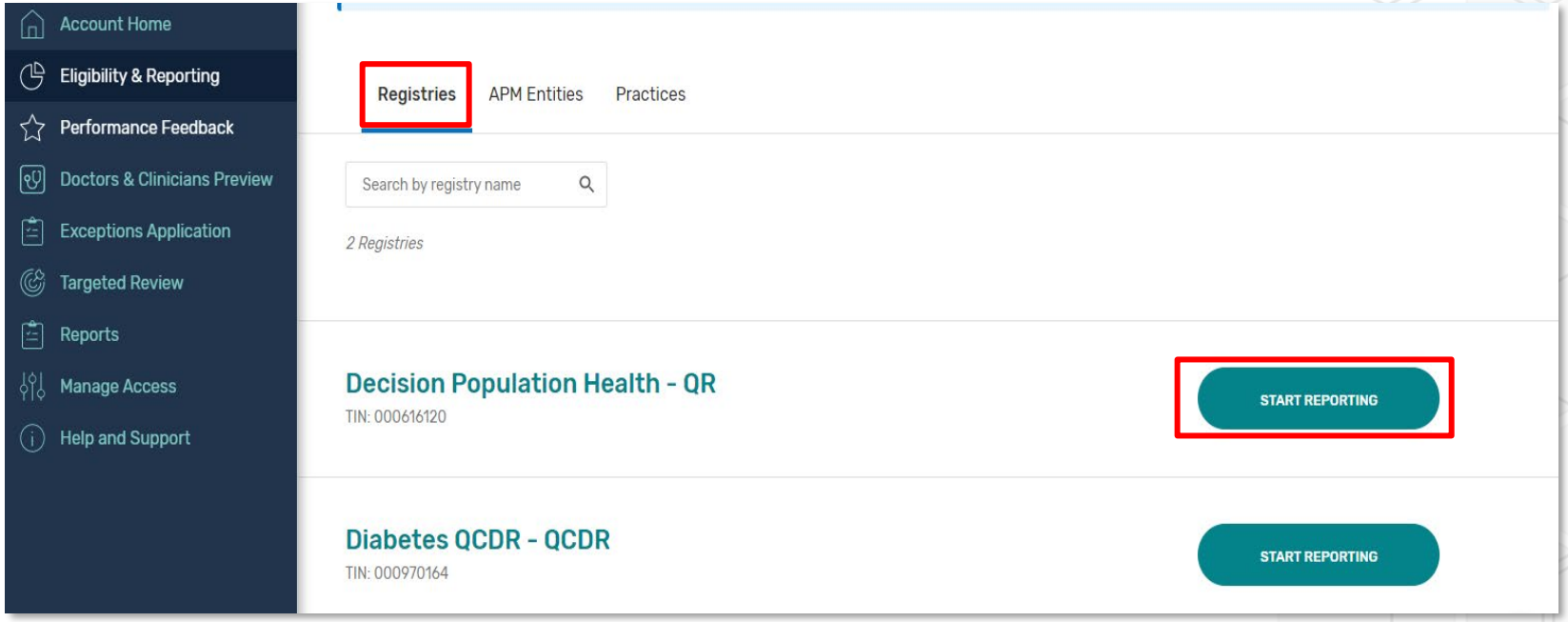
With this Access	You CAN do this during and after the submission period	You CAN'T do this during or after the submission period
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ Download your API token (security officials only) ✓ Upload a submission file on behalf of your clients (groups and/or individuals) ✓ Submit opt-in elections on behalf of your clients ✓ View preliminary scoring for your clients based on the data your organization submitted for them	✗ View data submitted directly by your clients ✗ View data submitted by another third party on behalf of your clients ✗ View data collected and calculated by CMS on behalf of your clients • Cost and administrative claims quality measures (if applicable)

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Registry Representatives (Continued)

From the Eligibility & Reporting page, make sure you click the Registries tab if you access to multiple organization types and select Start Reporting next to your registry's name to open your dashboard and start uploading files.

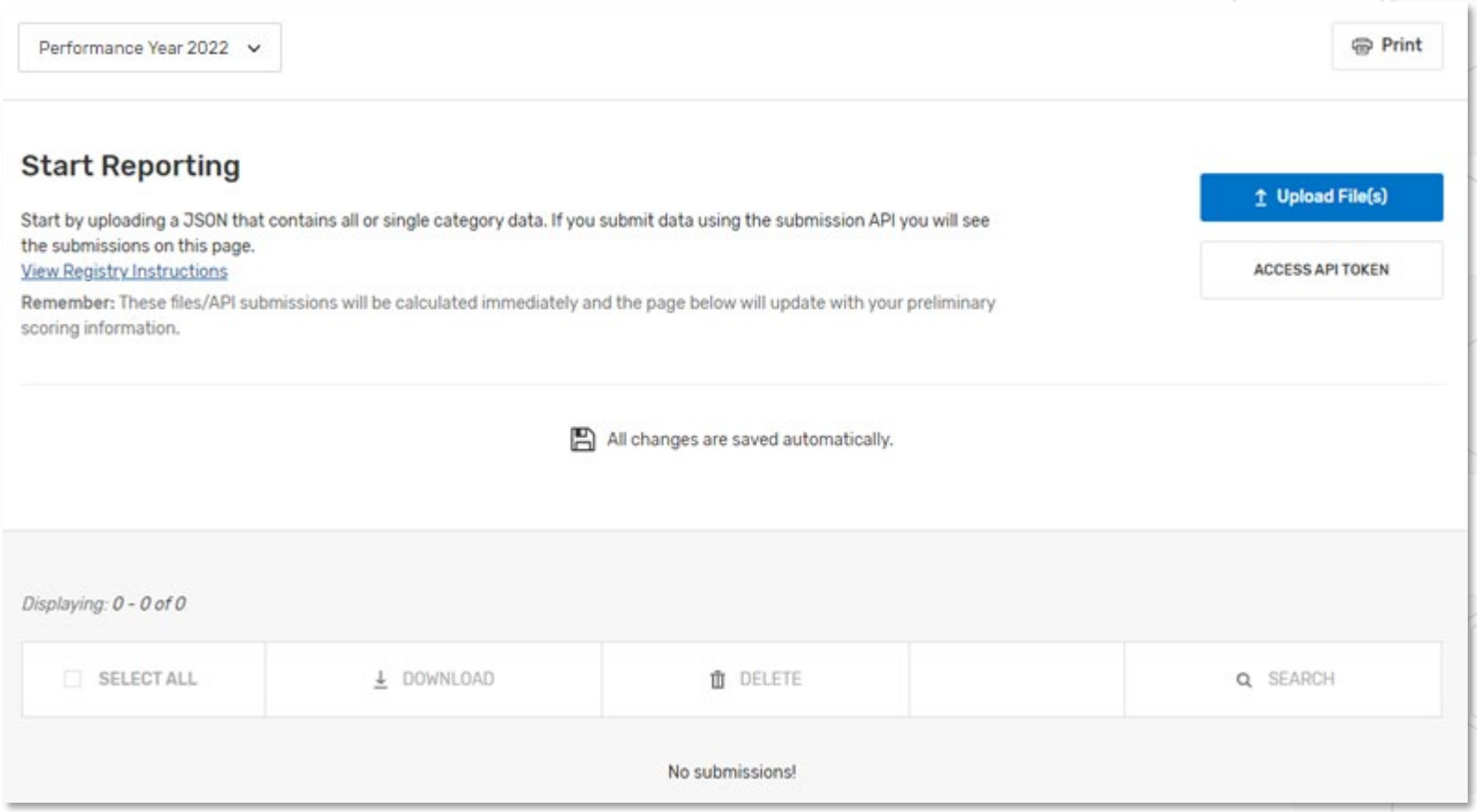


Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Registry Representatives (Continued)

You won't see any information until you've submitted data.



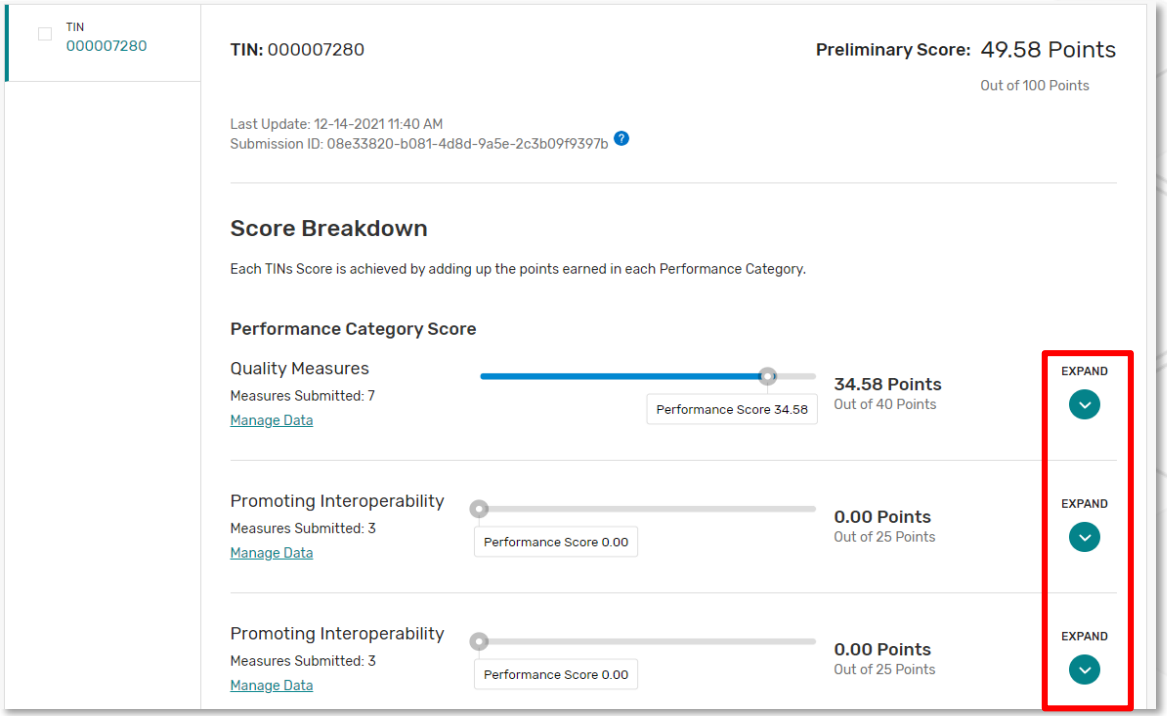
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Registry Representatives (Continued)

Once you've started submitting data, you will see a list of Taxpayer Identification Numbers (TINs) – for group submissions – and TIN/National Provider Identifiers (TIN/NPIs) – for individual submissions – along with their preliminary scoring based on data submitted by your registry.

You can click "Expand" next to each performance category score to see a breakdown by measure or activity reported.

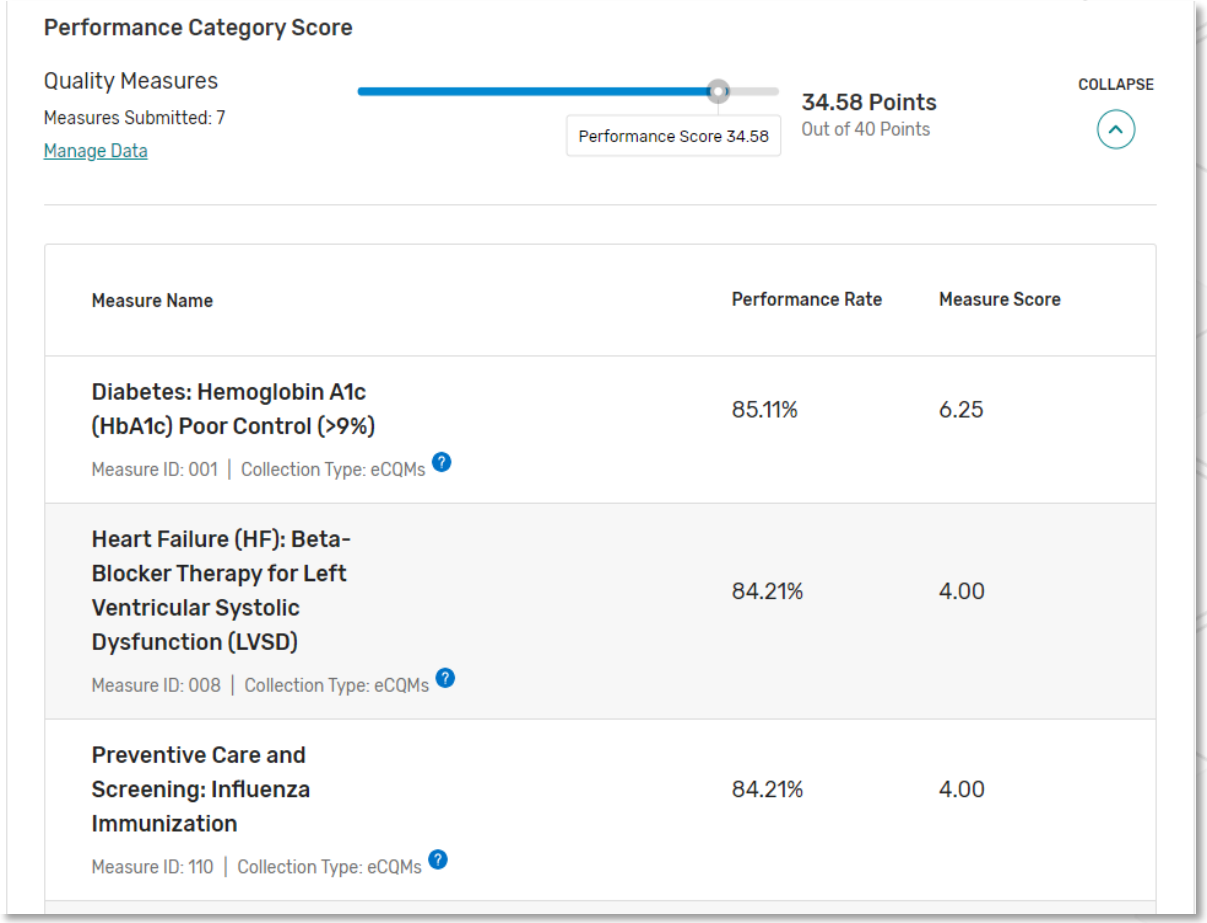


(All data included in screenshots is fictitious, for illustrative purposes.)

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Registry Representatives (Continued)



(All data included in screenshots is fictitious, for illustrative purposes.)

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives

This section includes information for users with a Staff User or Security Official role for a **Practice organization**, identified by Taxpayer Identification Number (TIN).

With this Access	You CAN do this during the submission period	You CAN'T do this during the submission period
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ Access information about eligibility and special status at the individual clinician and group level ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your practice (as a group and/or individuals) • Includes Promoting Interoperability data for MIPS APM participants ✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals) ✓ View data submitted on behalf of your practice (group and/or individual) ✓ View preliminary scoring for Part B claims measures reported throughout the performance period • This data will be updated during the submission period to account for claims received by CMS until March 1, 2023 • **REMINDER**: We'll only score small practices as a group if they submit data at the group level for another performance category) ✓ View preliminary performance feedback for the group and individual clinicians	✗ View cost measures feedback (if applicable) • Cost data won't be available during the submission period ✗ View facility-based scoring for quality / cost (if applicable) • **REMINDER:** Facility-based scoring isn't available for Performance Year 2022. ✗ View data submitted by your APM Entity • **Example:** If you're a Participant TIN in a Shared Savings Program ACO, you won't be able to view the quality data reported by the ACO through the CMS Web Interface ✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group)

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Group vs Individual Reporting

NEW: Reporting Options (Practices with Clinicians in a MIPS APM)

MIPS eligible clinicians participating in a MIPS APM, and groups that include these clinicians, have 2 options for reporting their MIPS data.

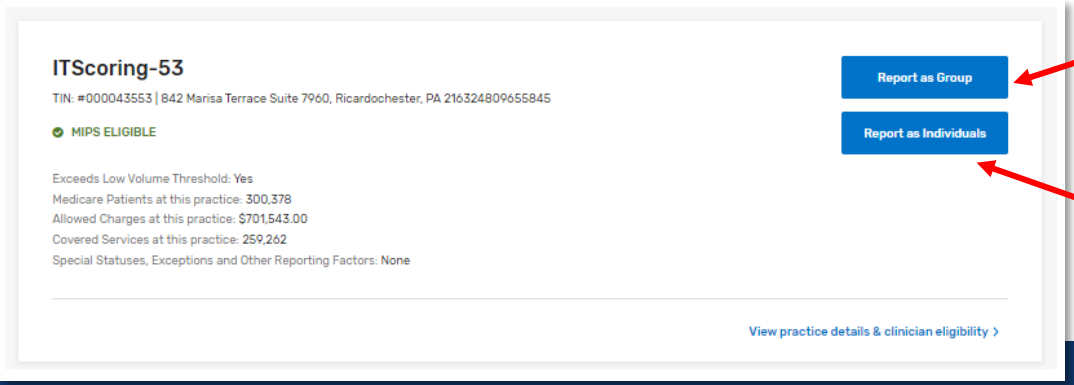
Traditional MIPS, established in the first year of the Quality Payment Program, is the original framework for collecting and reporting data to MIPS. Under traditional MIPS, participants select from over 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

- If you're reporting as a group and select **Traditional MIPS**, the final score and associated payment adjustment will apply to all of the MIPS eligible clinicians in your group.

The APM Performance Pathway (APP) is a streamlined reporting framework (with specified measures) for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.

- If you're reporting as a group and select **APM Performance Pathway (APP)**, the final score and associated payment adjustment will only apply to the MIPS eligible clinicians who also participate in a MIPS APM.
- Please note that there is a separate APP Submission Guide.

Learn how to report as a group under the APP.



As a group. You're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

As Individuals. You're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

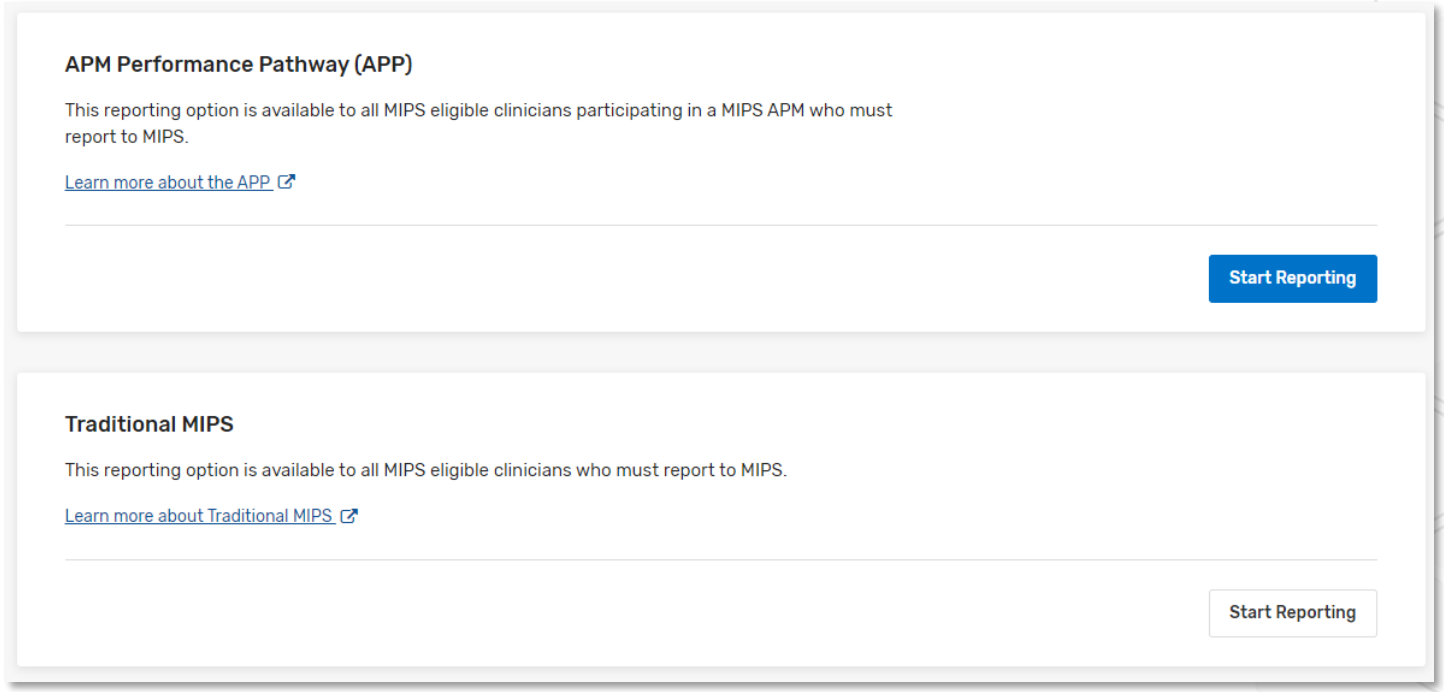
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Group vs Individual Reporting (Continued)

Once you click Report as Group/Report as Individuals, you'll be directed to a new Reporting Options page, where you'll need to indicate whether you're reporting via the APP or traditional MIPS.



Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Did you know?

The level at which you participate in MIPS (individual or group) applies to all performance categories. We will not combine data submitted at the individual and group level into a single final score.

For example:

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

NOTE: We'll **only** calculate a quality score at the group level for small practices reporting Medicare Part B claims measures for their MIPS eligible clinicians **if** the practice also submits data at the group level for another performance category.

NOTE: The 2021 performance year was the last year that we'll automatically calculated a group score from claims measures reported for individual clinicians without another group-level submission by the practice.

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

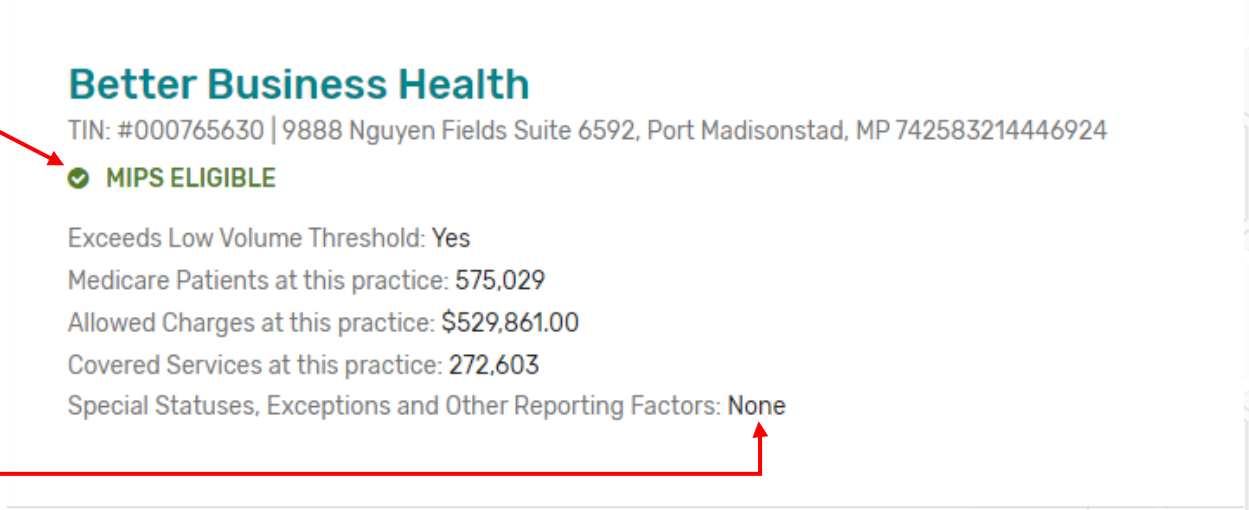
Reporting as a Group

When you report as a group, you're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

From the Eligibility & Reporting page, you can view eligibility and special statuses at the practice level, which are applicable to group reporting.

Practice-level eligibility (applies to group reporting only)

Practice-level **special statuses and exception applications** (applies to group reporting only)



Understanding What Information is Available by Organization Type

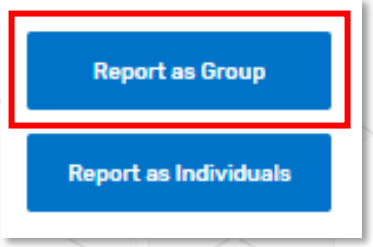
Quality Payment PROGRAM

Practice Representatives (Continued)

Eligibility Refresher (Group Reporting)

You See	This Means
PRACTICE LEVEL (Applies to Group Reporting)	
MIPS ELIGIBLE	If you choose to report as a group, all of your MIPS eligible clinicians (including those who are individually below the low-volume threshold) will receive a payment adjustment based on your group submission
MIPS EXEMPT	You can choose to voluntarily report as a group, but none of your clinicians will receive a payment adjustment You will also see this status when your group was "opt-in eligible" and a practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to voluntarily report.
Opt-in Option: Opt-in eligible as group	Your practice isn't eligible for MIPS and your clinicians will not receive a MIPS payment adjustment from group reporting **unless** you make an election to Opt-In as a group. **No action is needed if you don't want to submit data.** If you want to submit group-level data, you will be prompted to make an election before you can submit data. • **Opt-In to MIPS** and your clinicians will receive a MIPS payment adjustment (even if no data is submitted) • **Voluntarily Report** and your clinicians will NOT receive a MIPS payment adjustment based on any data submitted
MIPS ELIGIBLE VIA OPT-IN	A practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to opt-in to MIPS. Your MIPS eligible clinicians will receive a payment adjustment.

If your practice is **"MIPS eligible"** or **"MIPS exempt"** as a group, clicking Report as a Group will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.



Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Opt-in Eligible

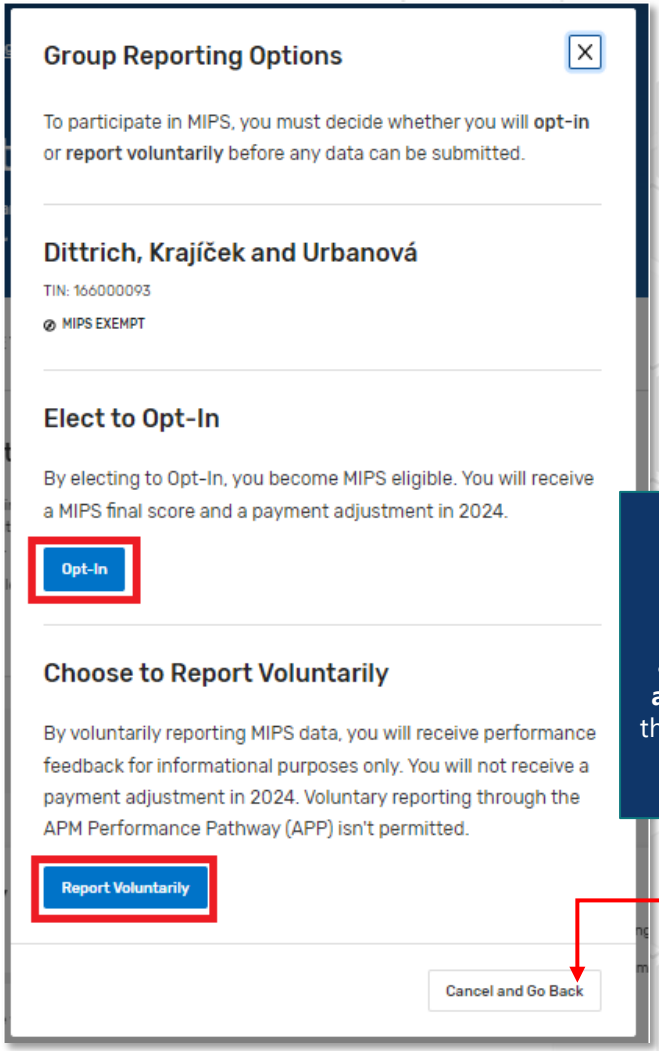
If your practice is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election can't be changed.

Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the practice to receive a MIPS final score based on a group submission and for all MIPS eligible clinicians to receive a payment adjustment.
- Select **Report Voluntarily** if you're electing for the practice to receive a MIPS final score based on a group submission, but no payment adjustment for your clinicians.

NOTE: You can't voluntarily report the APM Performance Pathway.

Review the 2022 MIPS Opt-In and Voluntary Reporting Election Guide for more information.



Change Your Mind?

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Reporting as Individuals

When you're reporting as individuals, you're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

Users with access to their practice can view eligibility and special statuses at the individual level, which are applicable to the specific clinician for individual reporting.

Click **Report as Individuals** or **View Clinician Eligibility** (under the option to Report as Individuals) to access Practice Details and Clinicians.

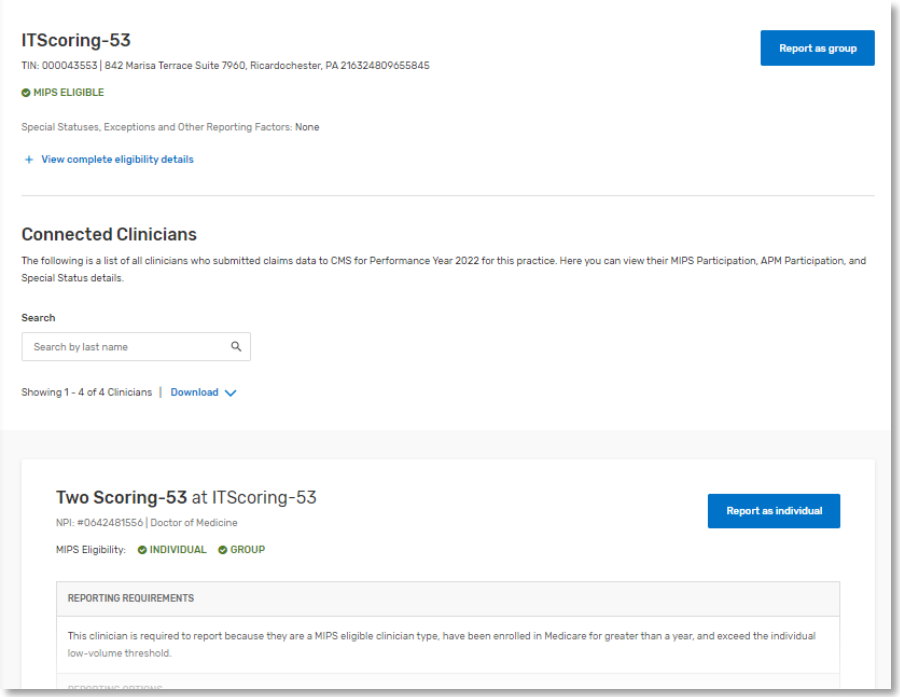
This page displays the clinicians who (identified by National Provider Identifier, or NPI) billed services under your practice's TIN **with dates of service between October 1, 2021, and September 30, 2022,** and received by CMS by October 30, 2022.

- This includes clinicians who left your practice and/or have terminated the reassignment of their billing rights to your practice's TIN in PECOS during this timeframe.

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)



Did you know?

Clinicians who started billing for services under your Taxpayer Identification Number (TIN) between October 1 and December 31, 2022 **won't** appear on the QPP website during the submission period.

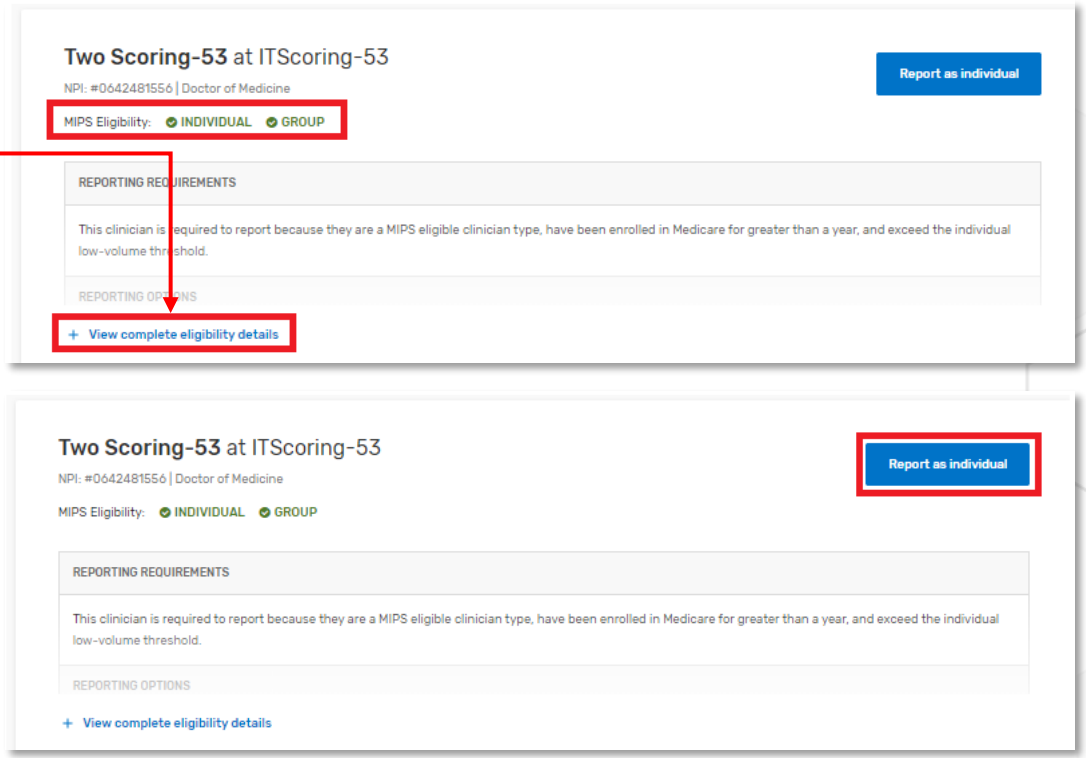
- These clinicians will be added to your practice's downloadable Payment Adjustment CSV with final performance feedback in July 2023:
  - They'll receive a neutral MIPS payment adjustment if your practice reported as individuals; or
  - They'll receive a MIPS payment adjustment based on the group's final score (provided they are otherwise eligible for MIPS) if your practice reported as a group.

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Practice Representatives (Continued)

Each clinician will have an eligibility indicator at the individual and group level. If your practice is reporting as individuals, click **View complete eligibility** details to better understand the clinician's reporting requirements, reporting options and payment adjustment information



If the clinician is "**MIPS eligible**" or "**MIPS exempt**" as an individual, clicking Report as Individuals will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

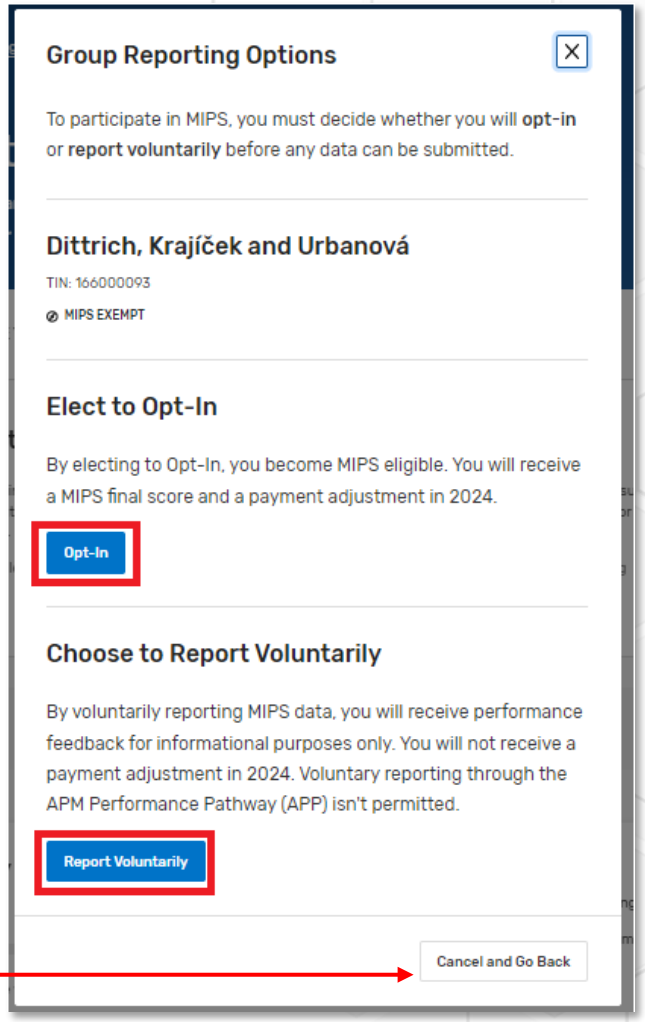
Practice Representatives (Continued)

Opt-in Eligible

If the clinician is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election **can't** be changed.

Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the clinician to receive a MIPS payment adjustment.
- Select **Report Voluntarily** if you're electing for the clinician to receive a MIPS final score but no payment adjustment.
    - **NOTE:** You can't voluntarily report the APM Performance Pathway.



Change Your Mind?

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page.

Review the 2022 MIPS Opt-In and Voluntary Reporting Election Guide for more information.

Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

APM Entity Representatives

This section includes information for users with a Staff User or Security Official role for an **APM Entity organization**, identified by an APM Entity ID.

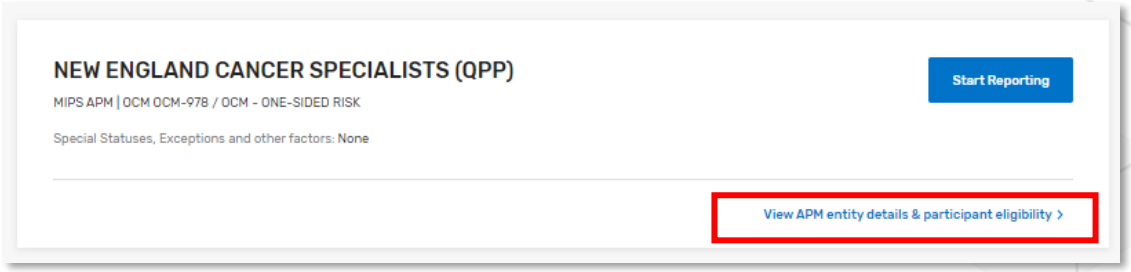
With this Access	You CAN do this during the submission period	You CAN'T do this during the submission period
Staff User or Security Official for an **APM Entity**	✓ Access a list of the practices (TINs) and clinicians participating in the APM Entity ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit quality data through the CMS Web Interface (Shared Savings Program ACOs, or other registered APM Entities) ✓ Upload a QRDAIII file with your eCQM data to meet your model-specific requirements (Primary Care First practice sites) ✓ Upload a file of APM Entity-level quality measure data (all APM Entities in MIPS APMs) ✓ View preliminary performance feedback on **quality** (and improvement activities if applicable) data submitted by or on behalf of the APM Entity	✗ View the Promoting Interoperability data reported by clinicians and groups in your APM Entity

Understanding What Information is Available by Organization Type

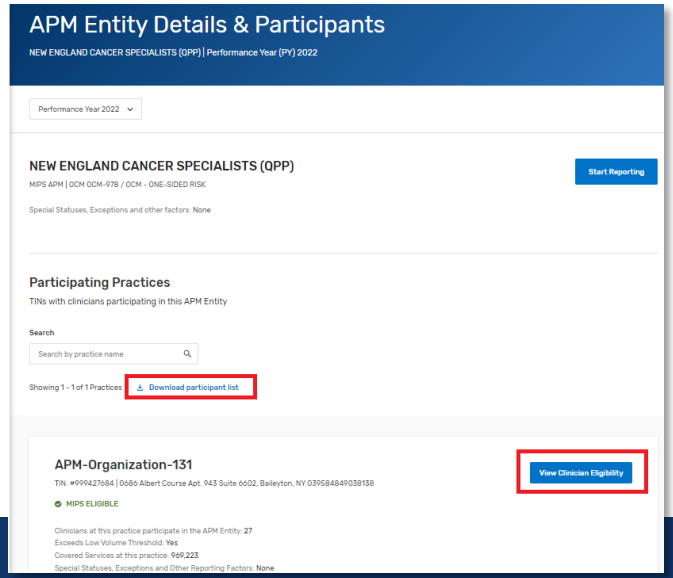
Quality Payment PROGRAM

APM Entity Representatives (Continued)

After signing in and clicking **Eligibility & Reporting** from the left-hand navigating, users with access to their APM Entity can access a list of the clinicians participating in the Entity by clicking **View Participant Eligibility** beneath Start Reporting.



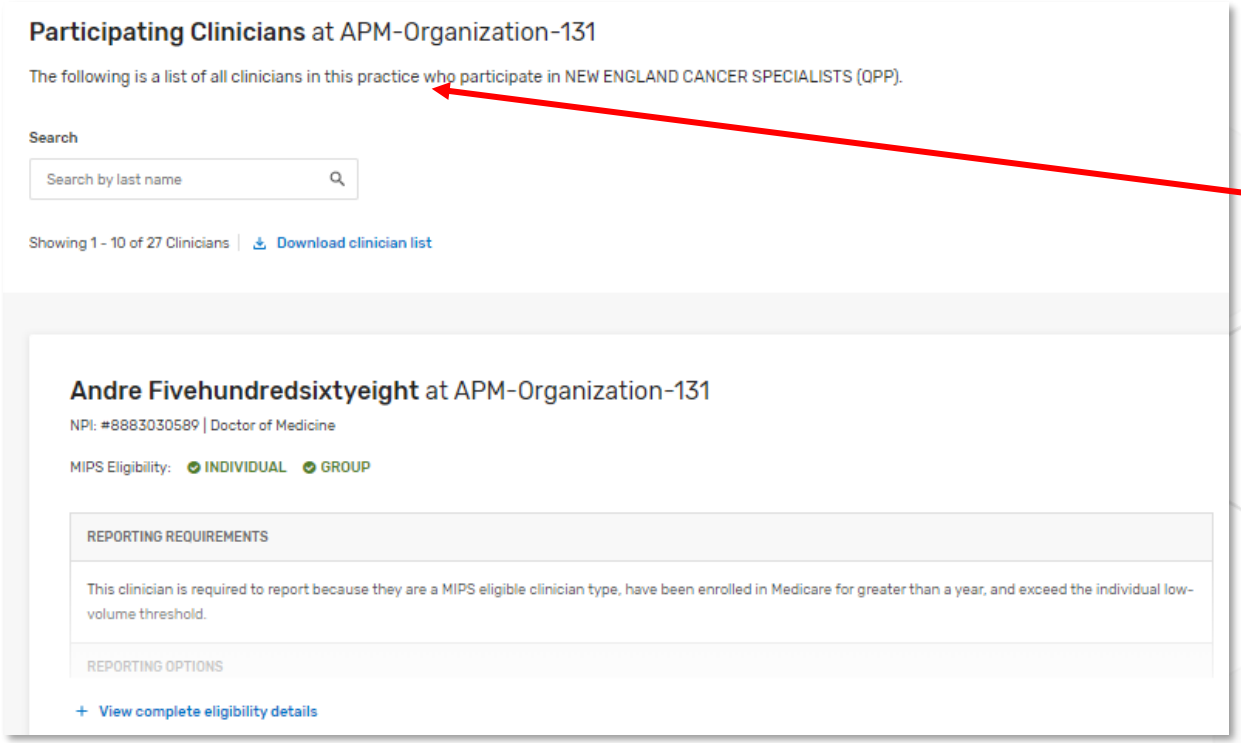
From the **APM Entity Details & Participants** page, you will be able to **download** a list of all your participants or **view** participants by Practice. This is a list of the clinicians identified as participating in your APM Entity on the 1st, 2nd or 3rd APM Snapshot dates (March 31, June 30, and August 31, 2021).



Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

APM Entity Representatives (Continued)



When you select View Clinician Eligibility by practice, only clinicians in the practice who are also participating in the APM Entity will be listed.

Understanding What Information is Available by Organization Type

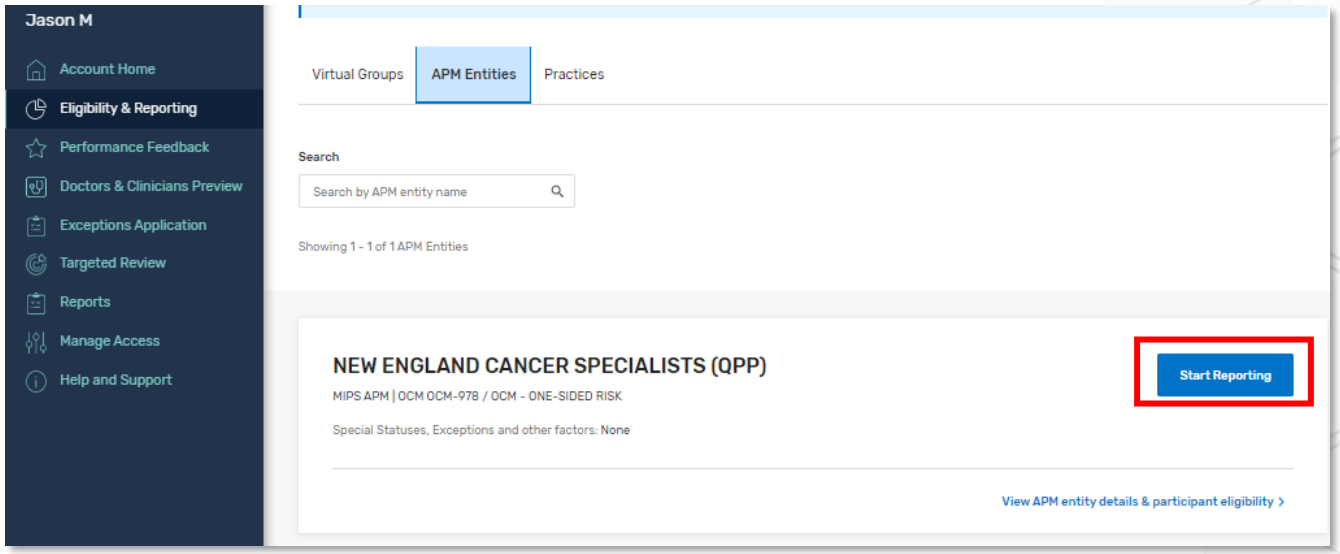
Quality Payment PROGRAM

APM Entity Representatives (Continued)

Reporting Options

Once logged in, you will see the Account Dashboard, which will list all the APM Entities for which you can report data. This is based on the permissions/roles associated with your account.

From the Eligibility & Reporting page, select Start Reporting next to the APM Entity for which you'd like to report data.



From here, you'll be directed to a new Reporting Options page which outlines any required or optional reporting.

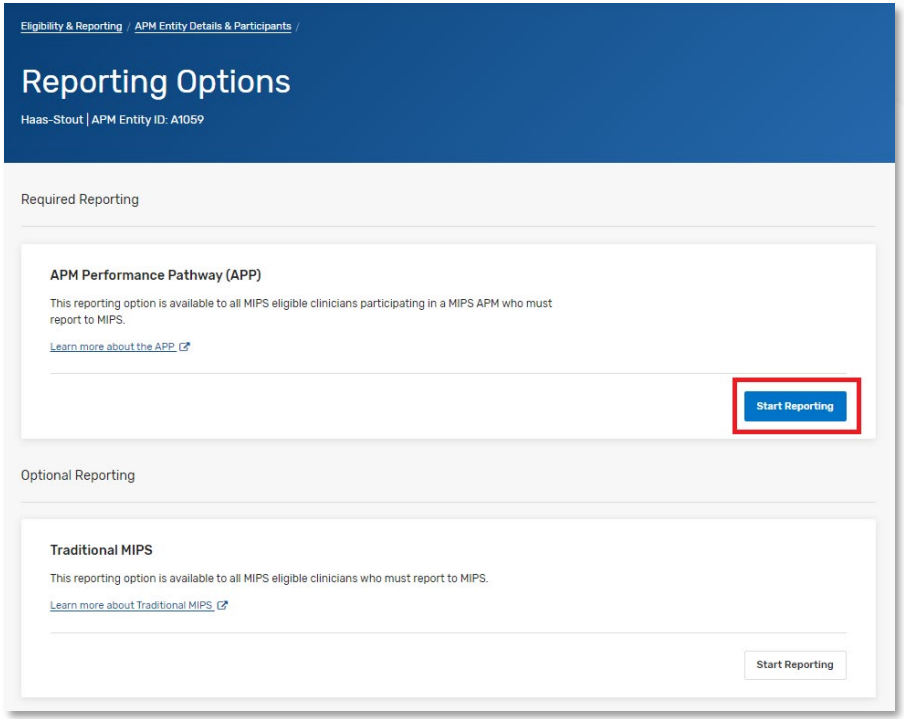
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

APM Entity Representatives (Continued)

Shared Savings Program ACOs

Shared Savings Program ACOs are required to report the APP quality measure set as part of their participation in the Shared Savings Program. From the Reporting Options page, you'll select **Start Reporting** underneath the **APM Performance Pathway (APP)** option, and then you'll click **Report APP** on the subsequent pop-up modal. Please refer to the **2022 APP Submission Guide** for more information.



Learn how to report eCQMs or MIPS CQMs as a Medicare Shared Savings Program ACO for the APP.

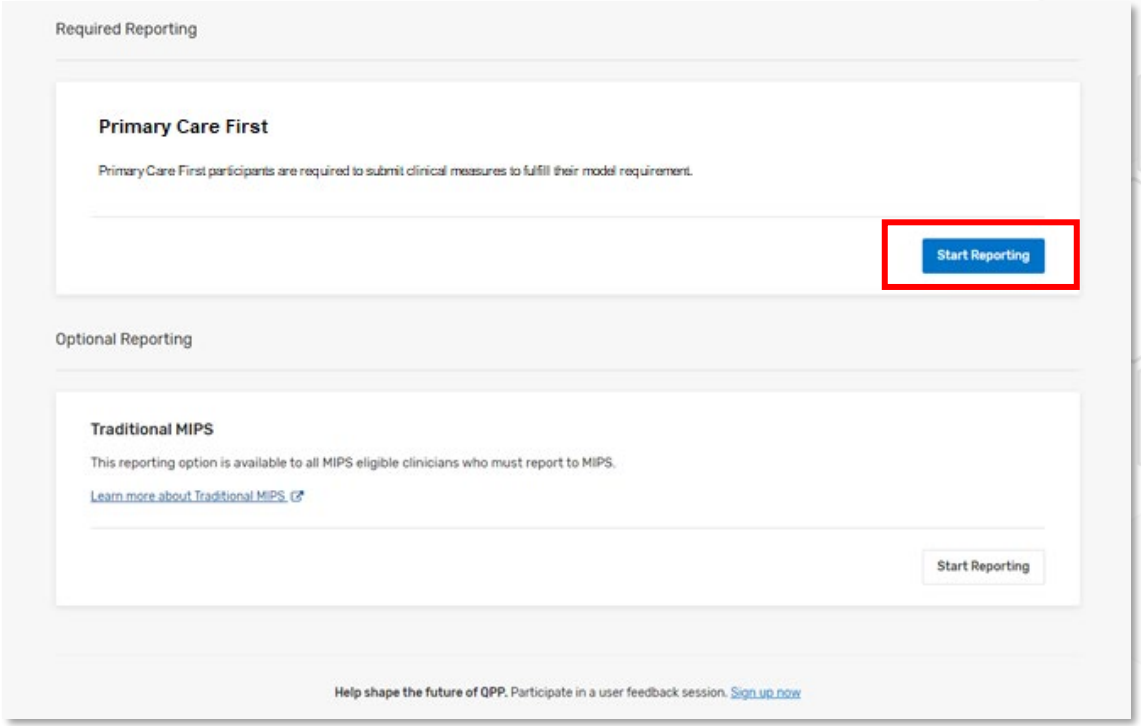
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

APM Entity Representatives (Continued)

Primary Care First Practice Sites

You'll see your model-specific reporting identified as Required Reporting, with the APM Performance Pathway (if your organization qualifies as a MIPS APM) and traditional MIPS listed as optional. In the screenshot below, the practice site isn't a MIPS APM, and therefore doesn't have the option to report the APM Performance Pathway.



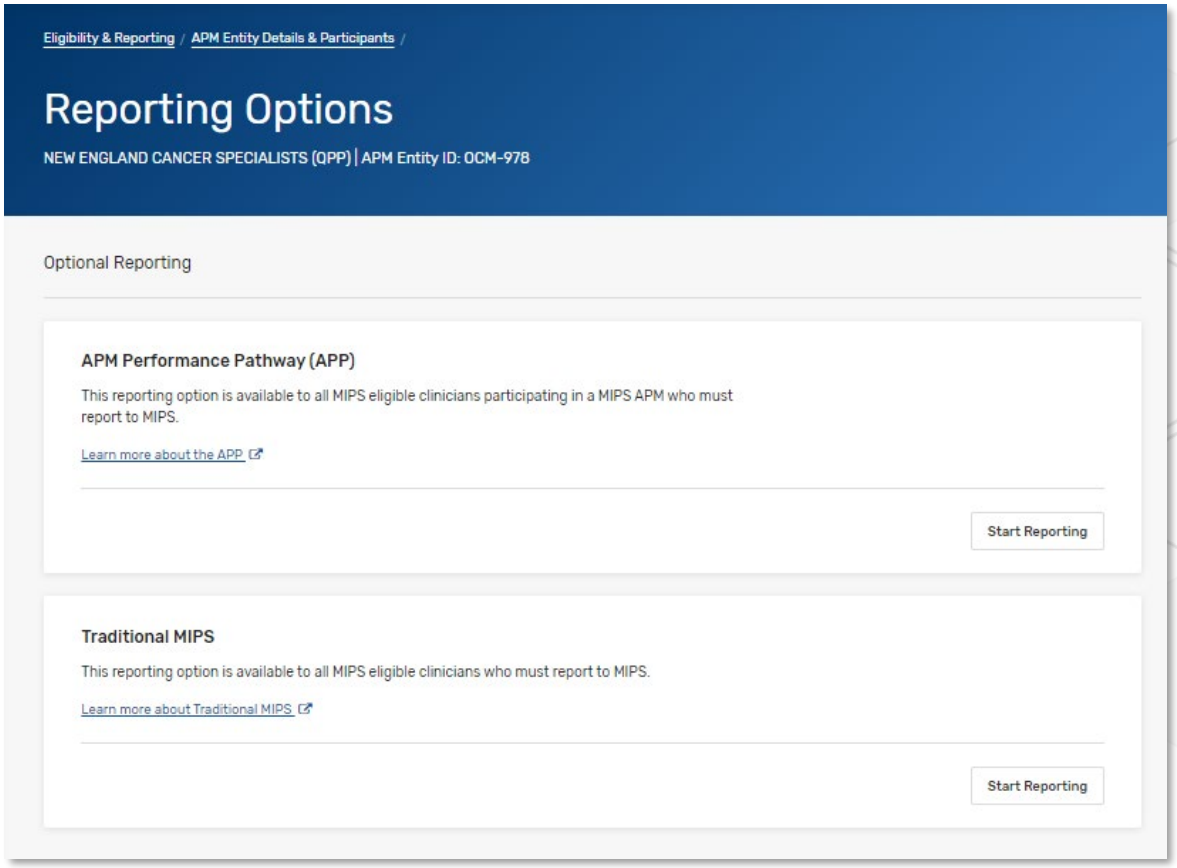
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

APM Entity Representatives (Continued)

APM Entities in All Other Models

If your organization qualifies as a MIPS APM, you'll see both traditional MIPS and the APM Performance Pathway listed as optional.



Understanding What Information is Available by Organization Type

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Virtual Group Representatives

This section includes information for users with a Staff User or Security Official role for a **Virtual Group organization**, identified by Virtual Group ID.

With this Access	You CAN do this during the submission period	You CAN'T do this during the submission period
Staff User or Security Official for a Virtual Group	✓ Access information about the practices (TINs) and clinicians participating in the virtual group ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your virtual group ✓ View data submitted on behalf of your virtual group ✓ View performance feedback for the virtual group	✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission)

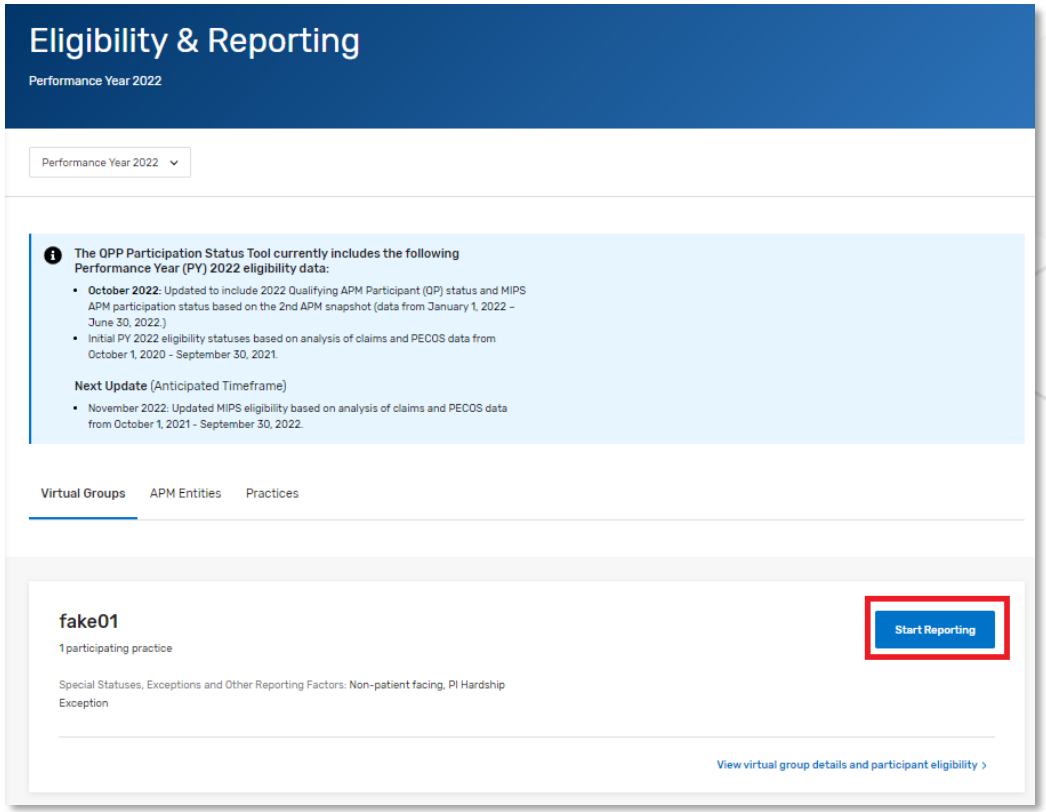
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Virtual Group Representatives (Continued)

From the Eligibility & Reporting page, users with access to their virtual group can review any **special statuses and other reporting factors** attributed to the virtual group.

They can also access a list of the practices and clinicians participating in the virtual group by selecting **View participant eligibility**.

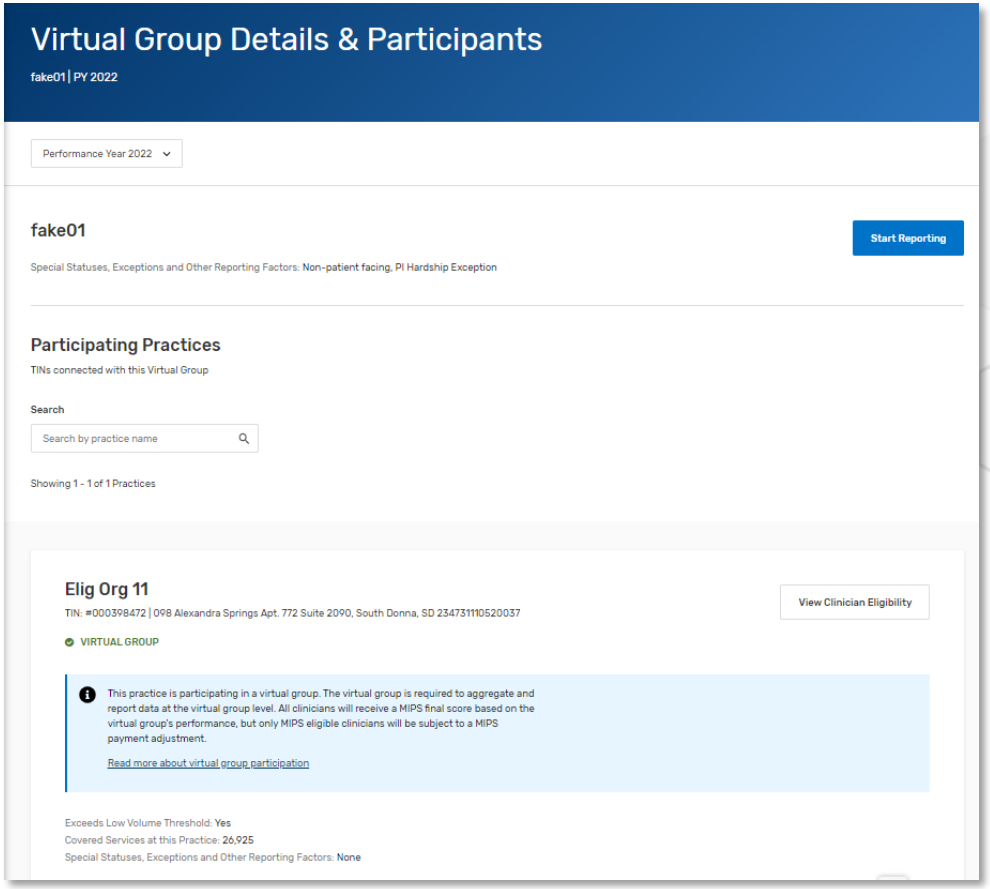


Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Virtual Group Representatives (Continued)

From the Participating Practices page, you can access a list of clinicians in each participating practice but can't download a list of all clinicians participating in the virtual group.



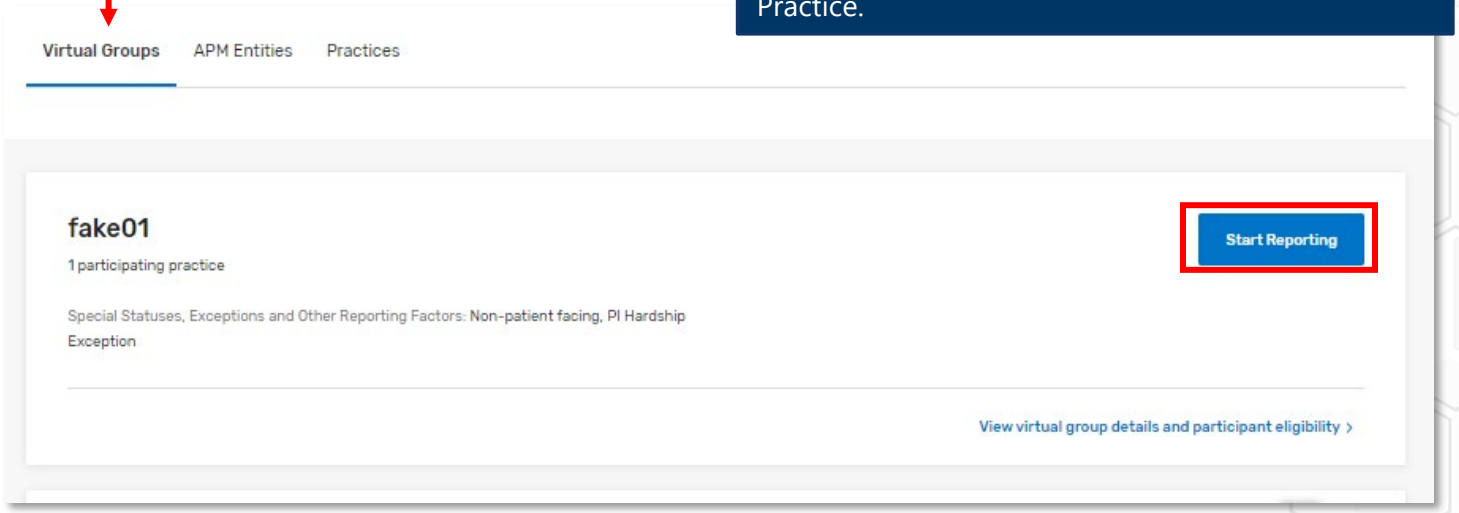
Understanding What Information is Available by Organization Type

Quality Payment PROGRAM

Virtual Group Representatives (Continued)

From the Eligibility & Reporting page, select **Start Reporting** next to the appropriate Virtual Group organization.

Make sure you see **Virtual Groups** as your organization type or click **Virtual Groups** if you have access to another organization type, such as Practice.



Did you know?

- Data submitted by Practices participating in the Virtual Group will be considered voluntary reporting (both individual and group submissions).
- Appendix B offers helpful information about Virtual Group access.

Quality Payment
PROGRAM

Submitting and Reviewing Data

Submitting and Reviewing Data

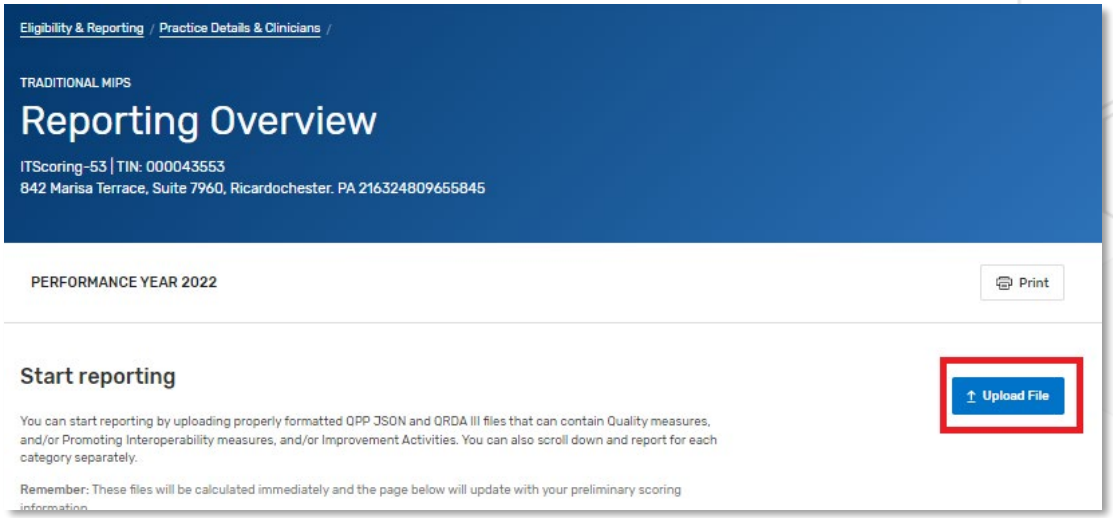
Reporting Overview Page

From the Reporting Overview page, you'll be able to:

- Upload a file
- View the Preliminary Total Score
- View preliminary performance category scores and weights
- Access previously submitted data (by you or a third party)

Upload a File

You can upload a Quality Reporting Data Architecture Category III (QRDA III) or QPP JavaScript Object Notation (JSON) file with data for any or all performance categories by selecting Upload a File.

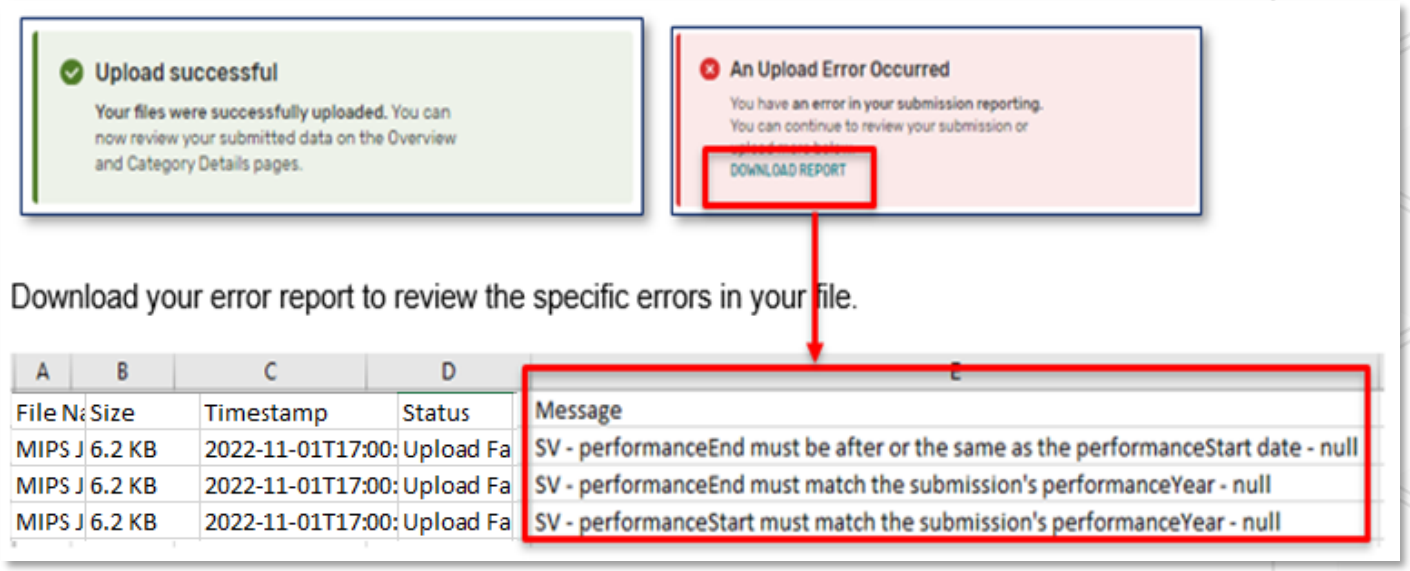


Submitting and Reviewing Data

Quality Payment PROGRAM

Reporting Overview Page (Continued)

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

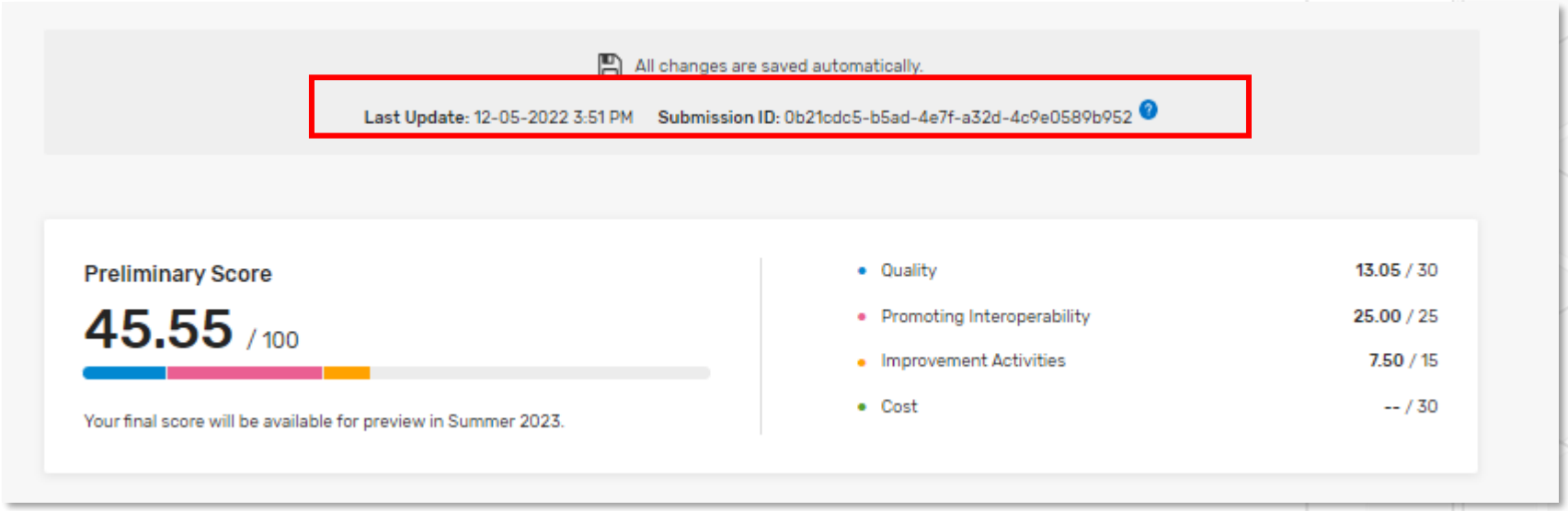


Submitting and Reviewing Data

Quality Payment PROGRAM

Preliminary Total Score

You will see a Preliminary Total Score based on data submitted to date (by you and/or a third party). This preliminary score will update as new data is submitted.



On each page, you'll see the most recent date that submission data was updated.

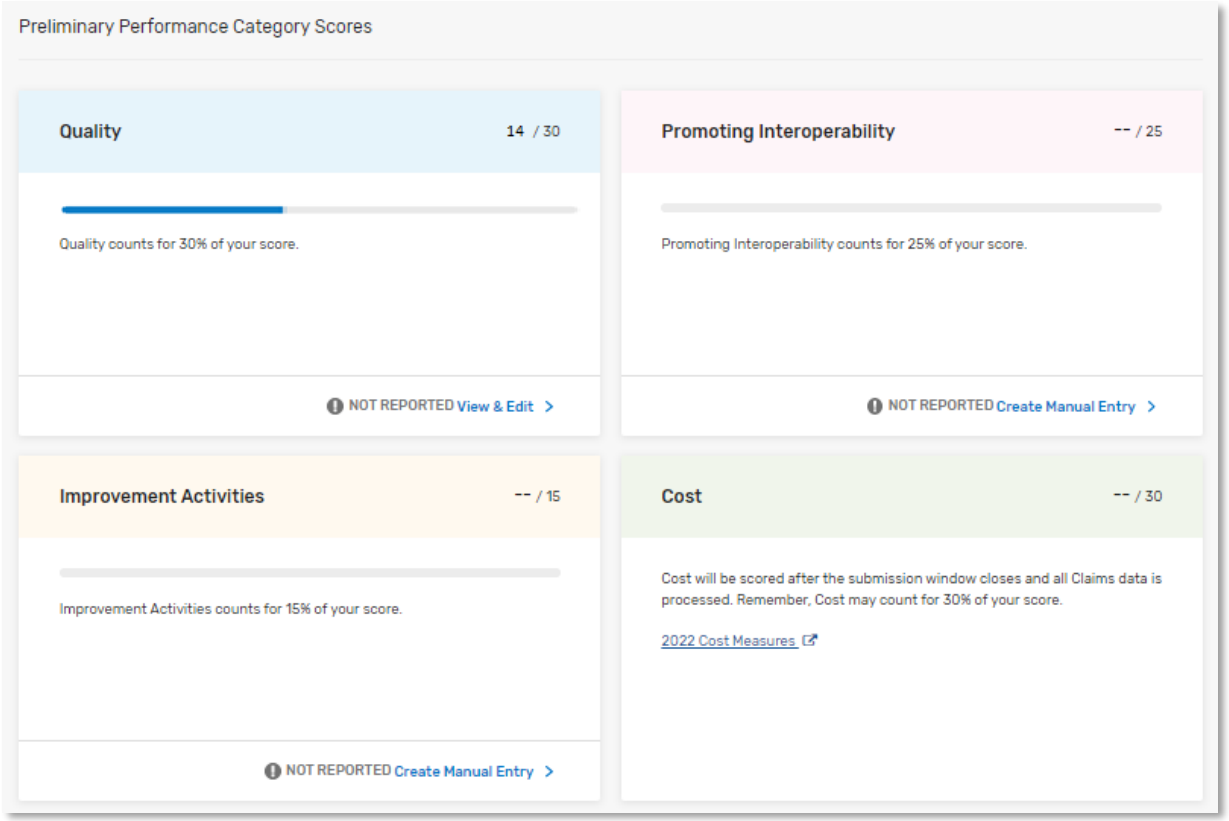
You will also see a **Submission ID**. This unique identifier is associated with all data submitted by and/or on behalf of each clinician, group virtual group, or APM Entity.

Submitting and Reviewing Data

Quality Payment PROGRAM

Preliminary Performance Category Scores and Weights

You will see your preliminary scores and the current weight for each performance category, any special statuses that impact your reporting requirements, along with an indicator of whether data has been submitted.



Did you know?

Preliminary Quality Scores will reflect CMS Web Interface submissions on a measure-by-measure basis as you complete the minimum requirement for each measure.

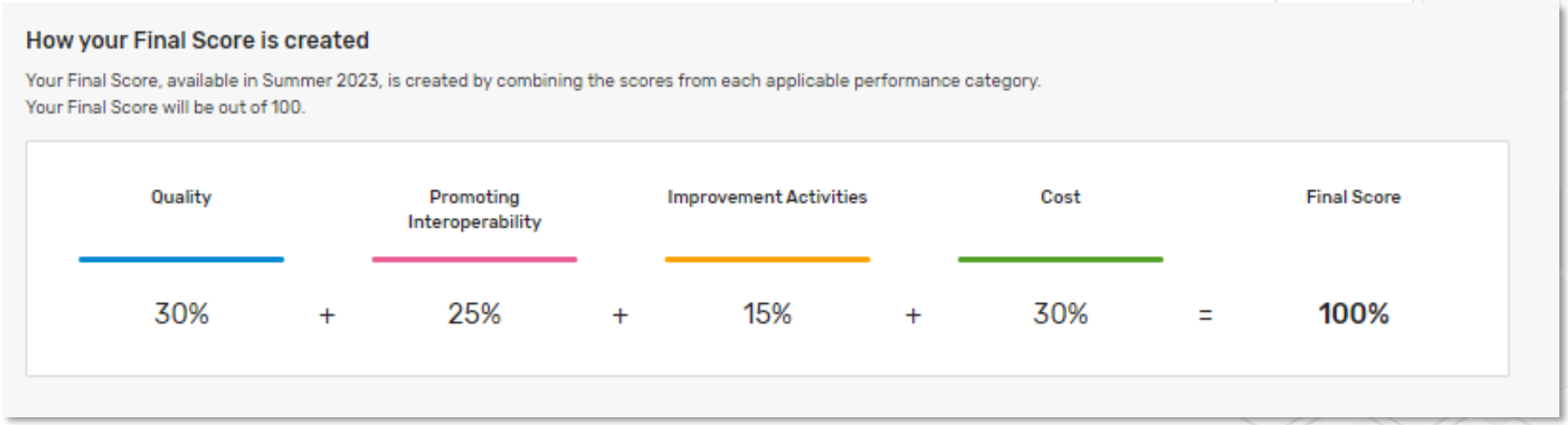
If you see a weight of 0% for any performance category (displayed as "N/A"), you can still submit data, but you will be asked to confirm that you wish to continue as this will override your reweighting.

Submitting and Reviewing Data

Quality Payment PROGRAM

Preliminary Performance Category Scores and Weights (Continued)

Further down the page, you will also see a breakdown of the current weights of each performance category.

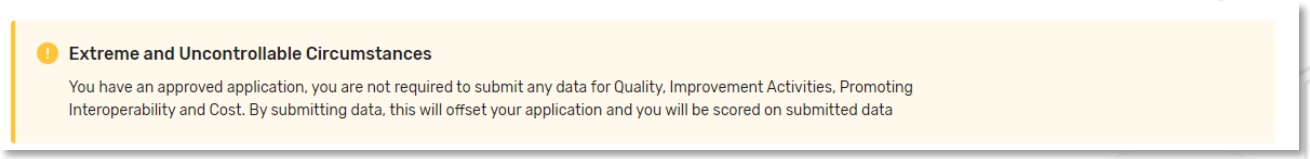


Submitting and Reviewing Data

Quality Payment PROGRAM

MIPS EUC Applications

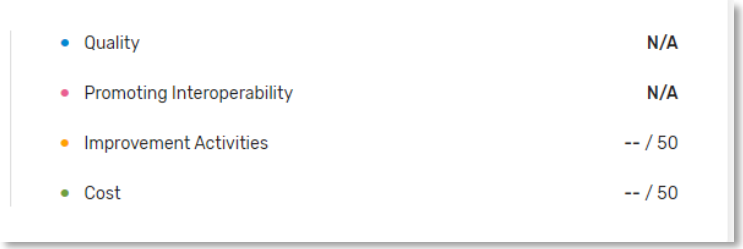
If you have an approved application due to extreme and uncontrollable circumstances (EUC), such as the COVID-19 public health emergency, you will see a banner on the Reporting Overview page indicating this.



Groups and Virtual Groups

As you scroll down the page, you'll see "N/A" as the weight for any category included in the approved application for which you **haven't** submitted data.

If data has been submitted for a performance category included in an approved application (or a performance category wasn't included in the application, you will see the performance category's weight and preliminary scoring information).



APM Entities

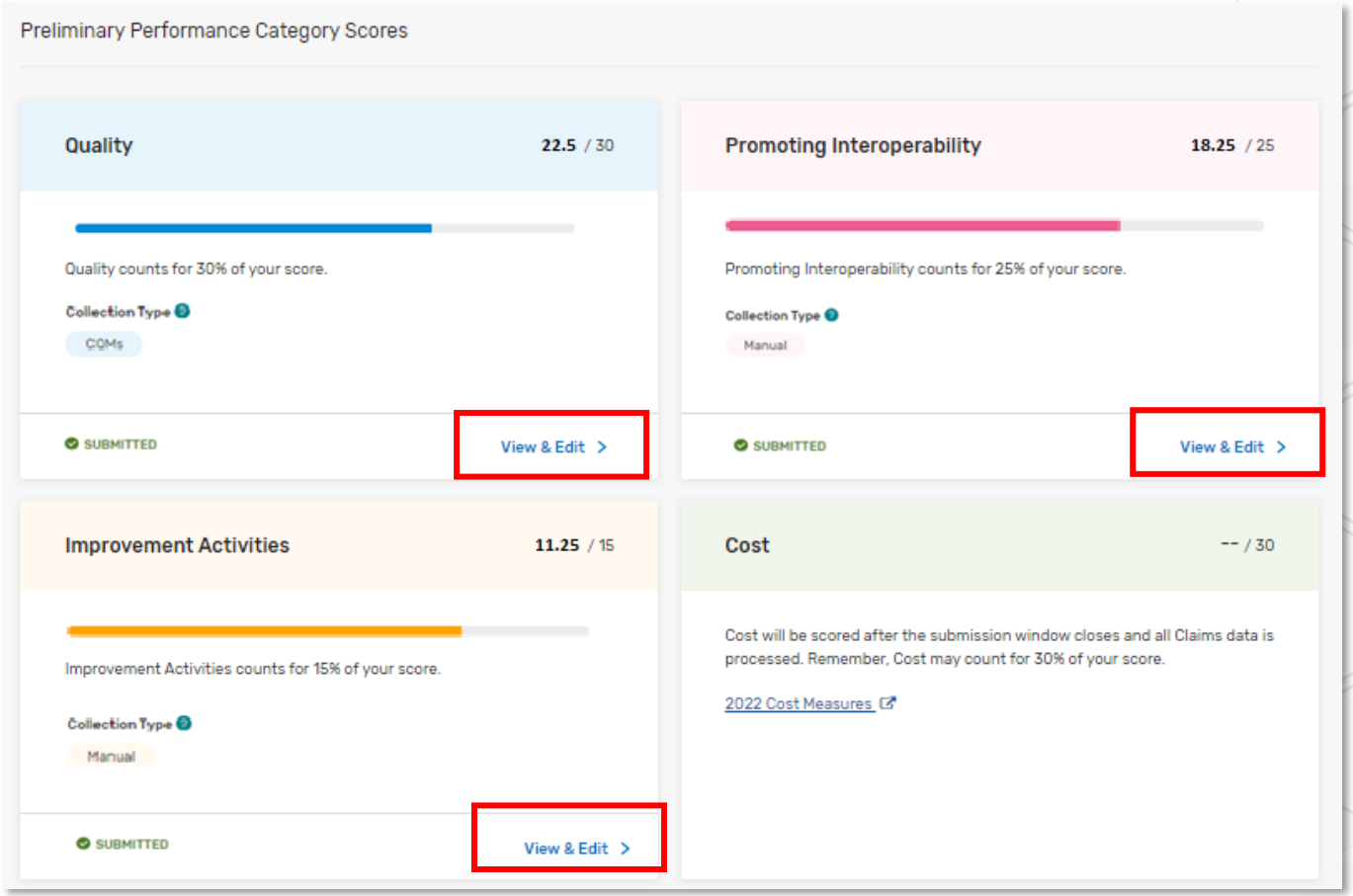
As you scroll down the page, you'll see "N/A" as the weight for all performance categories, even if data has been submitted.

Submitting and Reviewing Data

Quality Payment PROGRAM

Access Previously Submitted Data

Click **View & Edit** to access details about the data that's already been submitted for a performance category.

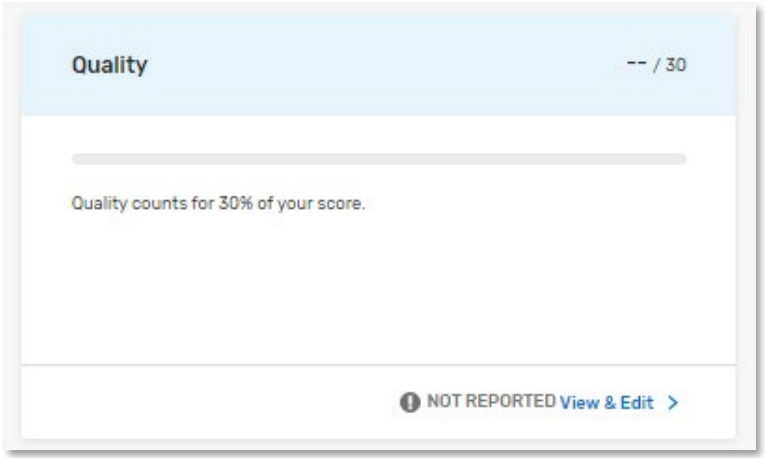


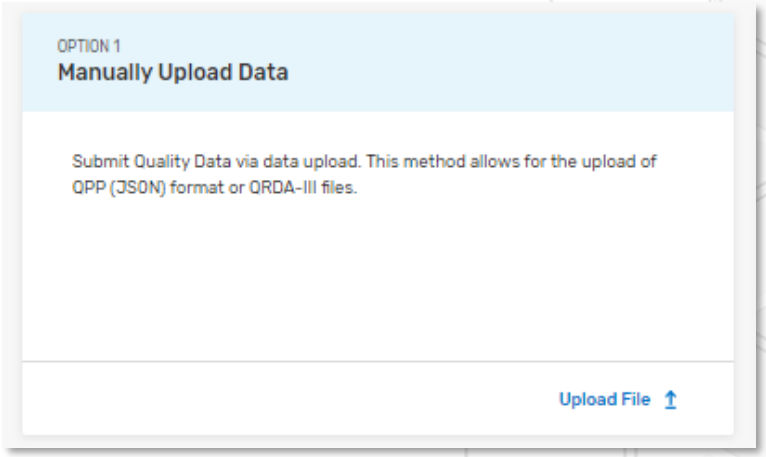
Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Upload Your Quality Measures

You can upload files for any or all performance categories from the Reporting Overview page. Alternately, if no quality data has been reported, you can upload your own QRDA III or QPP JSON file with your eCQMs or MIPS CQMs by clicking **View & Edit** in the Quality section of the Reporting Overview and then **Upload File(s)**:





Once quality measures have been submitted, you will need to upload new files from the Reporting Overview page.

Having trouble uploading your QRDAIII file?

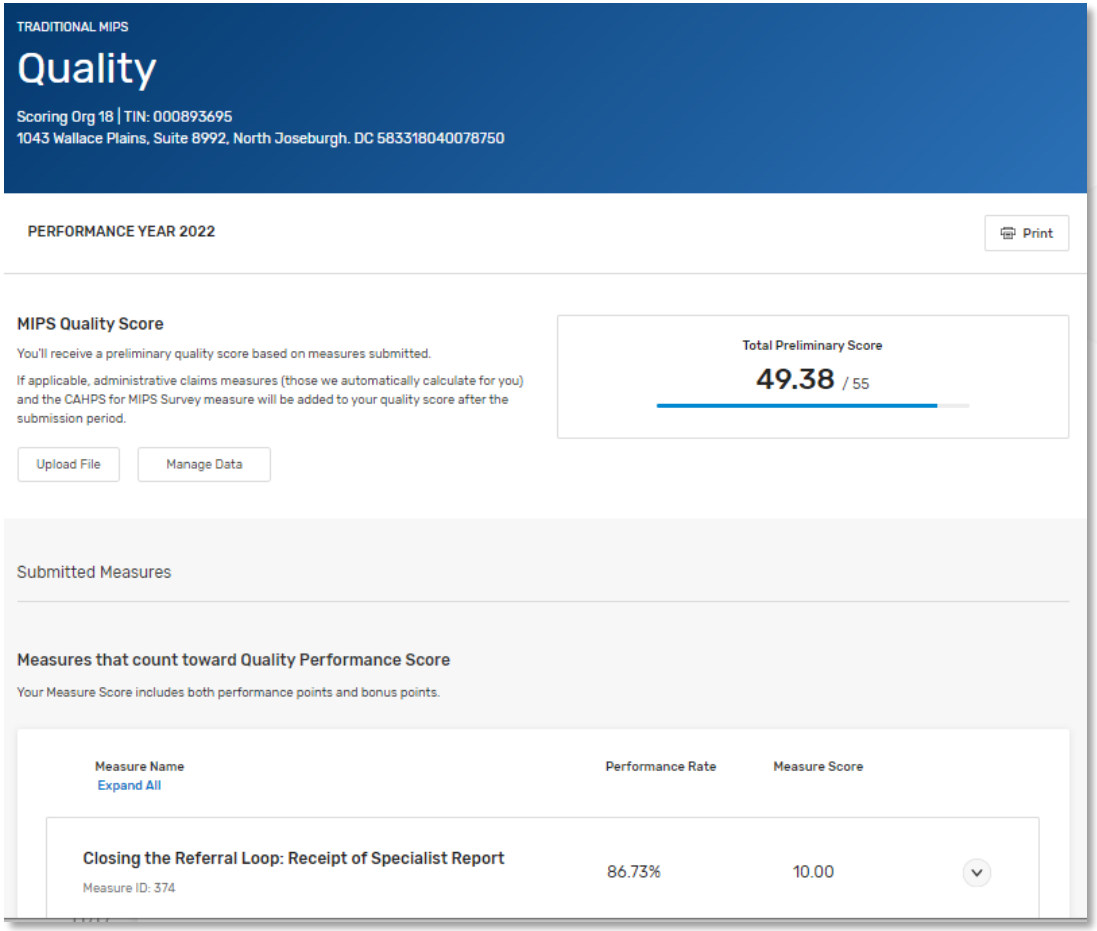
Skip ahead to the troubleshooting section of this guide.

Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Review Previously Submitted Data

From the Reporting Overview, click **View & Edit** in the Quality section to access the Quality details page.



Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Review Previously Submitted Data (Continued)

During the submission period, this page will reflect:

- Medicare Part B claims measures reported by clinicians in a small practice throughout the performance period (available by late January 2023), and
- eCQMs or MIPS CQMs that you have uploaded directly or were submitted by a third party (such as a Qualified Registry or QCDR), and
- QCDR measures submitted on your behalf by a QCDR

Medicare Part B Claims Measures

Only clinicians in small practices (fewer than 16 clinicians) can report Medicare Part B claims measures. If you don't see your preliminary scores for Part B claims measures, check the QPP Participation Status lookup tool to see if you have the small practice special status.

We'll only automatically calculate a quality score at the group level if the practice also submits data at the group level for another performance category.

We intend to update preliminary Part B claims measure scores on a monthly basis during the submission period (to account for the 60-day run out period for claims measure processing).

Submitting and Reviewing Quality Data

Review Previously Submitted Data (Continued)

During the submission period, this page WON'T reflect:

- Scoring for the CAHPS for MIPS Survey measure.
- Scoring on any administrative claims quality measures.

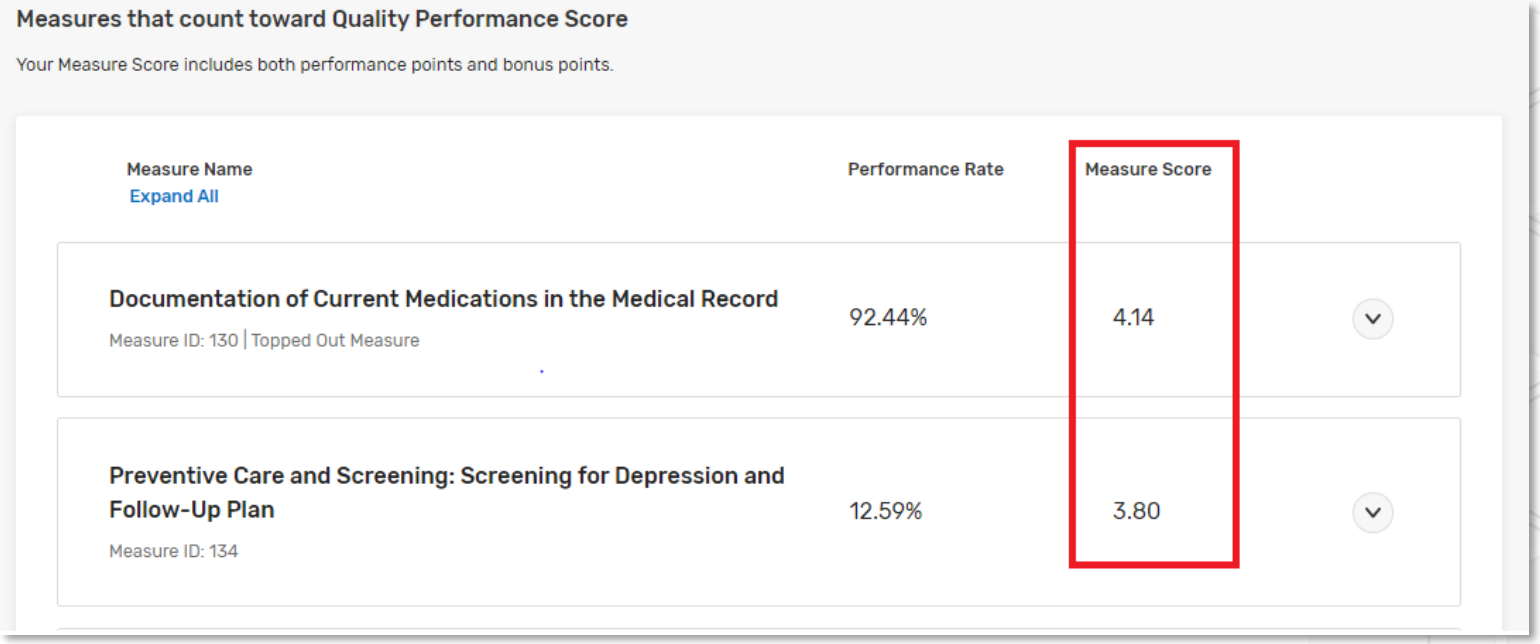
Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Measure Information

Measures may be divided into 2 groups:

1. Measures whose performance points count toward your quality performance category score. The measure score will display your performance points (those achieved based on performance in comparison to the measure's benchmark).



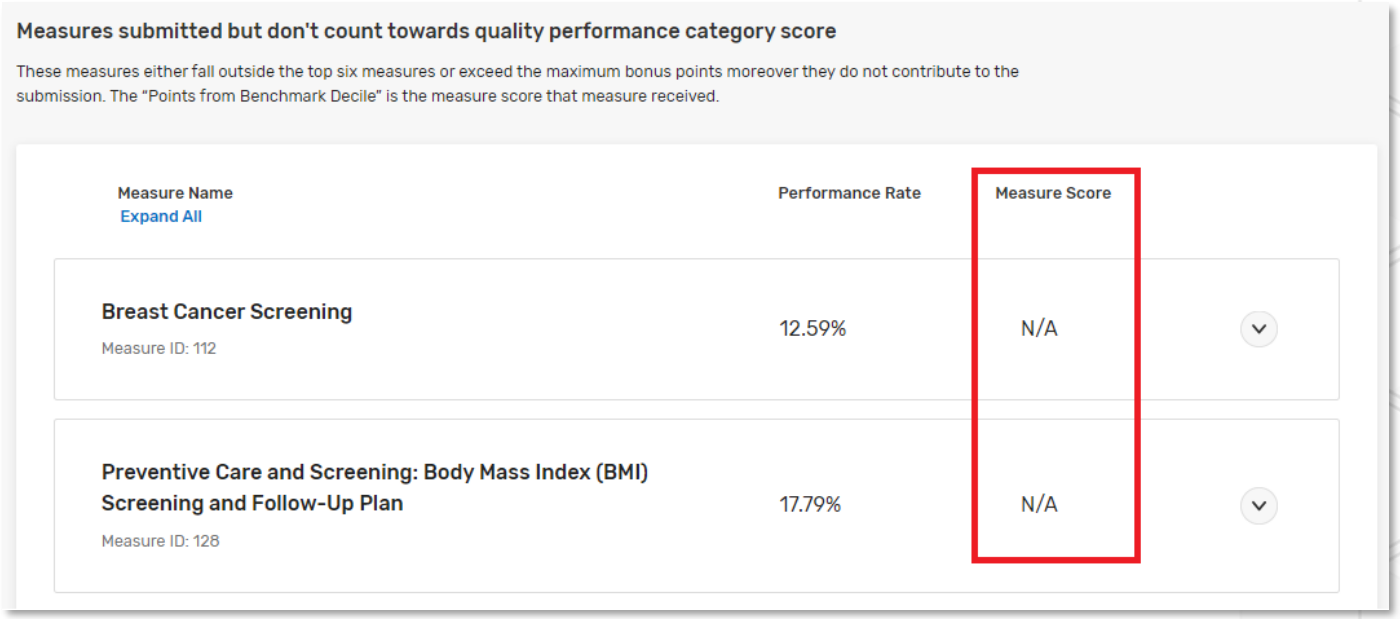
Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Measure Information (Continued)

Measures may be divided into 2 groups (Continued):

2. Measures that contribute no points to your quality performance category score. You will see an "N/A" in the measure score.



Submitting and Reviewing Quality Data

Measure Information (Continued)

In addition to the required outcome measure (or high priority measure if no outcome measure is available), we'll use your 5 highest scoring measures across collection types to determine your quality performance category score.

- For example, a small practice may report 3 measures by claims and upload a QRDA III file with 3 eCQMs to meet the requirement of submitting 6 measures.

If you submit the same measure through multiple collection types, we'll use the collection type that earned the most performance points.

Exception: We'll only combine CMS Web Interface measures with the CAHPS for MIPS Survey measure. If you report through the CMS Web Interface and report measures from other collection types (such as eCQMs or QCDR measures), we'll use whichever results in a higher quality score – either your CMS Web Interface measures OR those submitted through other collection types.

What's a collection type?

A collection type refers to a set of quality measures with comparable specifications and data completeness requirements. The same measure may be reported through multiple collection types, where each collection type has a distinct measure specification for collecting the data and calculating the measure.

For example, Measure 130 (Documentation of Current Medication in the Medical Record) may be reported as:

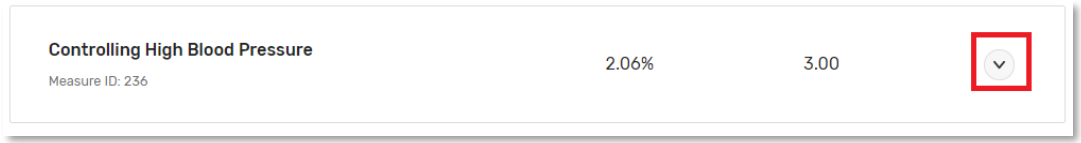
- A Medicare Part B Claims Measure
- A MIPS Clinical Quality Measure (MIPS CQM)
- An Electronic Clinical Quality Measure (eCQM)

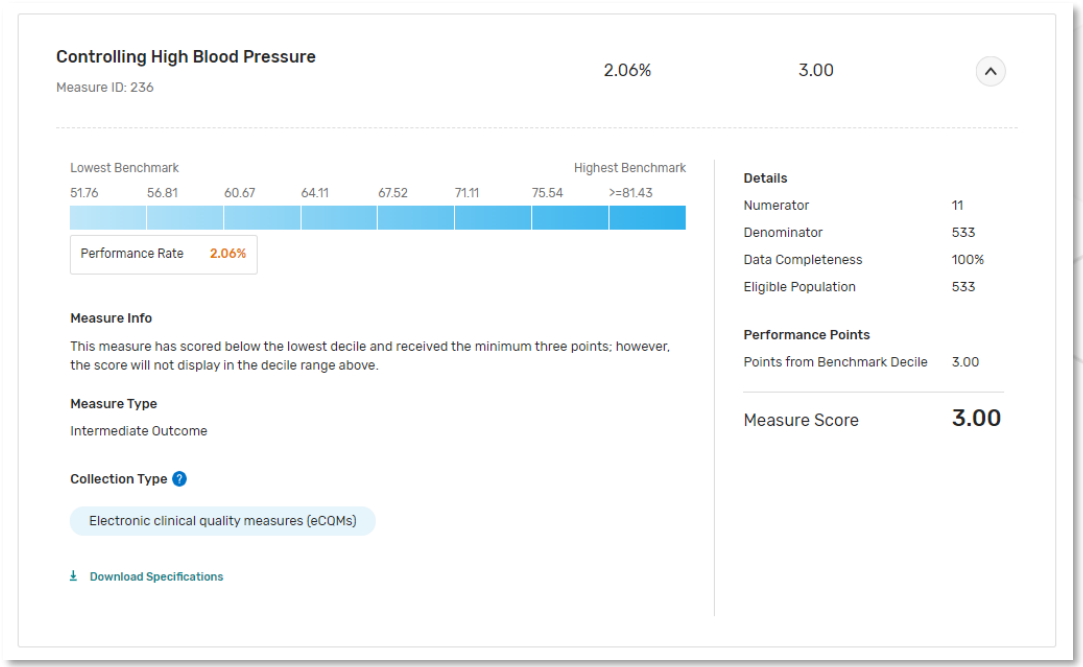
Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Measure Information (Continued)

To view measure details, click the down arrow on the right side of the measure information:





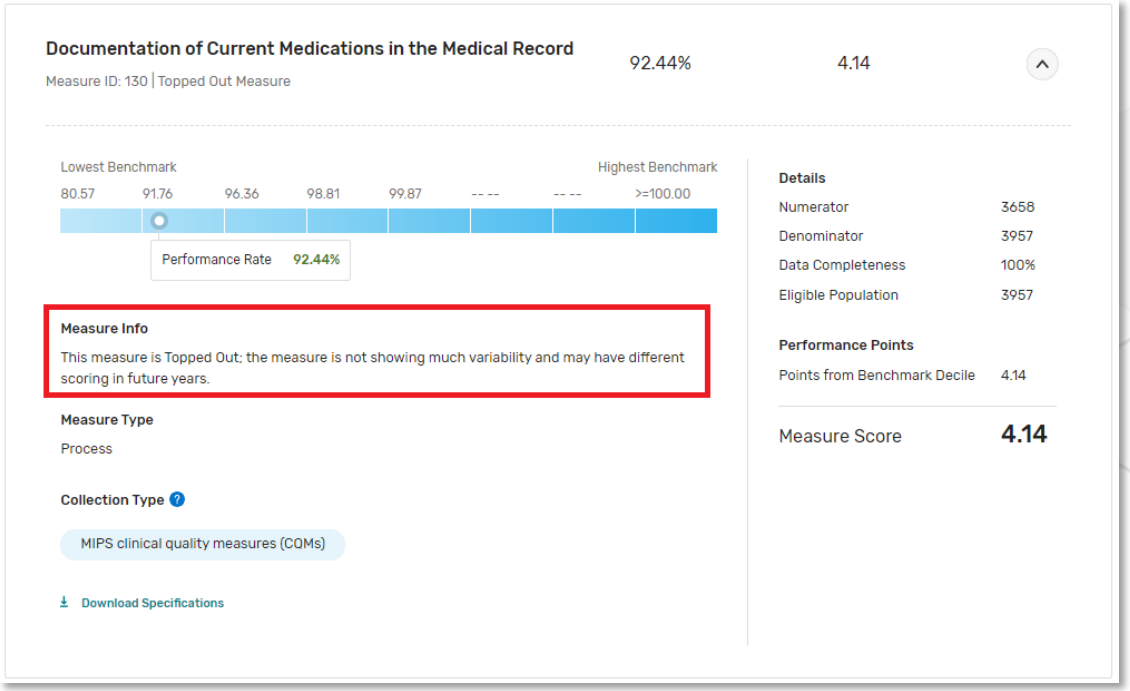
From here, you will see performance points (those earned by comparing your performance to a historical benchmark), and other scoring details about the measure.

Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Topped-Out Measures

A topped-out measure is one where performance is high with little variation among those reporting the measure – a topped out **process** measure is defined as a measure with a median performance rate of 95% or greater (or 5% or less, for inverse measures).

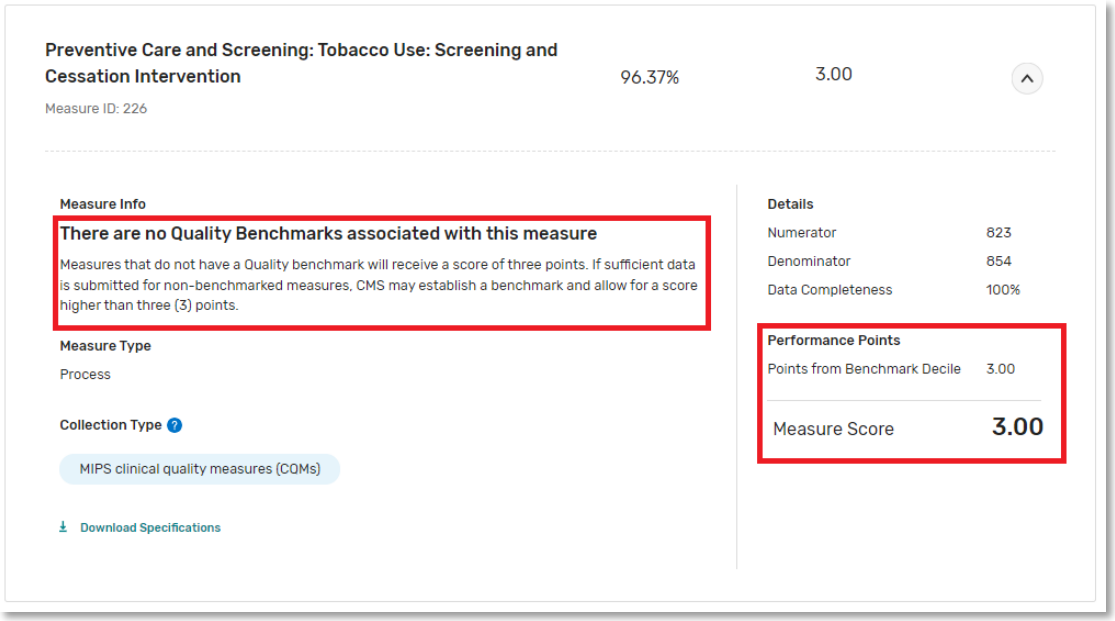


Did you know?
Not all topped out measures are capped at 7 points. To be capped at 7 points, a measure must in its 2nd (or 3rd or 4th) consecutive year of being topped out through the same collection type. Refer to "Seven Point Cap" column in the 2022 Quality Benchmarks file.

Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Measures Without a Historical Benchmark



If you report a measure without a historical benchmark, you will see **3 performance points** provided the measure met data completeness and case minimum requirements.

If we can calculate a performance period benchmark, we will update the measure's performance points in your final performance feedback (available summer 2023).

Did you know?

Beginning with the 2023 performance year, measures without a benchmark will receive 0 points. (Small practices will continue to earn 3 points.)

Submitting and Reviewing Quality Data

Submitting Fewer than 6 Measures

Clinicians who don't have 6 available quality measures and who report Medicare Part B claims measures or MIPS CQMs may qualify for the Eligible Measure Applicability, or EMA, process. We check for unreported, clinically related measures – or whether you reported all measures in a specialty measure set with fewer than 6 measures – which can result in a denominator reduction in the Quality performance category.

If you submit fewer than 6 MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA. Denominator reductions for MIPS CQM submissions will be immediately reflected in the Total Quality Score calculation section.

Did you know?

If you reported Medicare Part B Claims measures, the EMA process is generally applied **after the submission period** to account for the 60-day claims run out period (during which time, CMS may still receive Medicare Part B claims with dates of service in 2022).

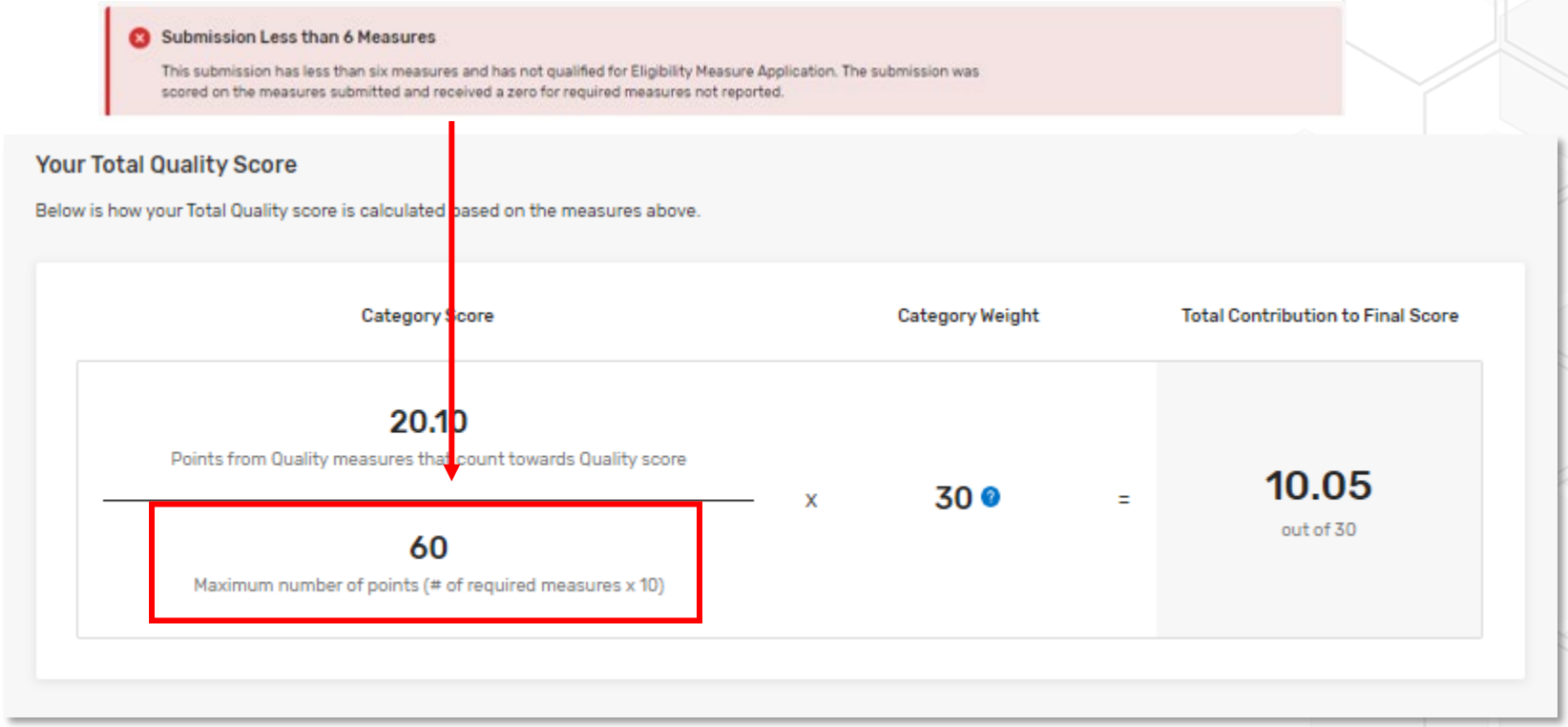
For more information on EMA, review the 2022 EMA and Denominator Reductions User Guide on the QPP Resource Library.

Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Submitting Fewer than 6 Measures (Continued)

Submission (MIPS CQMs) doesn't qualify for denominator reduction

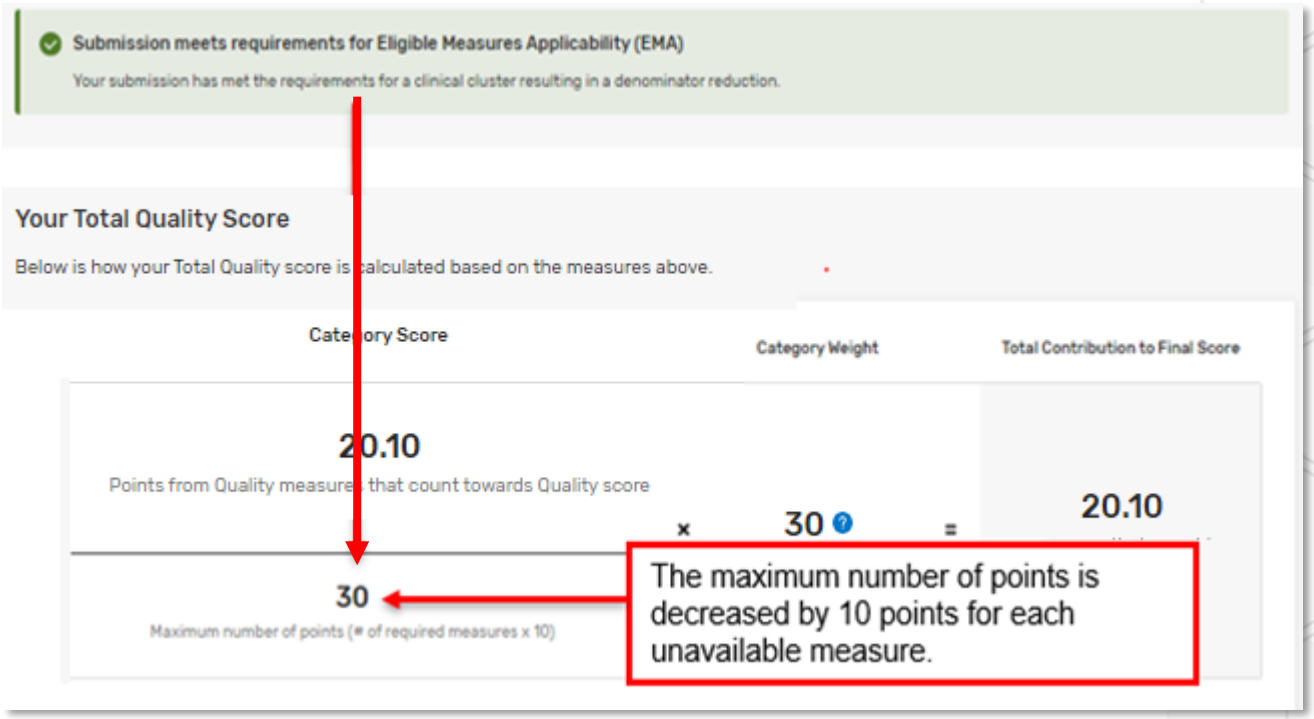


Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Submitting Fewer than 6 Measures (Continued)

Submission (MIPS CQMs) qualifies for denominator reduction



Submitting and Reviewing Quality Data

Suppressed and Truncated Measures: Submission and Scoring Examples

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

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

Example 1.

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

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

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

Example 2.

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

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

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

Submitting and Reviewing Quality Data

Suppressed and Truncated Measures: Submission and Scoring Examples (Continued)

Example 3.

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

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

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

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

Example 4.

You submit 6 suppressed measures.

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

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

Suppressed and Truncated Measures: Submission and Scoring Examples (Continued)

Example 5.

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

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

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

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

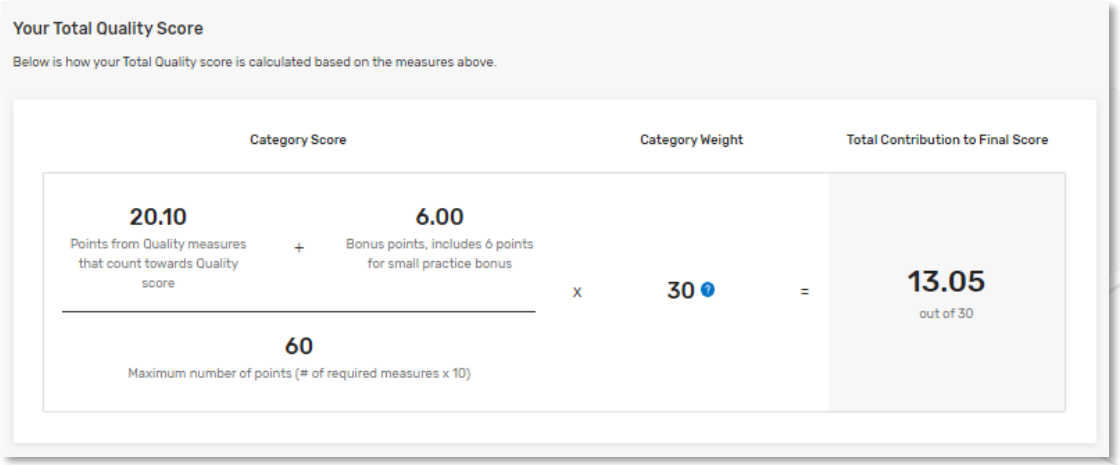
Submitting and Reviewing Quality Data

Quality Payment PROGRAM

Preliminary Quality Score Calculation

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 for small practices if applicable) by the maximum number of points available in the Quality performance category, then we multiply that number by the category weight.



Did you know?

The maximum number of points may change after the submission period if:

- The Eligible Measure Applicability (EMA) process, applied in some instances after the submission period, determines you didn't have 6 available measures to report.
  - This will cause the maximum points to decrease by 10 points for each unavailable measure.
- You can be scored on one or both administrative claims measures.
  - This will cause the maximum points to increase by 10 points for each scored measure.

Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

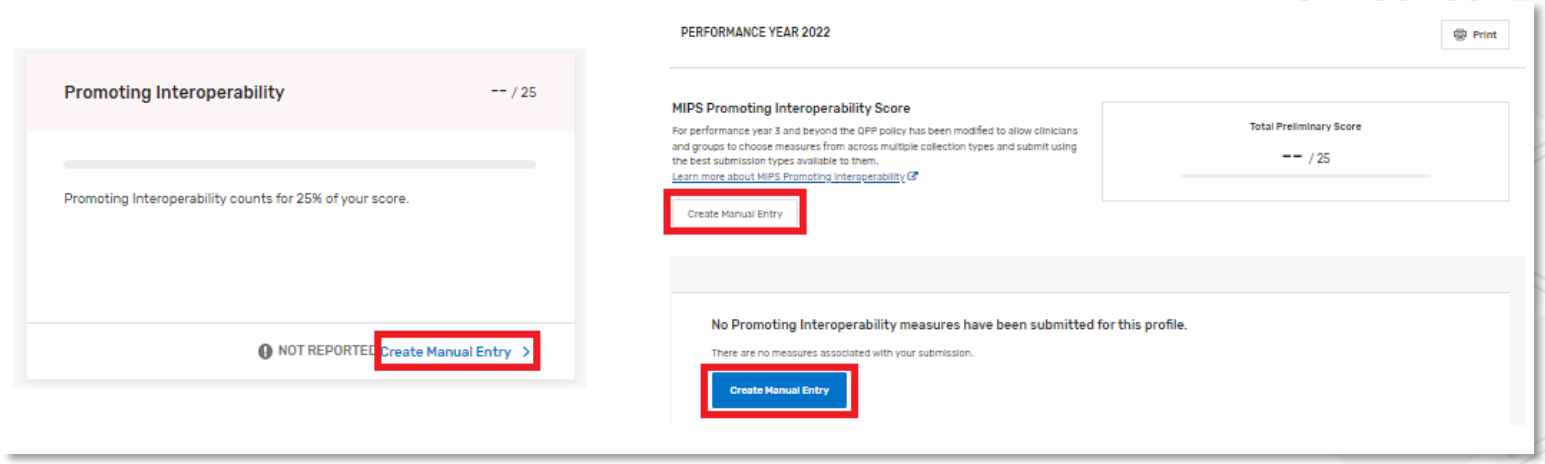
File Upload

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

Manual Entry (Attestation)

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

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



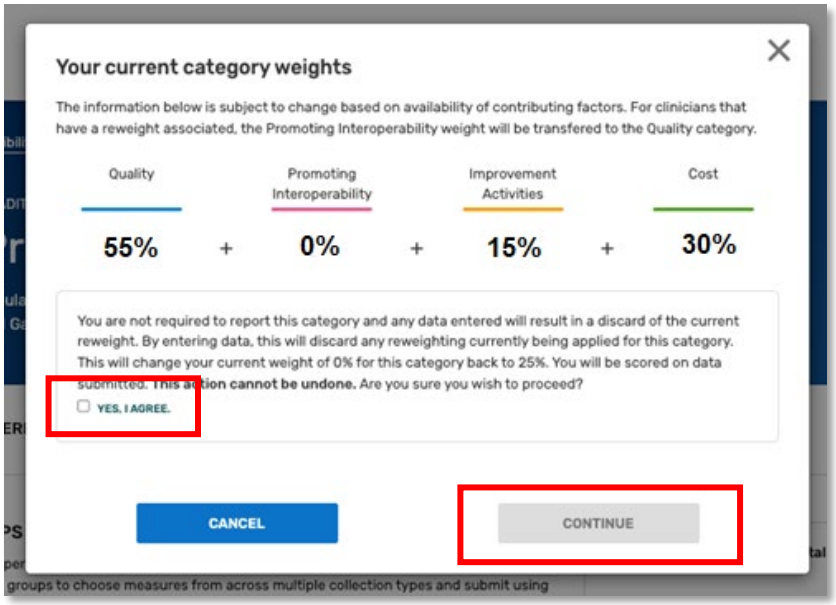
Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

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

- **If you click Continue and enter any data, including performance period dates, you <u>will</u> receive a score in this performance category.**



<u>Did you know?</u>

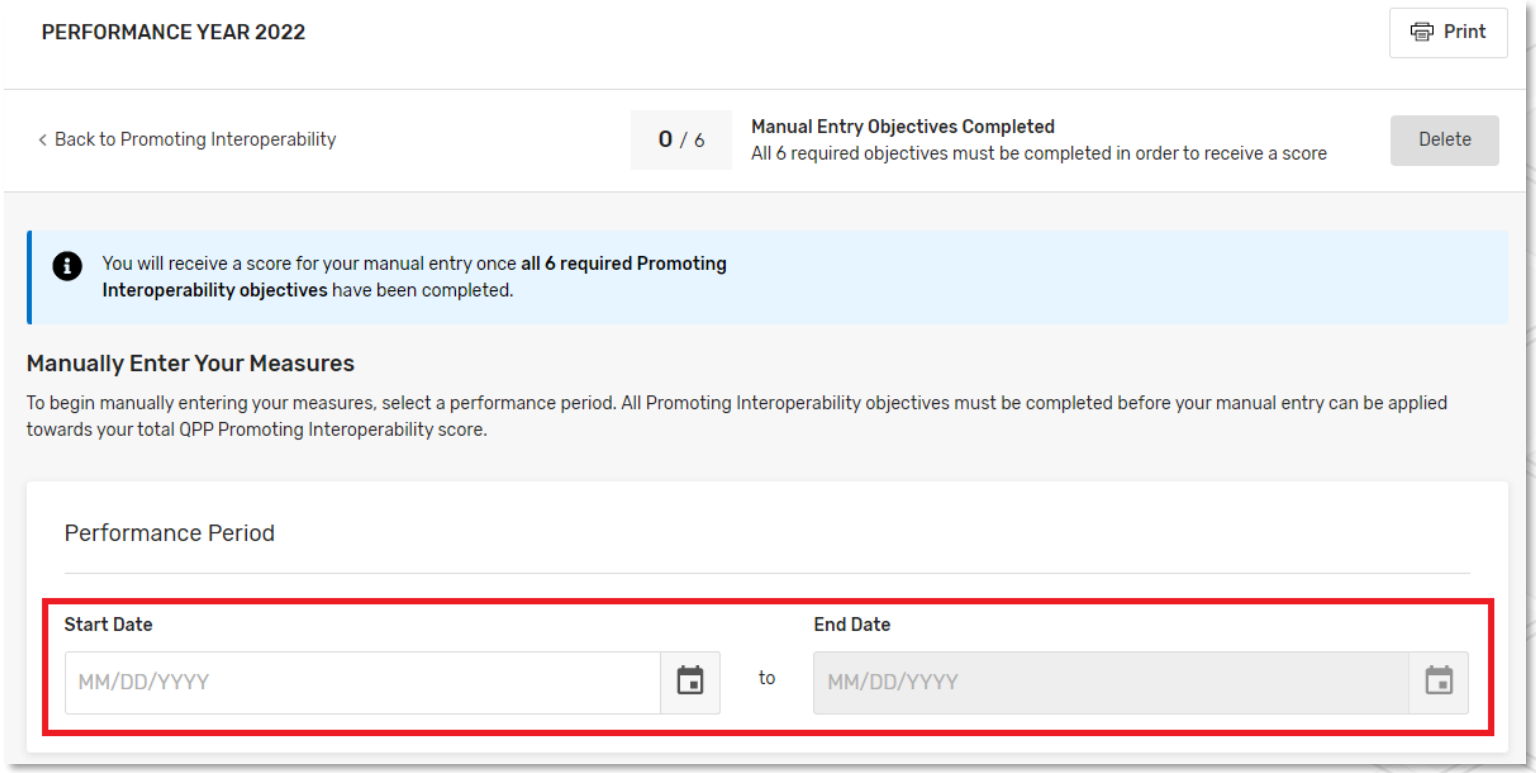
Small practices have a different redistribution when **Promoting Interoperability** is reweighted to 0%

- **Quality:** 40%
- **Improvement Activities:** 30%
- **Cost:** 30%

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

Submitting and Reviewing Promoting Interoperability Data

Manual Entry (Attestation) (Continued)



Reminder:

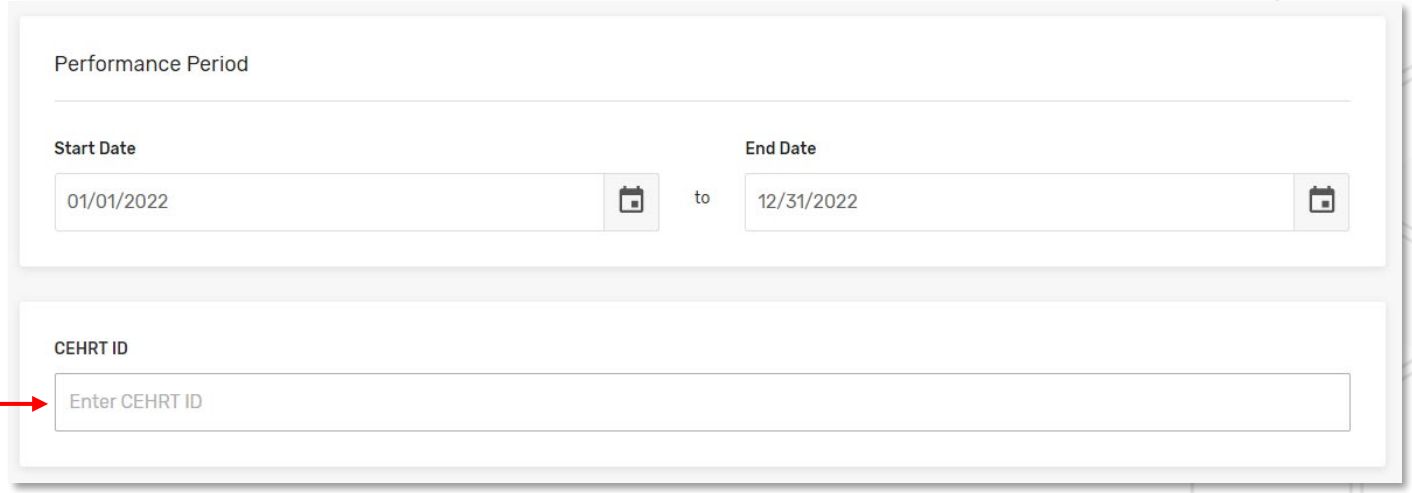
If your hardship request was approved but you still see a weight of 25%, don't enter any information (including performance period) on this page. This will override your reweighting, and you will be scored in this performance category.

Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Enter your CMS EHR Certification ID ("CEHRT ID")



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

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

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

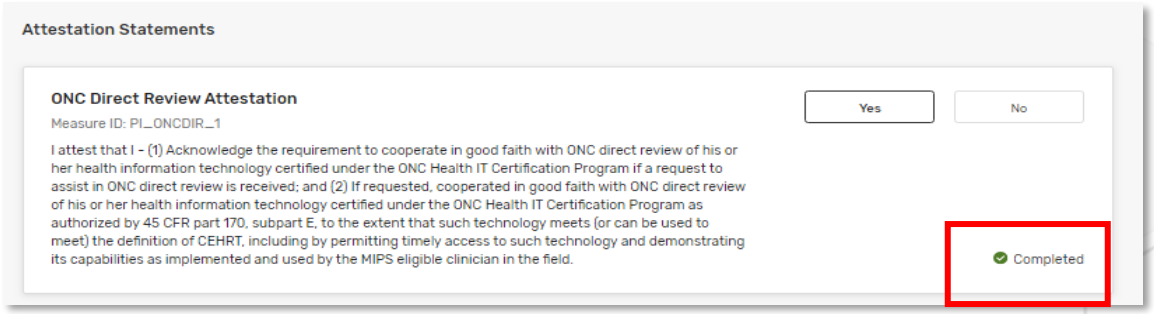
Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

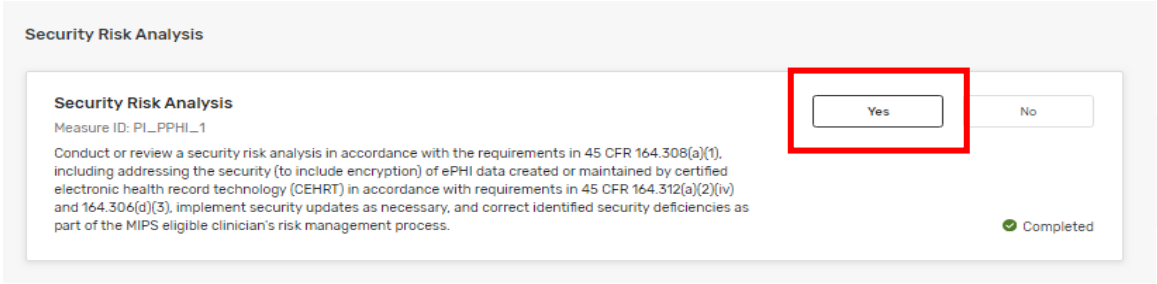
Manual Entry (Attestation) (Continued)

Complete Required Attestation Statements and Measures

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



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

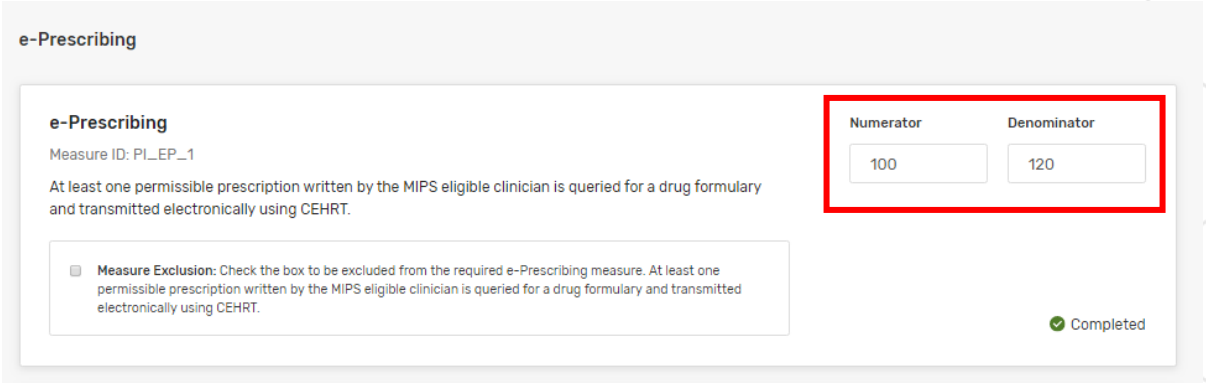


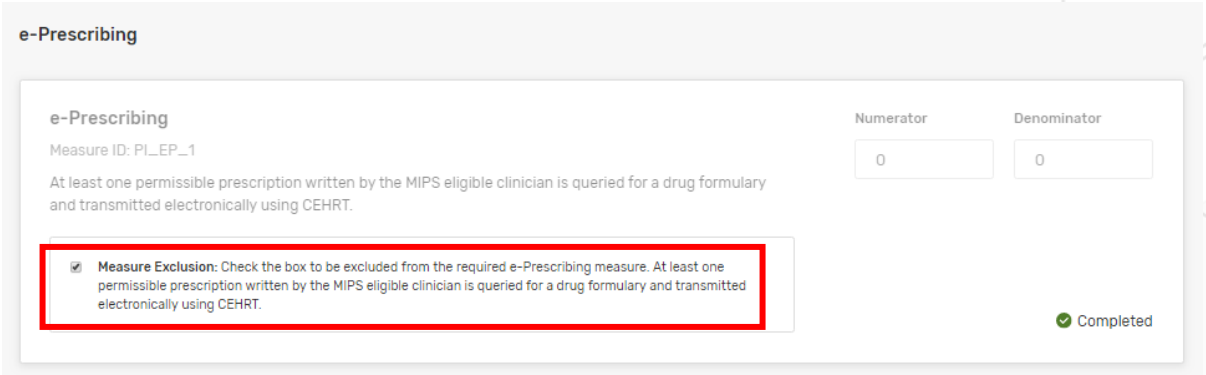
Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Complete Required Attestation Statements and Measures



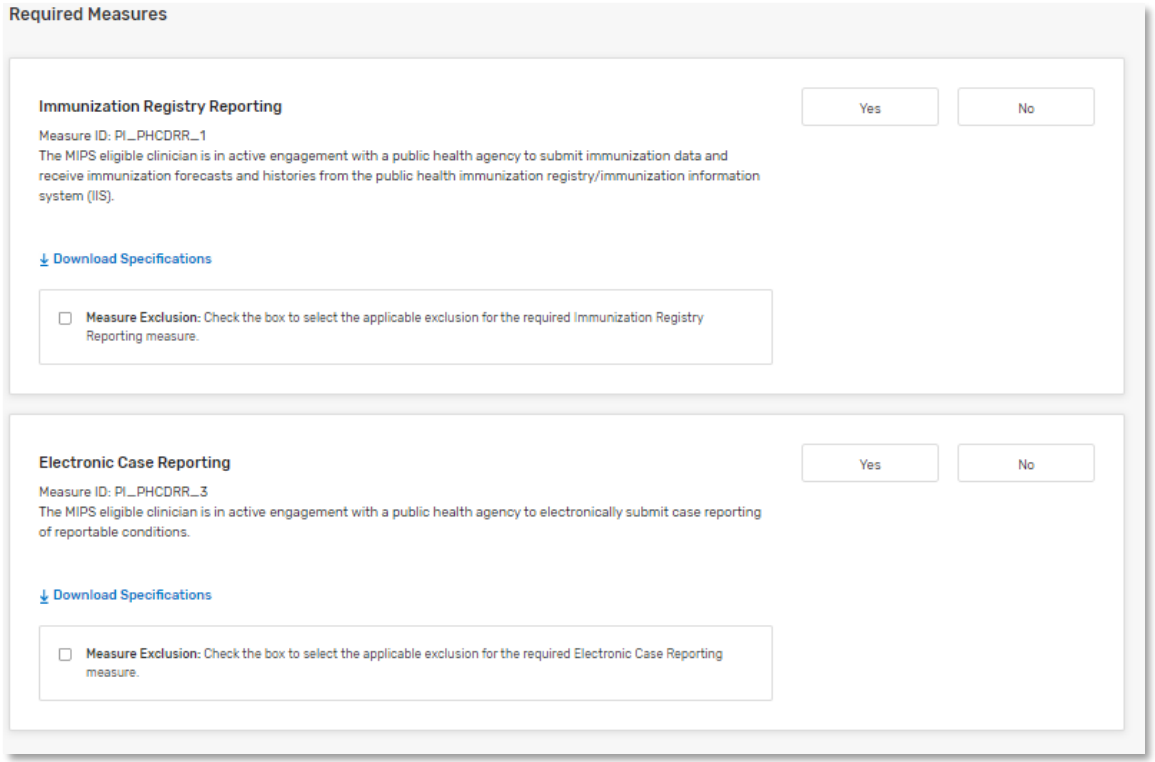


Submitting and Reviewing Promoting Interoperability Data

Manual Entry (Attestation) (Continued)

Quality Payment PROGRAM

Complete Required Attestation Statements and Measures – Public Health and Clinical Data Exchange



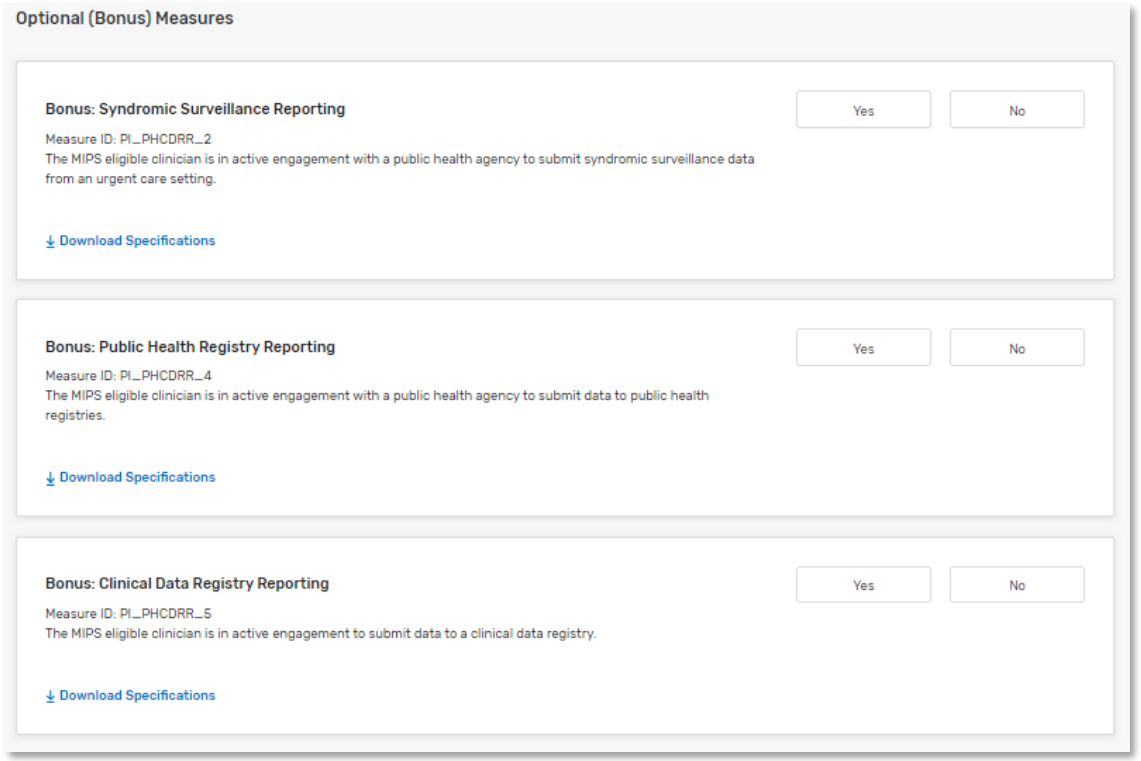
Reminder: Beginning in 2022, there are 2 required measures for this objective: Electronic Case Reporting and Immunization Registry Reporting.

Submitting and Reviewing Promoting Interoperability Data

Manual Entry (Attestation) (Continued)

Quality Payment PROGRAM

Complete Required Attestation Statements and Measures – Public Health and Clinical Data Exchange



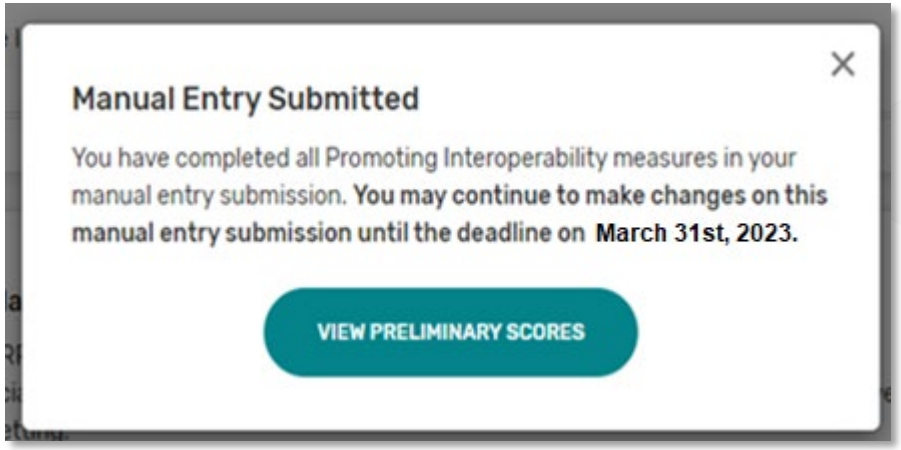
To earn an additional 5 bonus points in this performance category, you can choose to report 1 or more of the remaining, optional measures. There are 5 bonus points available whether you report 1, 2 or all 3 of the optional measures.

Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

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



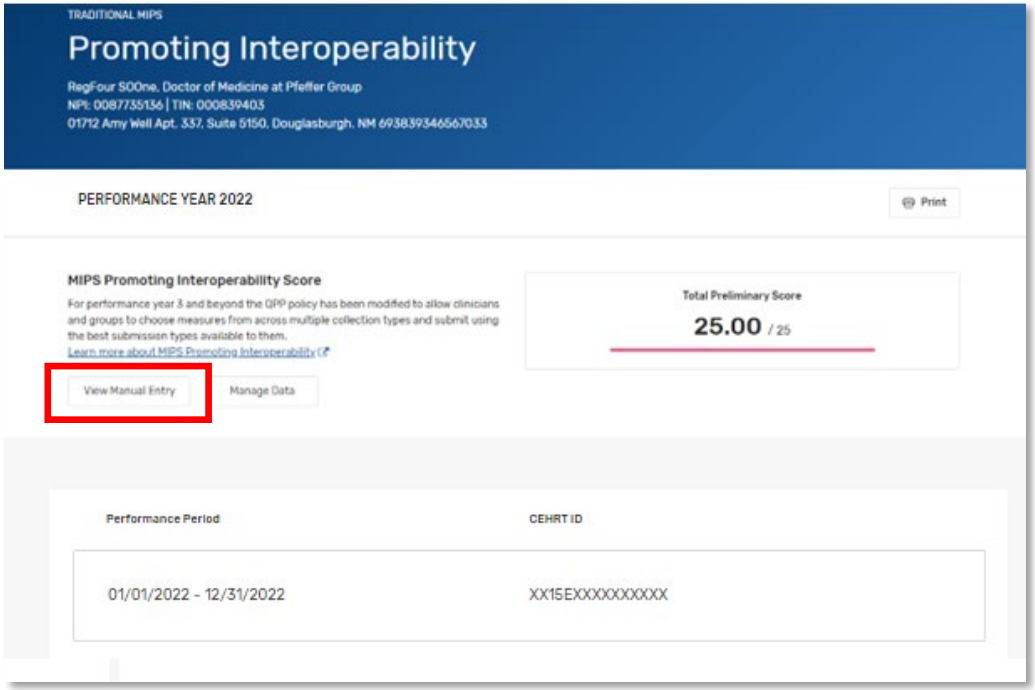
Still have questions? Learn more about how to manually attest for the Promoting Interoperability performance category.

Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Access Previously Submitted Data

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



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

Reminders

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

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

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

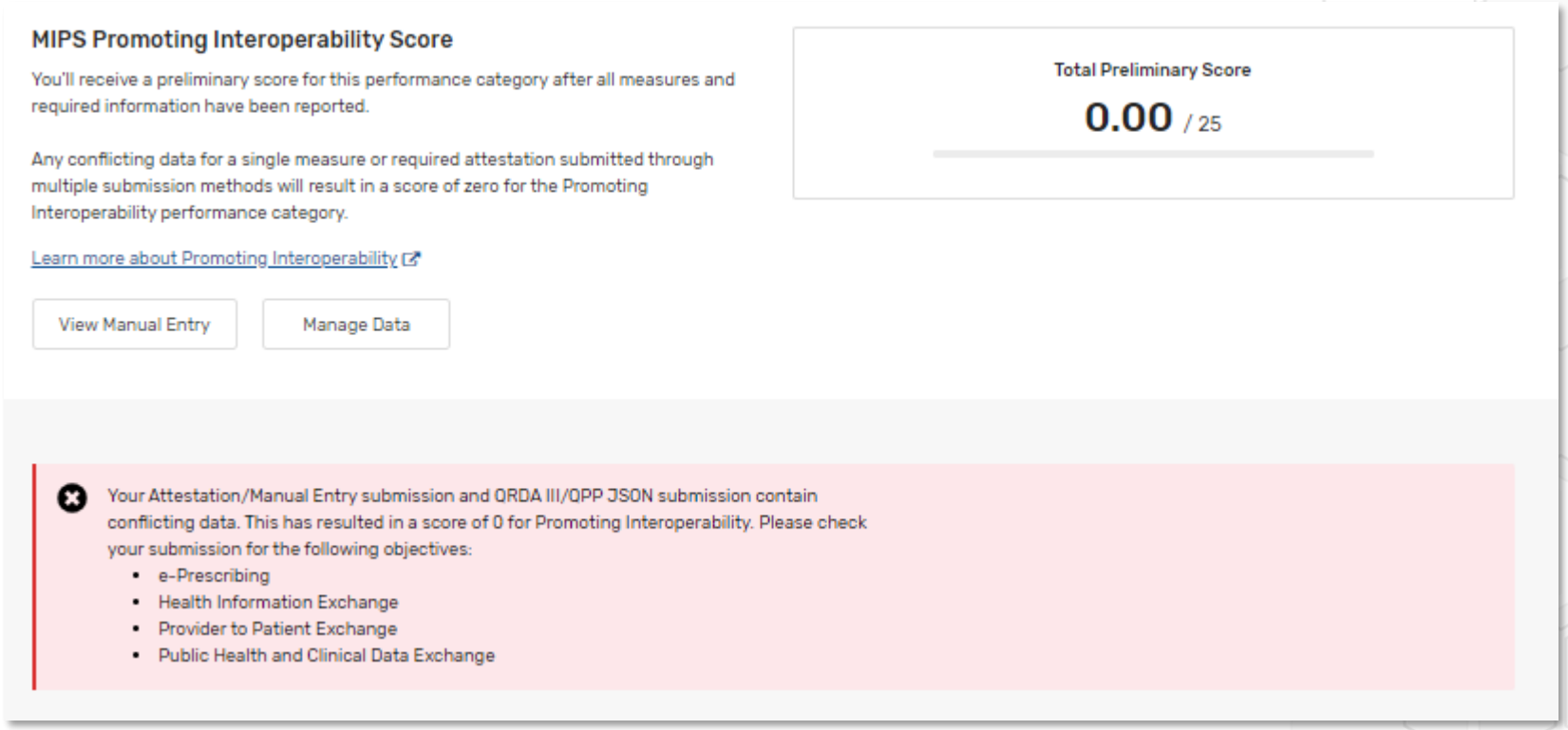
- If you see errors in your data, contact your third-party intermediary and ask them to delete the data they've submitted for you.

Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Access Previously Submitted Data (Continued)

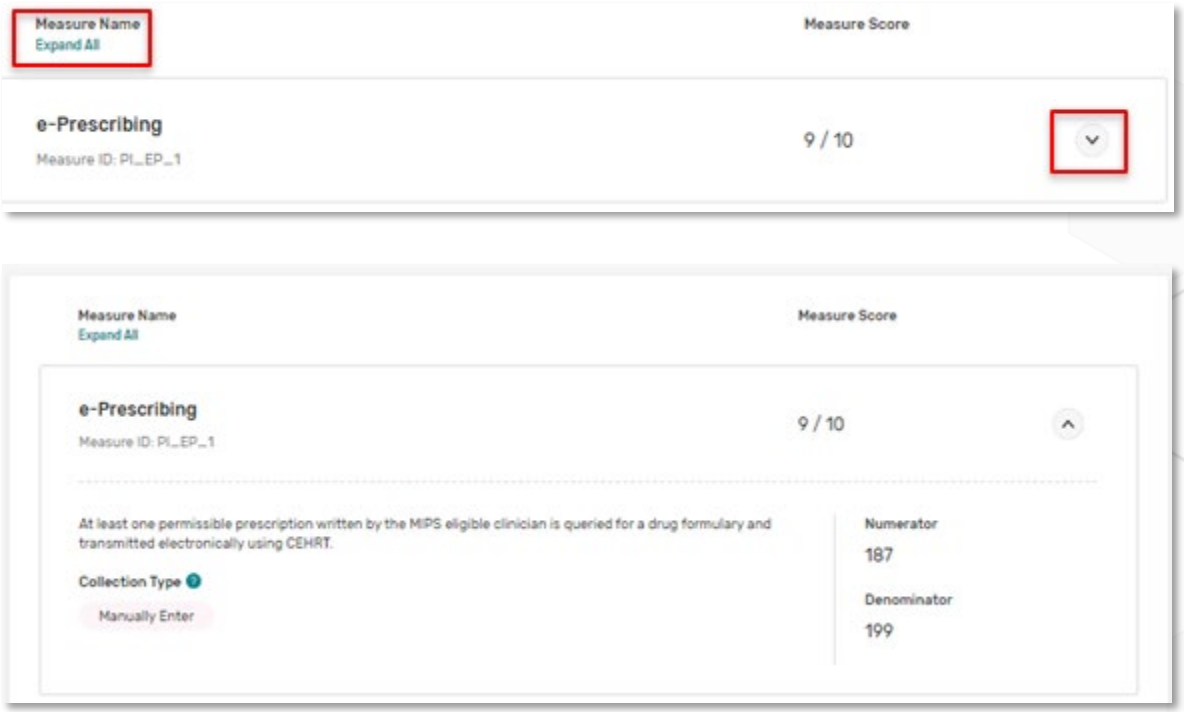
If you report Promoting Interoperability data through multiple submission types (ex. Manual entry and file upload) and there is **any conflicting data**, you will receive a **score of 0 out of 25** for the performance category.



Submitting and Reviewing Promoting Interoperability Data

Access Previously Submitted Data (Continued)

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

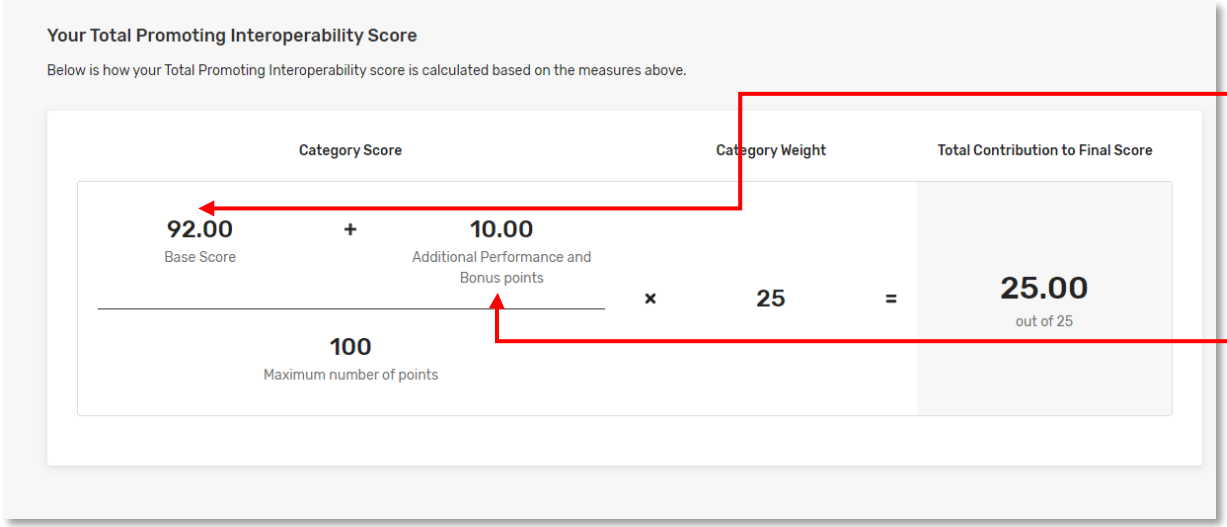


Submitting and Reviewing Promoting Interoperability Data

Quality Payment PROGRAM

Preliminary Promoting Interoperability Score Calculation

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



Sum of points earned for all required measures

Bonus points earned for reporting optional measure

Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

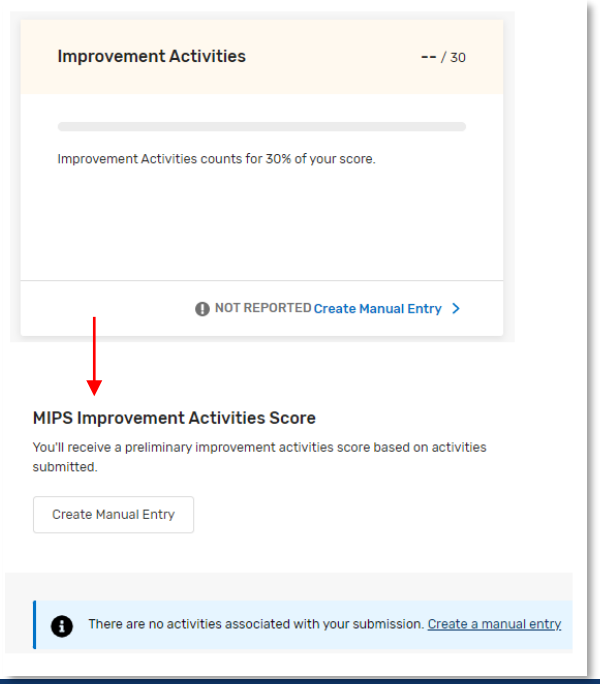
File Upload

You can upload a QRDA III or QPP JSON file with your Improvement Activities data on the Reporting Overview page.

Manual Entry (Attestation)

You can also attest to your Improvement Activities data by manually entering yes values to indicate you've completed the activity.

Click Create Manual Entry on the **Reporting Overview**, and then again on the **Improvement Activities** page.

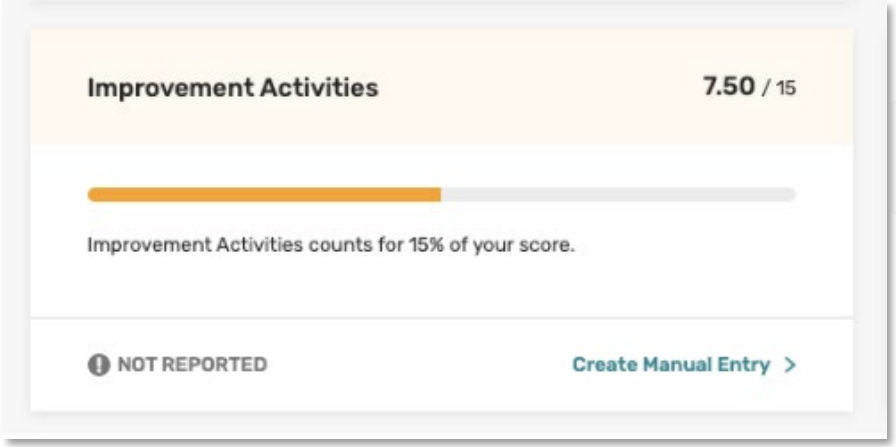


Submitting and Reviewing Improvement Activities Data

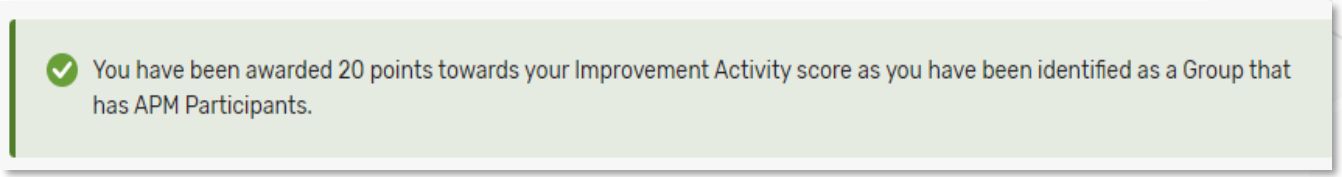
Manual Entry (Attestation) (Continued)

Clinicians in an APM reporting traditional MIPS will automatically receive 50% credit in the Improvement Activities performance category as long as some MIPS data is submitted, regardless of performance category.

On the Reporting Overview page, you will see 7.50 points out of 15 awarded, even if no Improvement Activities have been reported yet.



Once you select Create Manual Entry, you will see a message that 20 (out of 40 possible) points have been awarded based on your APM participation (or for Group reporting, based on having at least one clinician who participates in an APM).

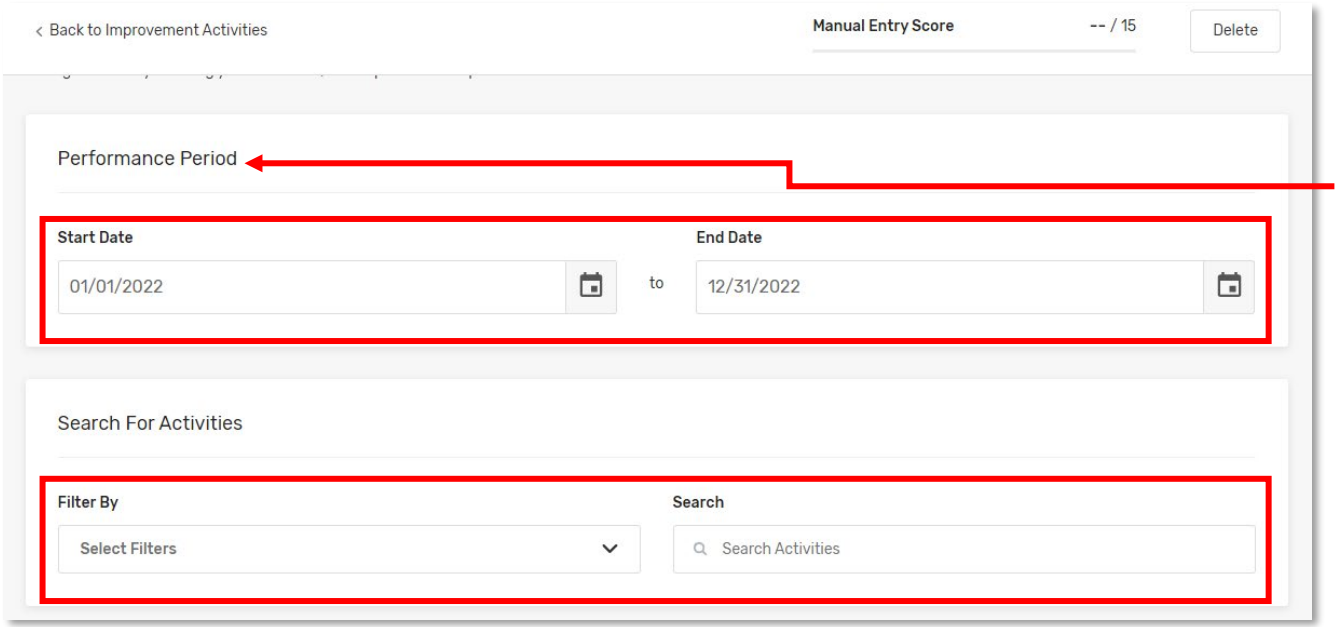


Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Once you enter your performance period, you can **search** for your activities by key term or **filter** by weight or subcategory. Check the box next to **Completed** to attest that the activity was performed.

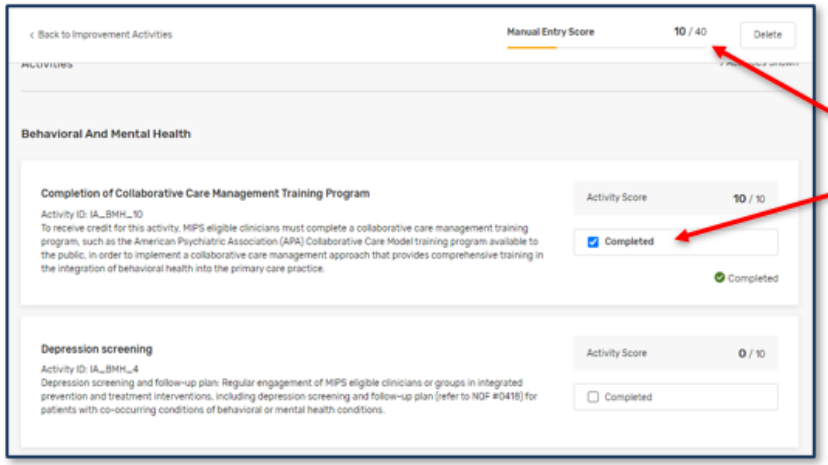


Each *activity* has a continuous 90-day performance period (or as specified in the activity description).
Your performance period at the category level:

- **Starts** on the first day in the year that any improvement activity was performed, and
- **Ends** on the last day in the year that any improvement activity was performed.

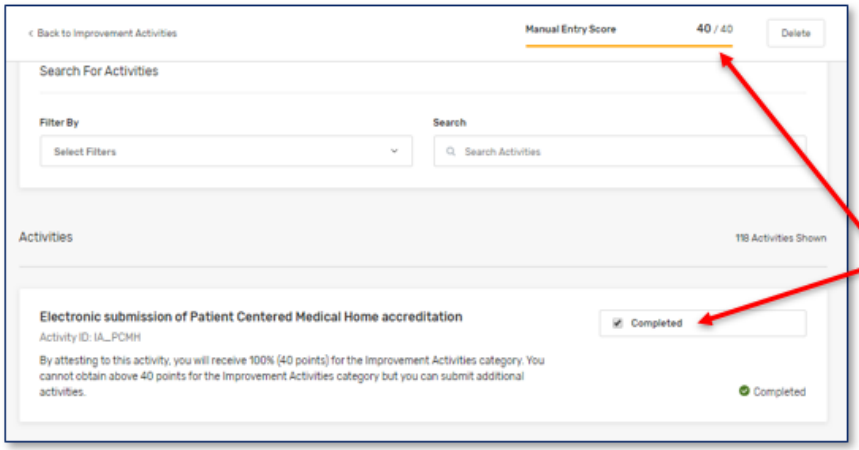
Submitting and Reviewing Improvement Activities Data

Manual Entry (Attestation) (Continued)



Once you mark your first activity as **completed**, you will see your in-progress **score** at the top of the page.

Reminder: You cannot earn more than 40 points in this category, even if you submit additional activities.



Helpful hint:

The Patient Centered Medical Home attestation is the first activity listed.

Once you select completed, you will see the maximum score in the performance category.

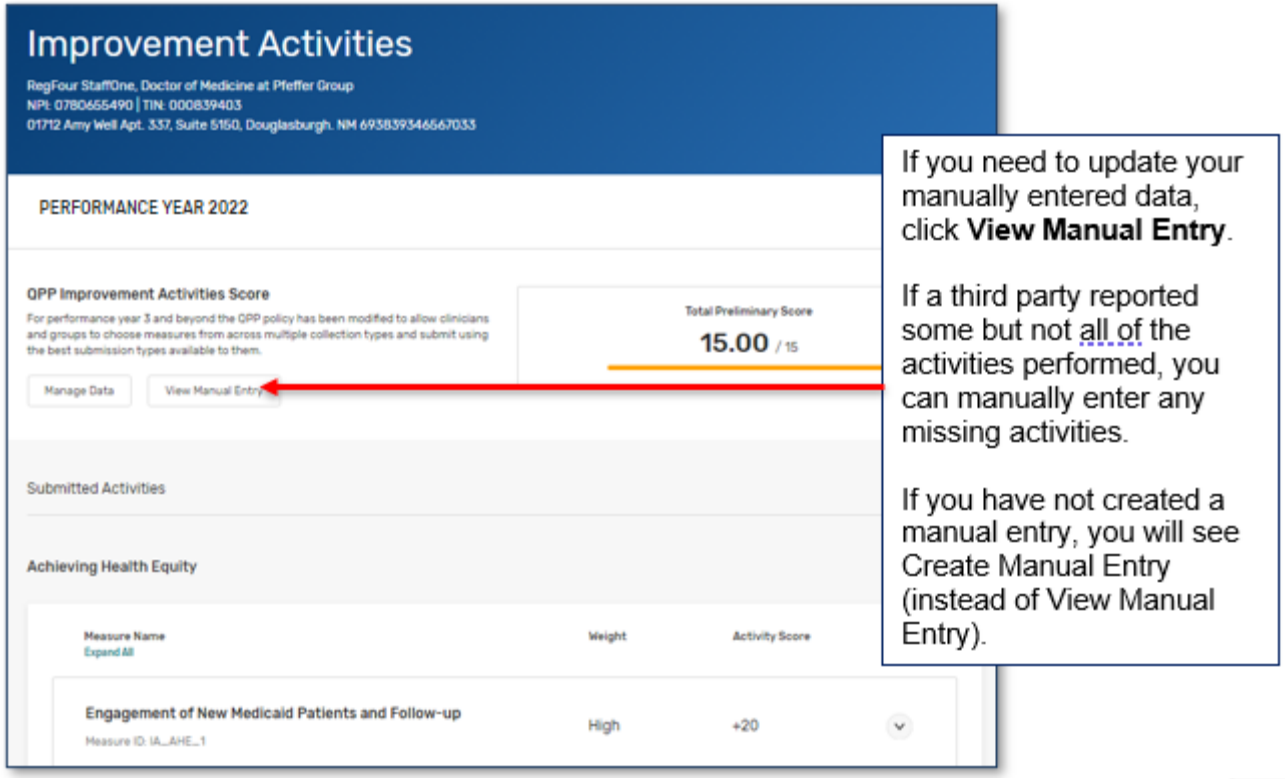
Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

Review Previously Submitted Data

Click **View & Edit** from the Reporting Overview.

You will land on a read-only page, letting you review the preliminary scoring details of your submission.

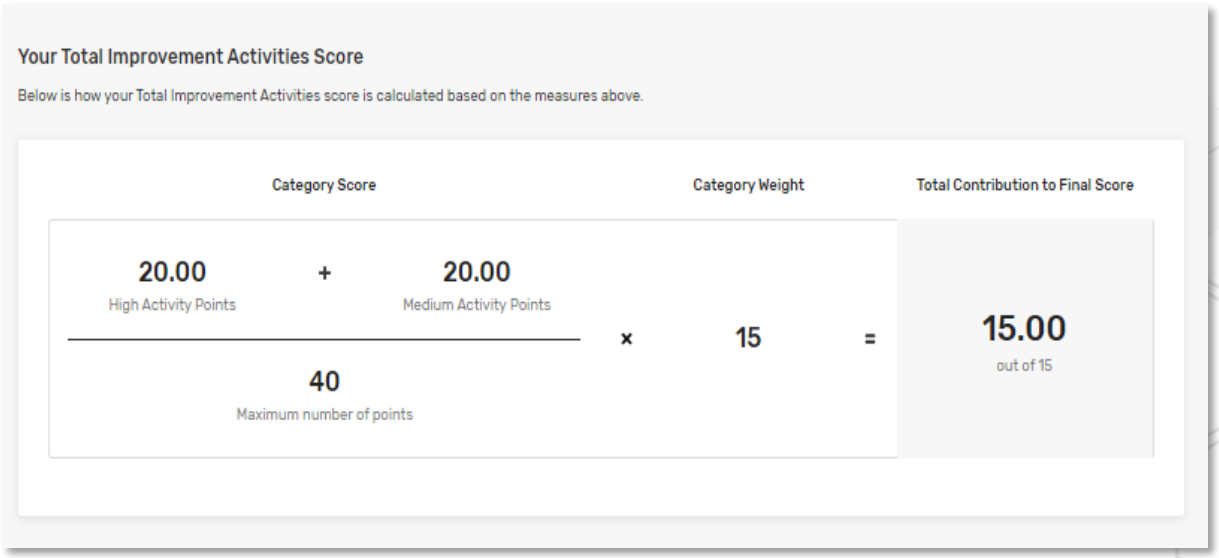


Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

Preliminary Improvement Activities Score Calculation

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.



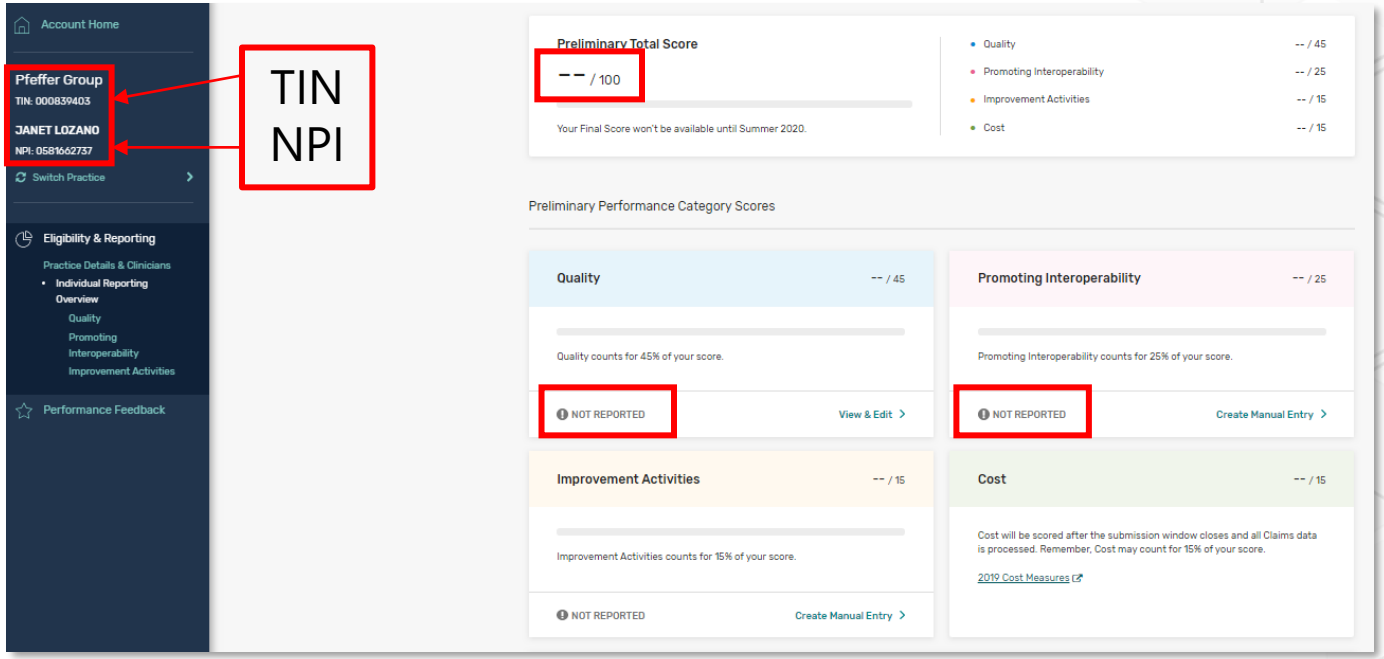
Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

QRDA III File Upload Troubleshooting

Don't See Successfully Uploaded Data

- **Scenario:** I successfully uploaded a QRDA III file with eCQMs and Promoting Interoperability data. Why can't I see the clinician's data after I hit "View Submission"?
- **Most Likely:** You uploaded a file for a different NPI.
- **Action:** Double check that NPI and TIN in your file match the information on the clinician profile you are in. Once you determine which NPI was included in that file, find that clinician in Practice Details & Clinicians and select Report as Individuals. You should see the successfully uploaded data results in the clinician's Reporting Overview.



Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

QRDA III File Upload Troubleshooting (Continued)

Common Error Message

"The measure GUID supplied 40280382-6963-bf5e-0169- e8dc81613f8b is invalid"

- **Example:** CT - The measure GUID supplied 40280382-6963-bf5e-0169- e8dc81613f8b is invalid. Please see the 2021 IG https://ecqi.healthit.gov/sites/default/files/2021-CMS-QRDA-III-Eligible-Clinicians-and-EP-IG-v1.3.pdf#page=44for valid measure GUIDs. - 3058
- **Action:** Search the 2022 QRDA III Implementation Guide (IG) (beginning on p. 43) for the GUID (also referred to as a UUID) listed in your error message.
  - If you can't find it, it is not a valid measure for the 2022 performance year
  - If you can find it, the eCQM was probably removed through rulemaking after the IG was published

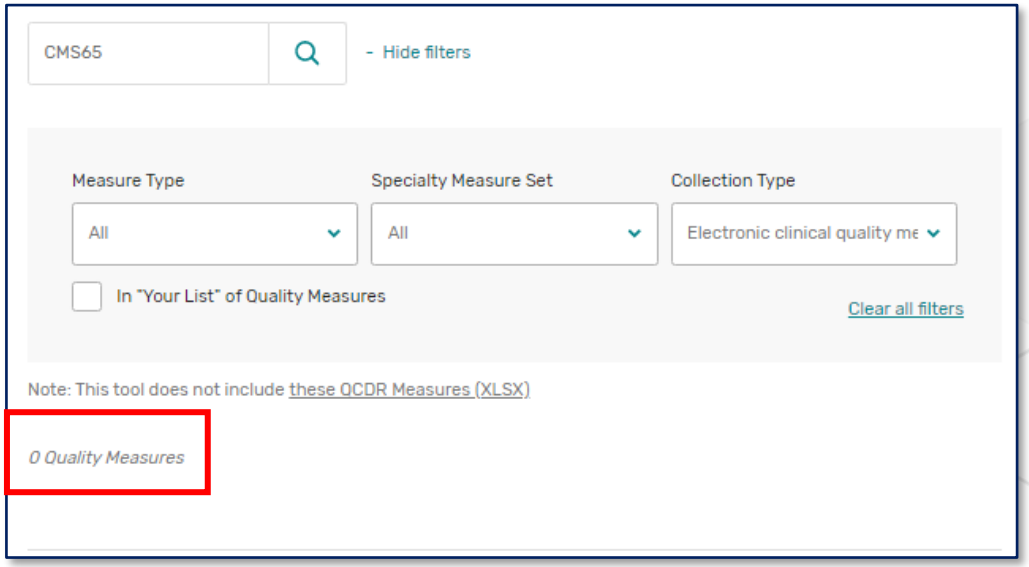
NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 128	CMS69v9	2c928085-7198-38ee-0171-9995e1f90412	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	3E32D9BB-3E5D-4D04-A8FE-C3304B782E92 D6590CC1-1156-48B4-8455-5540F23FDDB5 4CA78179-B2BF-41DC-A84F-47CE165F5002 462979D4-8A62-4DAC-9887-3085ED46BD2F 5CFA9CF5-F847-4C43-B828-3EEA31E1B8E8

Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

QRDA III File Upload Troubleshooting (Continued)

Search the 2022 Explore Measures & Activities Tool (filter by the eCQM collection type) for the associated eCQM ID to confirm it isn't valid for the 2022 performance year.



You can also search the eCQI resource center

(2022 Performance Period Eligible Professional/Clinician eCQMs)

Submitting and Reviewing Improvement Activities Data

Quality Payment PROGRAM

QRDA III File Upload Troubleshooting (Continued)

Individual vs Group Reporting

Are you submitting individually?
Make sure your file is coded as an ***individual*** submission and your individual NPI is in your file correctly.

Example:
<intendedRecipient>
<id root="2.16.840.1.113883.3.249.7"
extension="MIPS_INDIV" />
</intendedRecipient>

Are you submitting as a group?
Make sure your file is coded as a ***group*** submission and your group's TIN is in your file correctly without any NPIs.

Example:
<intendedRecipient>
<id root="2.16.840.1.113883.3.249.7"
extension="MIPS_GROUP" />
</intendedRecipient>

Helpful Hint:
Search "2.16.840.1.113883.4.6" (the object identifier) in the file and then look for the next occurrence of "extension=". The value immediately after "extension=" should be the 10-digit NPI.

Example:
<assignedEntity>
<id root="2.16.840.1.113883.4.6"
extension="1234567890" />
</assignedEntity>

Helpful Hint:
Search for "2.16.840.1.113883.4.2" in the file and then look for the next occurrence of "extension=". The value immediately after "extension=" should be the 9-digit TIN.

Example:
<representedOrganization>
<id root="2.16.840.1.113883.4.2"
extension="123456789" />
<name>CT</name>

Quality Payment
PROGRAM

Help, Resources, and Version History

Help, Resources, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

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

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

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

Help, Resources, and Version History

Quality Payment PROGRAM

Additional Resources

Date	Description
2022 Data Submission FAQs	Answers to frequently asked questions submission questions relevant for Performance Year 2022.
2022 MIPS Data Submission Videos	Video series about reporting Performance Year 2022 data and making opt-in elections.
2022 CMS Web Interface User Guide	Step by step instructions with screenshots for Performance Year 2022 reporting through the CMS Web Interface.
2022 CMS Web Interface Videos	Video series about reporting Performance Year 2022 data through the CMS Web Interface
2022 MIPS Scoring Guide	Comprehensive information about scoring measures and calculating performance category scores and final scores.
2022 MIPS EMA and Denominator Reduction User Guide	An overview of the Eligible Measures Applicability (EMA) process and identifies the MIPS CQMs and Medicare Part B Claims measures that are clinically related.
2022 APP Quality Requirements	Resource that describes the APM Performance Pathway for the quality performance category for those APM participants reporting to the APP.

Help, Resources, and Version History

Version History

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

Date	Description
02/27/2023	Added Appendix C with measures truncated or suppressed as a result of ICD-10 coding changes. Added slides 58-60 for Suppressed and Truncated Measures: Submission and Scoring Examples.
01/20/2023	Updated call-out box on slide 6 and updated slides 16, 21, 25, 30, and 84 to include links to resources.
01/03/2023	Original Posting.

Appendices

Appendix A

Quality Payment PROGRAM

Data Submission and the Automatic EUC Policy

The tables on the following slides illustrate the Performance Year 2022 MIPS performance category reweighting policies that CMS will apply under the MIPS automatic EUC policy to clinicians that submit MIPS data as individuals.

- As a reminder, this policy was triggered by the following events for the 2022 performance year:
- Certain counties in Kentucky for the Kentucky severe storms, flooding, landslides, and mudslides.
- Certain counties in New Mexico for the New Mexico wildfires and straight-line winds.
- Puerto Rico following Hurricane Fiona.
- Certain areas in Florida following Tropical Storm Ian.

Note: Participants in APMs are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category, which will override reweighting of this performance category.

Appendix A

Data Submission and the Automatic EUC Policy (Continued)

Table 1: Reweighting for Clinicians Not in a Small Practice

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[1]	100%	0%	0%	0%	Neutral
Promoting Interoperability Only[1]	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability[1]	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

1 APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Appendix A

Data Submission and the Automatic EUC Policy (Continued)

Table 2: Reweighting for Clinicians in a Small Practice

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[2]	100%	0%	0%	0%	Neutral
Promoting Interoperability Only[2]	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability[2]	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	50%	0%	50%	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

2 APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view based on your access (role) and organization type during the submission period (January 3 – March 31, 2023).

With this Access	You CAN	You CANNOT
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ Access information about eligibility and special status at the individual clinician and group level ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your practice (as a group and/or individuals) • Includes Promoting Interoperability data for MIPS APM participants ✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals) ✓ View data submitted on behalf of your practice (group and/or individual) ✓ View preliminary scoring for Part B claims measures reported throughout the performance period • This data will be updated during the submission period to account for claims received by CMS until March 1, 2023 ✓ View preliminary performance feedback for the group and individual clinicians	✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View facility-based scoring for quality / cost (if applicable) ✗ REMINDER: Facility-based scoring isn't available in Performance Year 2022. View data submitted by your APM Entity ✗ ***Example.*** If you're a Participant TIN in a Shared Savings Program ACO, you will not be able to view the quality data reported by the ACO through the CMS Web Interface ✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group)

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view based on your access (role) and organization type during the submission period (January 3 – March 31, 2023).

With this Access	You CAN	You CANNOT
Clinician Role	*You can't do anything related to Performance Year 2022 submissions with this role* *This is a view-only role to access performance feedback*	
Staff User or Security Official for a **Virtual Group**	✓ Access information about the practices (TINs) and clinicians participating in the virtual group ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your virtual group ✓ View data submitted on behalf of your virtual group ✓ View performance feedback for the virtual group	✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission)
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ Download your API token (security officials only) ✓ Upload a submission file on behalf of your clients (groups and/or individuals) ✓ Submit opt-in elections on behalf of your clients ✓ View preliminary scoring for your clients based on the data you submitted for them	✗ View data submitted directly by your clients ✗ View data submitted by another third party on behalf of your clients ✗ View data collected and calculated by CMS on behalf of your clients ✗ Cost measures (if applicable)

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view based on your access (role) and organization type during the submission period (January 3 – March 31, 2023).

With this Access	You CAN	You CANNOT
Staff User or Security Official for an **APM Entity**	✓ Access a list of the practices (TINs) and clinicians participating in the APM Entity ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit quality data through the CMS Web Interface (Shared Savings Program, or other registered APM Entities) ✓ Upload a QRDA III file with your eCQM data (Primary Care First) ✓ Upload a file of APM Entity-level MIPS quality measure data (all APM Entities in a MIPS APM) ✓ View preliminary performance feedback on quality data submitted by or on behalf of the APM Entity ✓ View the automatic 50% reporting credit available to some APMs	✗ View the Promoting Interoperability data reporting by clinicians and groups in your APM entity ✗ View quality data reported by clinicians and groups in your APM Entity

Appendix C

Quality Measures with MIPS Scoring or Submission Changes

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

02/02/2023: Updated based on MIPS quality measures impacted by International Classification of Diseases, Tenth Revision (ICD-10) updates effective October 1, 2022. (MIPS CQM and Medicare Part B claims measures were truncated and eCQMs were suppressed.) Download this fact sheet for more information. We've also added new suppressed measure scoring examples on pages 58 through 60 of this guide.

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

Appendix C

Quality Measures with MIPS Scoring or Submission Changes

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

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Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 238/ Use of High-Risk Medications in Older Adults	MIPS CQM	**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 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.)	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.

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Quality Measure ID/ Title	Impacted Collection Type(s)	Reason for Measure Change	Result	Impact to scoring, submission and feedback expectations
Measure 239/ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	eCQM (CMS155v10)	Measure was significantly impacted by ICD-10 coding changes.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 259/ Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2)	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 281/ Dementia: Cognitive Assessment	eCQM (CMS149v10)	Measure was significantly impacted by ICD-10 coding changes.	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 282/ Dementia: Functional Status Assessment	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.
Measure 283/ Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period – those reporting this measure should only include data from the first 9 months of the performance period (January 1 – September 30, 2022) in their submission.

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

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

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Quality Measures with MIPS Scoring or Submission Changes

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

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Quality Measures with MIPS Scoring or Submission Changes

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