Quality Payment
PROGRAM

2023 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2024 Payment Adjustment FAQs

Purpose

This document answers key questions (with supporting screenshots) about the MIPS performance feedback experience now available.

- These FAQs are intended to help you navigate the information within your performance feedback.
- **This resource doesn't provide detailed information about MIPS reporting requirements and scoring.**

Review the following resources on the QPP Resource Library for detailed scoring information:

- 2023 Traditional MIPS Scoring Guide (PDF, 1MB)
- 2023 MVPs Implementation Guide (PDF, 2MB)
- **2023 APP Scoring Guide**, available in the 2023 APP Toolkit (ZIP, 2MB)
- 2023 Facility-based Quick Start Guide (PDF, 730KB)

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

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Fast Facts About Performance Feedback

What Is Performance Feedback?

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

- Performance category-level scores and weights.
- Bonus points and improvement scoring.
- Measure-level performance data and scores.
- Activity-level scores.
- Payment adjustment information.
- Supplemental reports for administrative claims quality and cost measures.
  - Learn more in the 2023 MIPS Performance Feedback: Supplemental Reports Guide (PDF, 824KB).
- Comparative quality and cost feedback (MVP reporting only).

Who Can Access MIPS Performance Feedback and Payment Adjustment Information?

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

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

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

How Do I Access Performance Feedback?

1. Sign in to the Quality Payment Program website.
2. Click "**View PY 2023 Final Performance Feedback**" on the home page or select "Performance Feedback" from the left-hand navigation.
   a. Acknowledge that you understand scores can change.
3. Select your organization (Practice, APM Entity, Virtual Group).
   a. Practice representatives can access individual, group, and subgroup feedback through the practice organization.

General Questions

Can I Download Feedback Reports?

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

How Can I Learn More about 2023 MIPS Reporting Requirements and Scoring?

These FAQs are intended to help you navigate your performance feedback. This resource doesn't provide detailed information about MIPS reporting requirements and scoring. Review the following resources on the QPP Resource Library for detailed information:

- 2023 Traditional MIPS Scoring Guide (PDF, 1MB)
- 2023 MVPs Implementation Guide (PDF, 1MB)
- **2023 APP Scoring Guide**, available in the 2023 APP Toolkit (ZIP, 2MB)
- 2023 Facility-based Quick Start Guide (PDF, 726KB)

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

If you believe an error has been made in the calculation of your 2025 MIPS payment adjustment, you have until 8 p.m. ET on October 11, 2024, to request a targeted review.

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

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

What's a Targeted Review?

A targeted review is a process through which MIPS eligible clinicians, groups, and MIPS APM participants (individual clinicians, participating groups, and the APM Entity) can request that CMS review the calculation of their MIPS payment adjustment factor. For more information on the targeted review process, please review the 2023 Targeted Review User Guide (PDF).

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

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

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

Accessing Final Score (Performance Feedback)

Before You Begin

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

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

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

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

How Can I Access My/Our MIPS Performance Feedback?

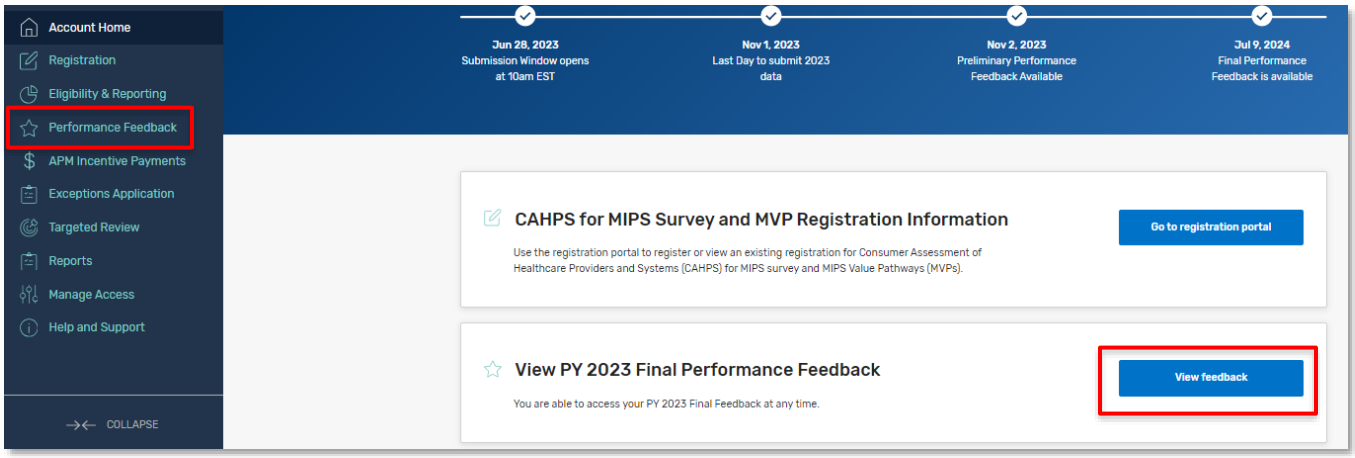
You can access your performance feedback through the QPP website by signing in with the same credentials that allowed you to submit and view data during the submission period.

- Please note that if you are a **Shared Savings Program ACO's** QPP Security Official or QPP Staff User contact in the ACO Management System (ACO-MS), then you can view performance feedback by signing in to the QPP website using your ACO-MS username and password.
- For guidance on how to add the QPP Security Official and QPP Staff User contacts to an ACO in ACO-MS, please refer to the ACO-MS User Access and ACO Contents Tip Sheet.

If you don't have an account or role for your organization, refer to the QPP Access User Guide (ZIP, 4.1 MB) for information on creating an account and requesting a role for your organization.

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

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



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

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

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

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

Can Third Party Intermediaries Access Performance Feedback?

Only authorized practice (or virtual group or APM Entity) representatives can access performance feedback. The Centers for Medicare & Medicaid Services (CMS) doesn't grant direct access to performance feedback for third party intermediaries (including QCDRs and Qualified Registries) because it contains sensitive information, including payment and patient information.

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

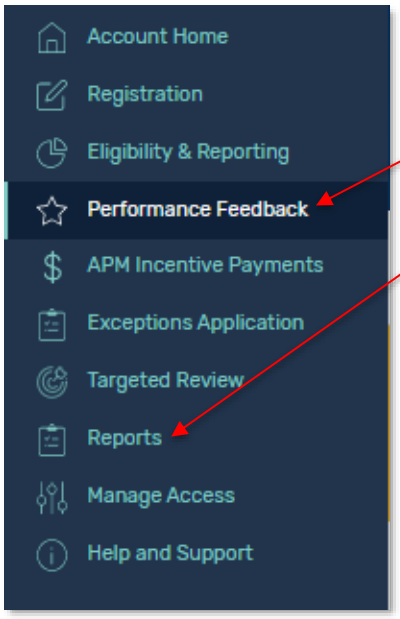
- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims.
- Supplemental (including patient-level) reports for administrative claims measures.
- Final score or payment adjustment information.

To view their clients' performance feedback, third party intermediaries would need to submit a request for a role for each practice (identified by Taxpayer Identification Number, or TIN), virtual group, or APM Entity they represent.

- The Security Official for each organization will decide whether to approve the request.
- If approved, the third party intermediary is authorized to access performance feedback and all other information available for the organization once signed into the QPP website.

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

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



You'll access your 2023 MIPS performance feedback through the **Performance Feedback** tab.

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

- 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Detail Reports.
- Historical CMS Web Interface reports for groups and APM Entities that have reported quality measures through the CMS Web Interface in previous years.
- Historical payment adjustment reports.

Navigating Into Performance Feedback and Frequently Asked Questions

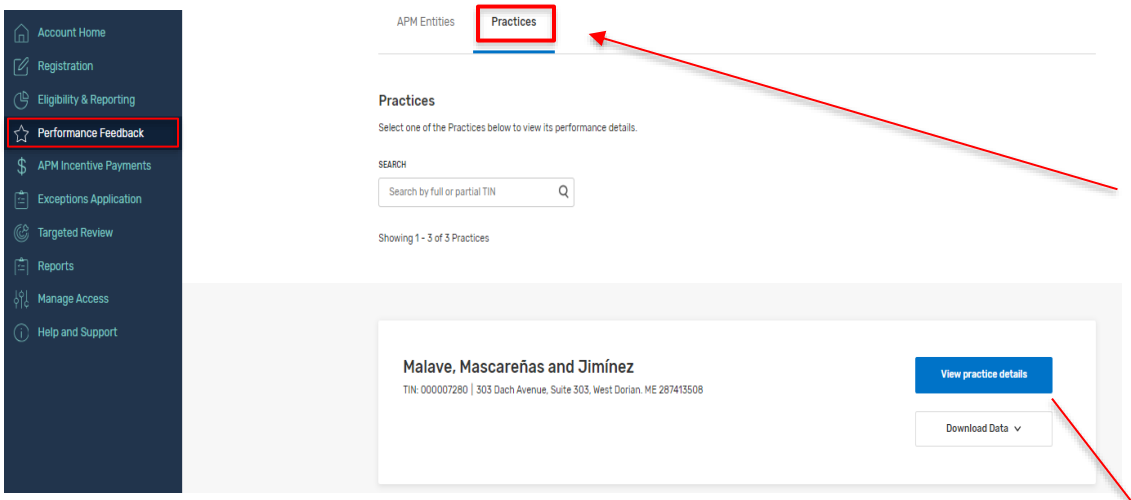
Organization Type	Details
Practice Representative	Screenshots for accessing performance feedback and frequently asked questions related to **individual**, **group**, and **subgroup** participation. • Applicable to users with the Staff or Security Official QPP Role for the practice, identified by Taxpayer Identification Number (TIN)
APM Entity (Including Shared Savings Program ACOs)	Screenshots for accessing performance feedback and frequently asked questions related to APM Entity participation. • Applicable to users with the Staff or Security Official QPP Role for the APM Entity, identified by APM Entity ID
Individual Clinician	Screenshots for accessing performance feedback and frequently asked questions related to individual, group, and subgroup participation. • Applicable to clinicians, identified by National Provider Identifier (NPI), with the QPP Clinician Role
Virtual Group	Screenshots for accessing performance feedback and frequently asked questions related to virtual group participation. • Applicable to users with the Staff or Security Official QPP Role for the virtual group, identified by Virtual Group ID

Navigating Into Performance Feedback: Practice Representatives

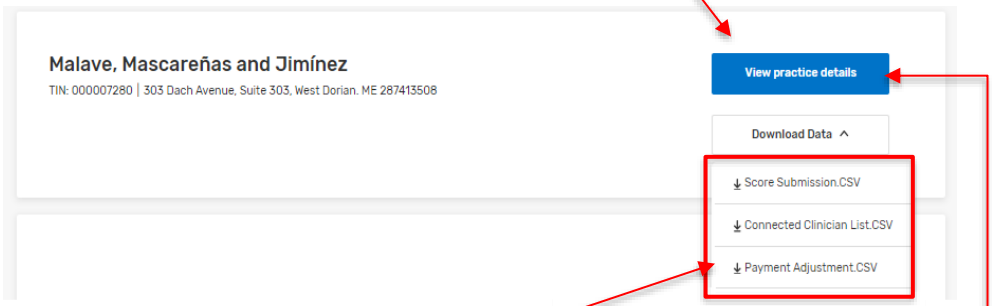
This section assumes you have either the QPP Staff User or QPP Security Official role for a **Practice** organization. (This is distinct from access to a virtual group and/or APM Entity organization.)

- Practice representatives can view feedback for individual clinicians, the group (if the practice participated as a group), and subgroups (if any clinicians in the practice registered to report an MVP as a subgroup).

Select **View Practice Details** to access group-, subgroup- or clinician-level performance feedback.



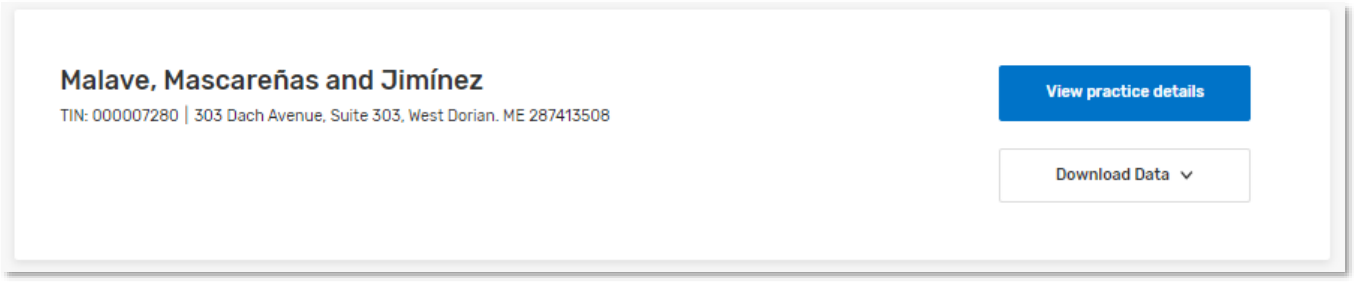
If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **Practices** tab.



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

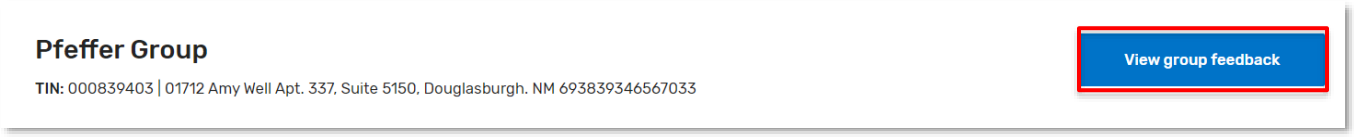
- Score Submission CSV (data submitted for your entire practice, which may or may not contribute to your final score).
- Connected Clinician List.
- **Payment Adjustments for each clinician in the practice.**

Click **View practice details** to access performance feedback.



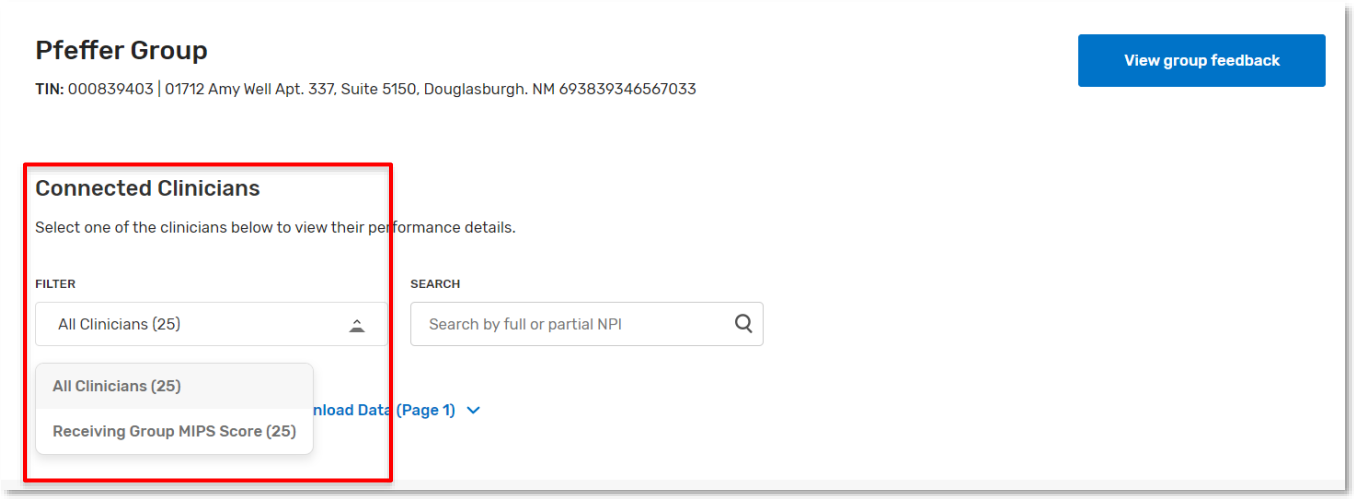
Group Feedback

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



Individual Feedback

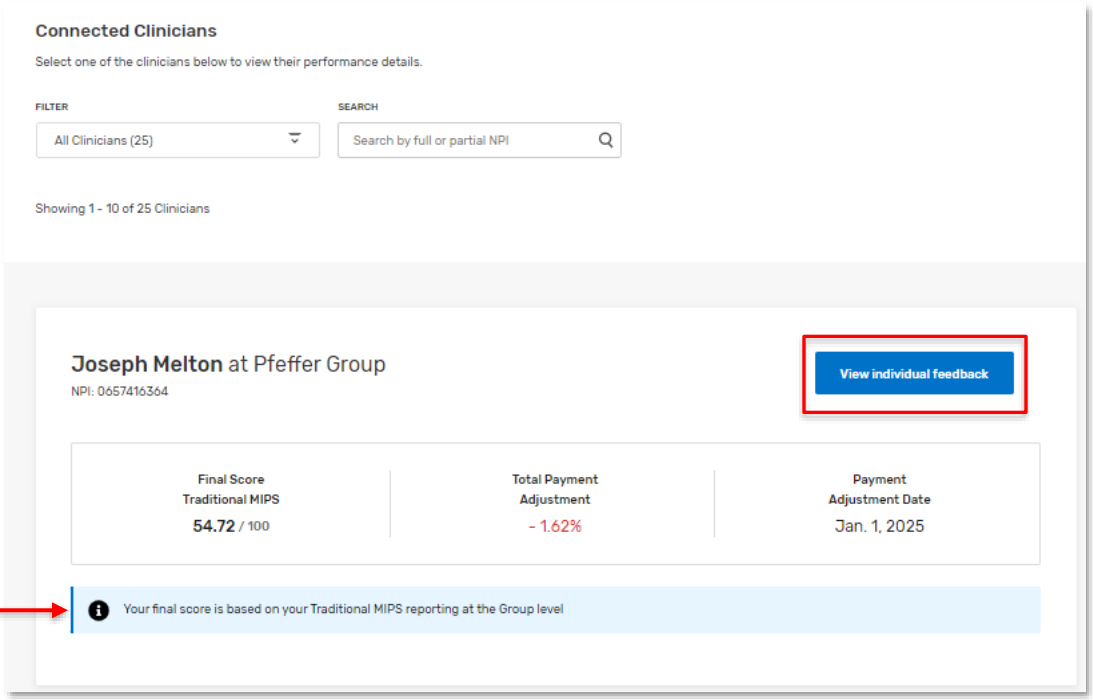
Under **Connected Clinicians**, you can see the final score attributed to the individual clinician beneath their name. You can also filter this list by the reporting and participation options the practice implemented to show which final score clinicians are receiving.



The blue alert below the clinician's name will identify the reporting option (traditional MIPS, MIPS Value Pathways, or APM Performance Pathway) and participation option (individual, group, or subgroup) associated with their final score.

- **Please note that you won't see information about final scores from virtual group or APM Entity participation.**

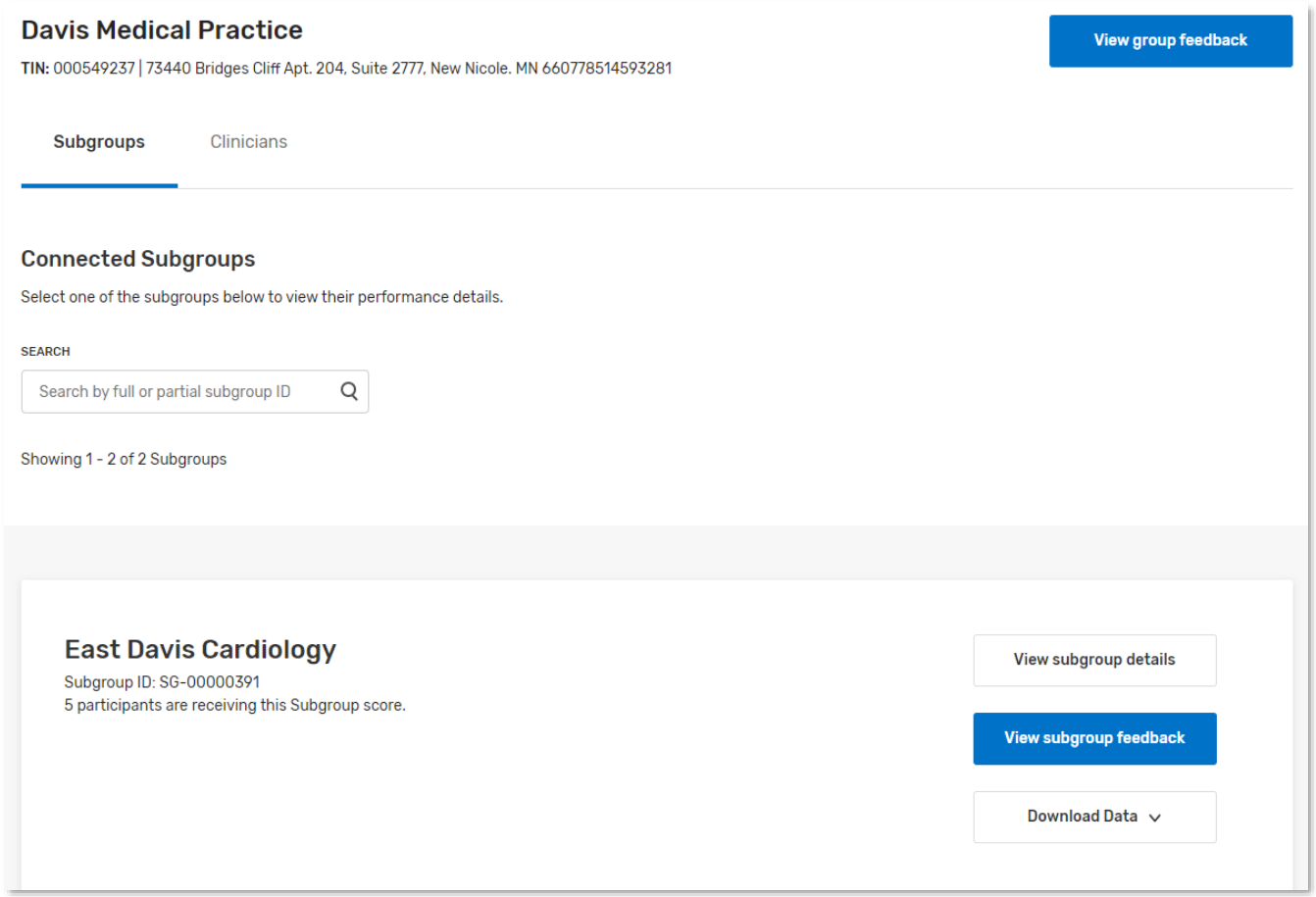
Select **View Individual Feedback** to the right of the clinician's name to access more details about their final score.



Subgroup Feedback

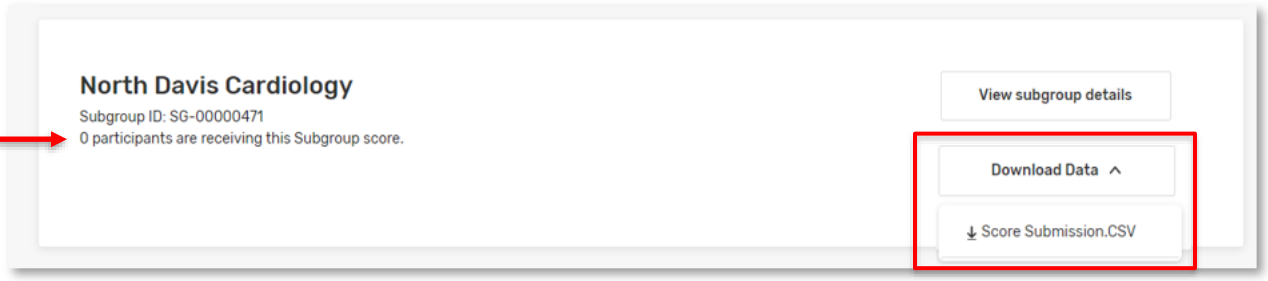
If any clinicians in the practice registered to report an MVP as a subgroup, you'll see the subgroup(s) listed under **Connected Subgroups**.

- Select **View subgroup feedback** to the right of the subgroup name to access performance feedback based on **subgroup participation** (aggregated data submitted on behalf of the clinicians in the subgroup).
- Select **View subgroup details** to view a list of the clinicians included in the subgroup's registration.
- Select **Download Data** – and choose "Submission Data.CSV" – for a list of all data submitted by the subgroup.



Note: The "**View subgroup feedback**" button won't display if the subgroup's final score isn't attributed to at least 1 clinician in the subgroup.

- If all the clinicians in the subgroup received a final score from individual or group participation (i.e., the subgroup score was lower than the group and individual scores), select "Score Submission.CSV" from the **Download Data** drop down to view scores from the subgroup's MVP reporting.



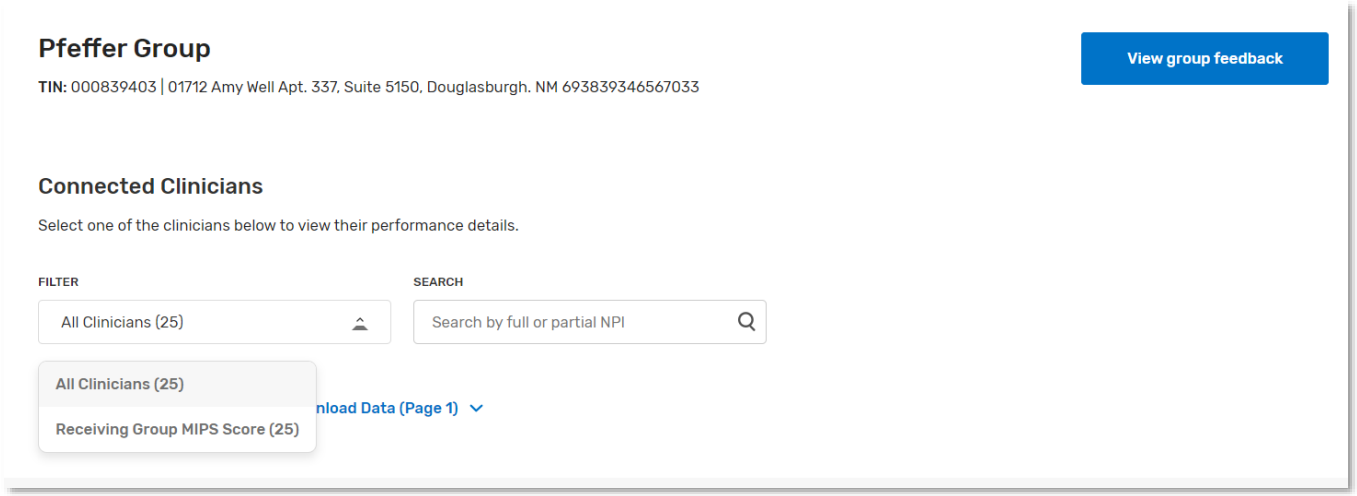
Continue with these Frequently Asked Questions or skip ahead to the Final Score Overview section.

Our Practice Participated in Multiple Ways. Can I Easily See Which Final Score Was Attributed to the Clinicians in Our Practice?

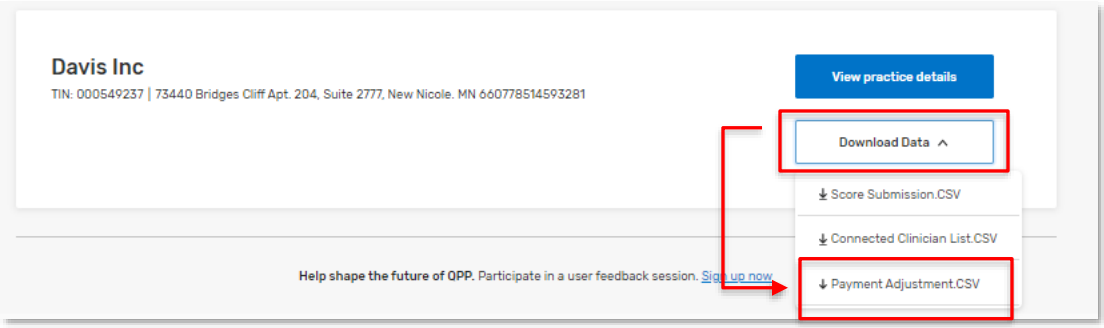
Yes, there are 2 ways to do this:

1. **Under Connected Clinicians** on the "Practice Details" page, you can filter your clinicians by the final scores attributed to the clinicians in your practice based on the reporting and participation options your practice implemented.

In the screenshot below, all MIPS eligible clinicians are getting the group's traditional MIPS score. However, there would be additional options in the filter if any clinicians had received their final score from individual traditional MIPS reporting or subgroup MVP reporting.



2. Before you get into the "Practice Details," you can **download the Payment Adjustment CSV** to see the final score, performance category scores, and associated payment adjustment earned by each clinician in the group.



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

If your practice didn't submit data as a group or subgroup for the 2023 performance year, you'll see a message indicating that your clinicians only reported as individuals.

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

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

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

Connected clinicians are all of the clinicians, identified by the National Provider Identifier (NPI) associated with your practice (TIN) through Medicare Part B claims billed October 1, 2022 – September 30, 2023, regardless of their individual MIPS eligibility. Your connected clinicians are displayed on the Practice Details page of performance feedback and can also be accessed through the Connected Clinicians List comma-separated values (CSV) download on the **Practice Details** page.

- Clinicians who started billing claims under your TIN October 1, 2023 – December 31, 2023, will appear in the Payment Adjustment CSV.

Can I Access a List of the Clinicians Participating in the Subgroups in Our Practice?

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

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

When you sign in with practice credentials, you're able to view final scores based on the data your practice submitted to QPP at the group, subgroup, or individual level. You **won't** be able to view final scores for the APM Entity (or virtual group, if applicable).

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

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

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

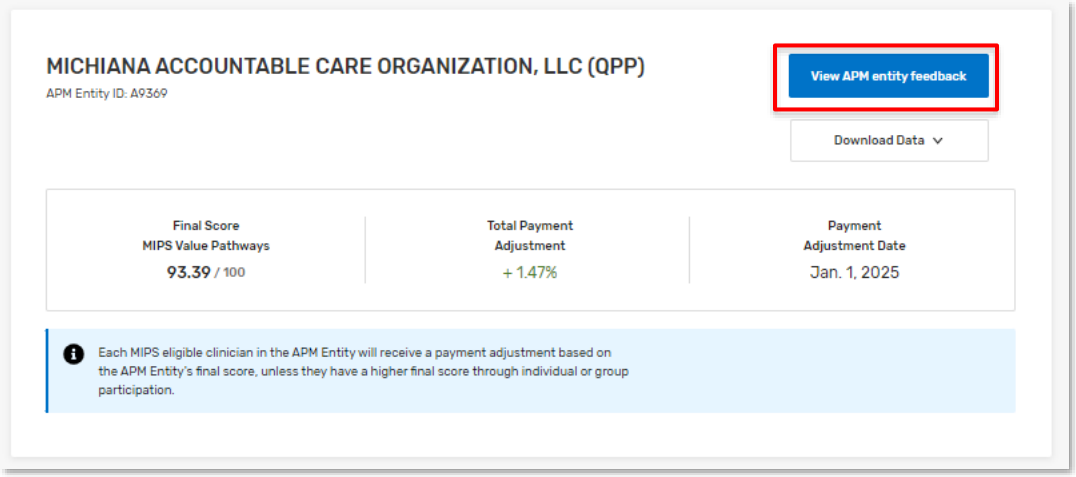
Navigating Into Performance Feedback: APM Entity Representatives

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

The following programs and models can review 2023 MIPS performance feedback, if applicable and available:

- Shared Savings Program ACO
- Bundled Payments for Care Improvement (BPCI) Advanced
- Independence at Home Demonstration
- Maryland Total Cost of Care (TCOC)
- Vermont All Payer ACO
- Primary Care First (PCF)

Select **View APM Entity Feedback** to access APM Entity-level performance feedback.

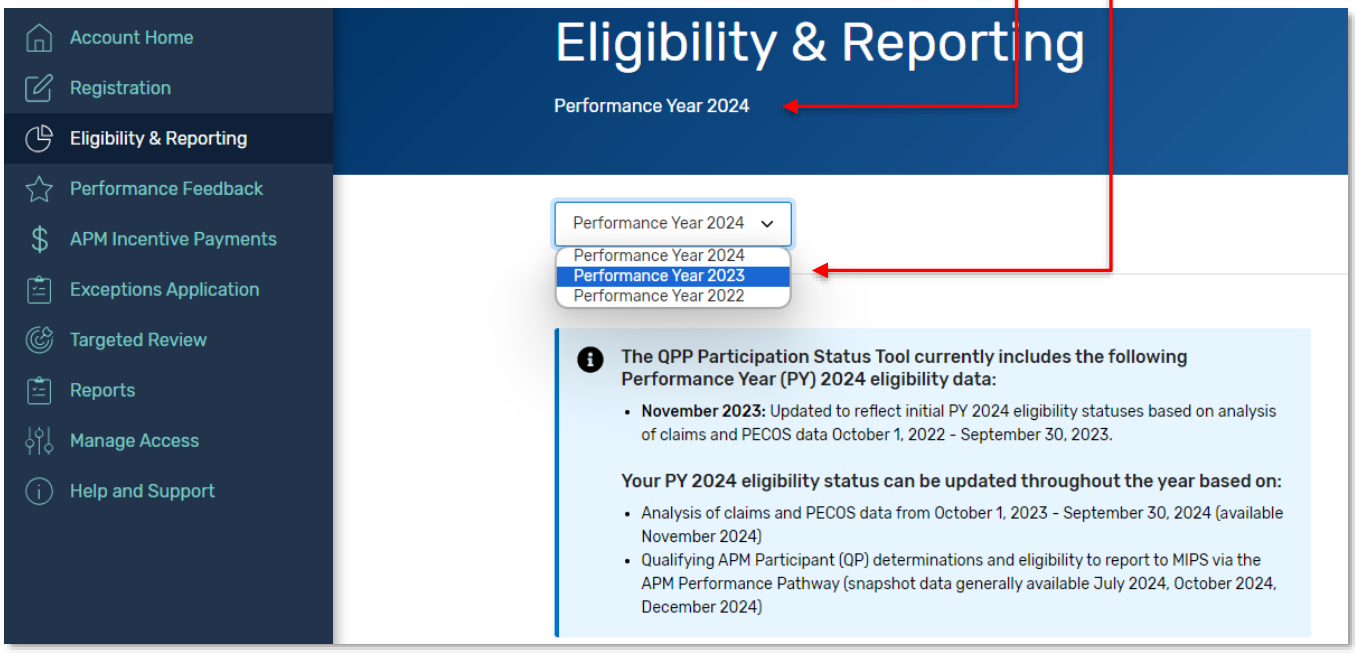


Continue with these Frequently Asked Questions or skip ahead to the Final Score Overview section.

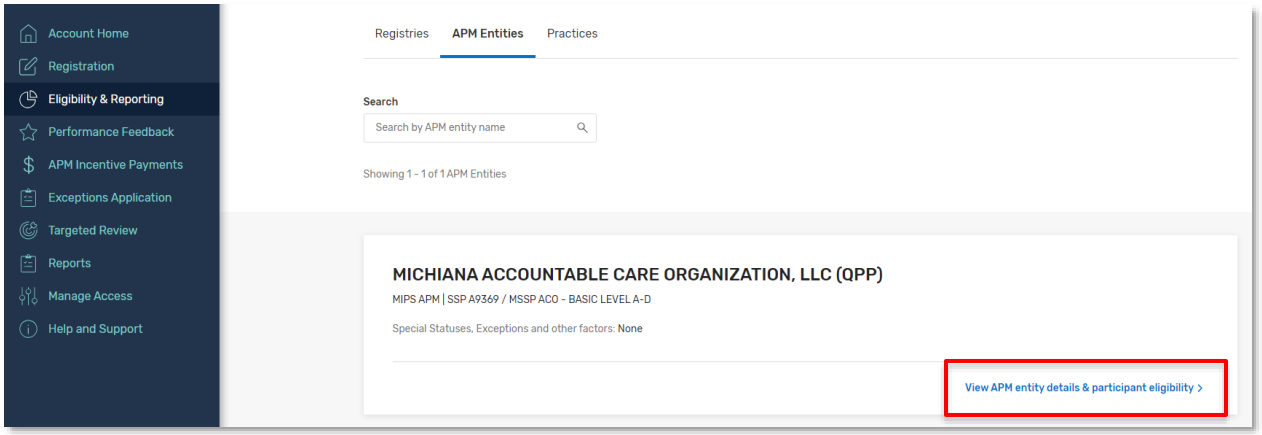
Can We Access a List of the Clinicians Associated with Our APM Entity?

Yes. You can download this list by clicking "**View Participant Eligibility**" from the **Eligibility & Reporting** tab.

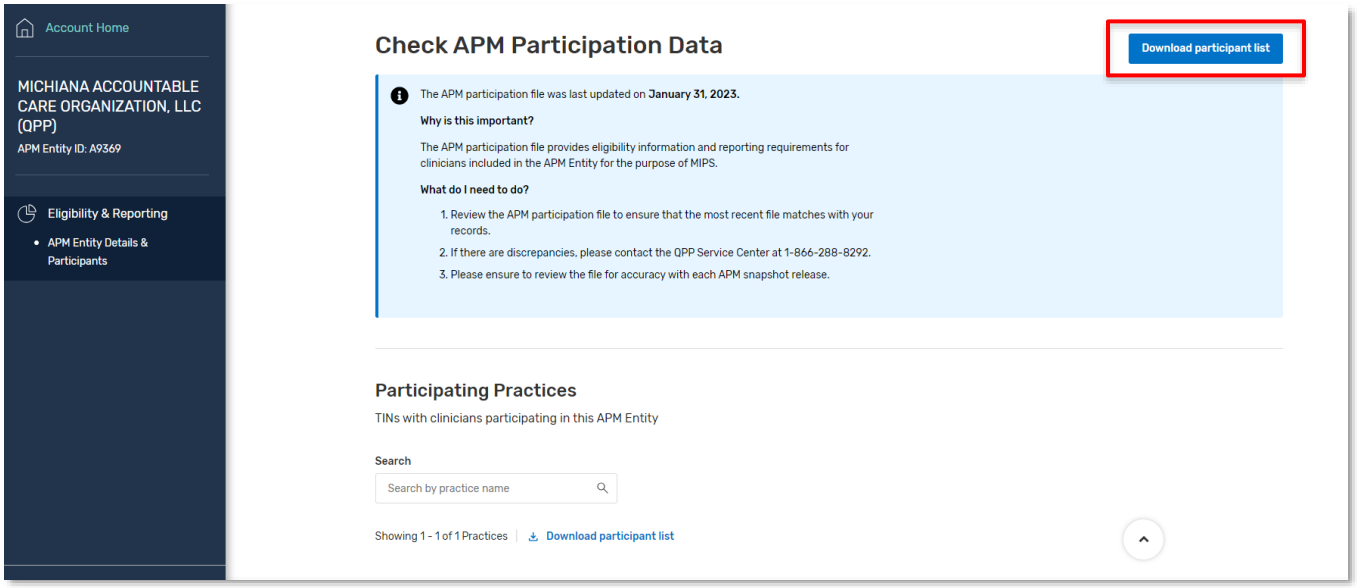
- It will default to Performance Year 2024
- **You'll need to change the selection in the drop-down to Performance Year 2023.**



From here, you'll select **View APM entity details & participant eligibility**.



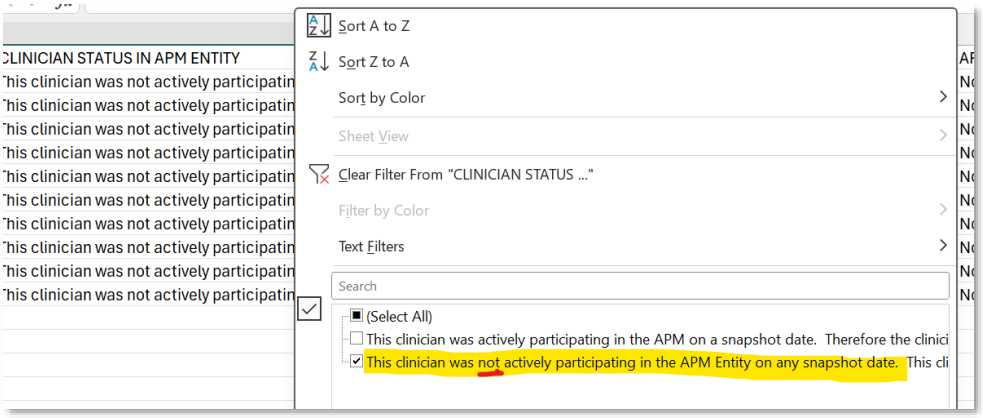
Once you land on the APM Entity Details & Participants screen, you can click **Download Participant List** for a list of all participating practices and clinicians associated with the APM Entity.



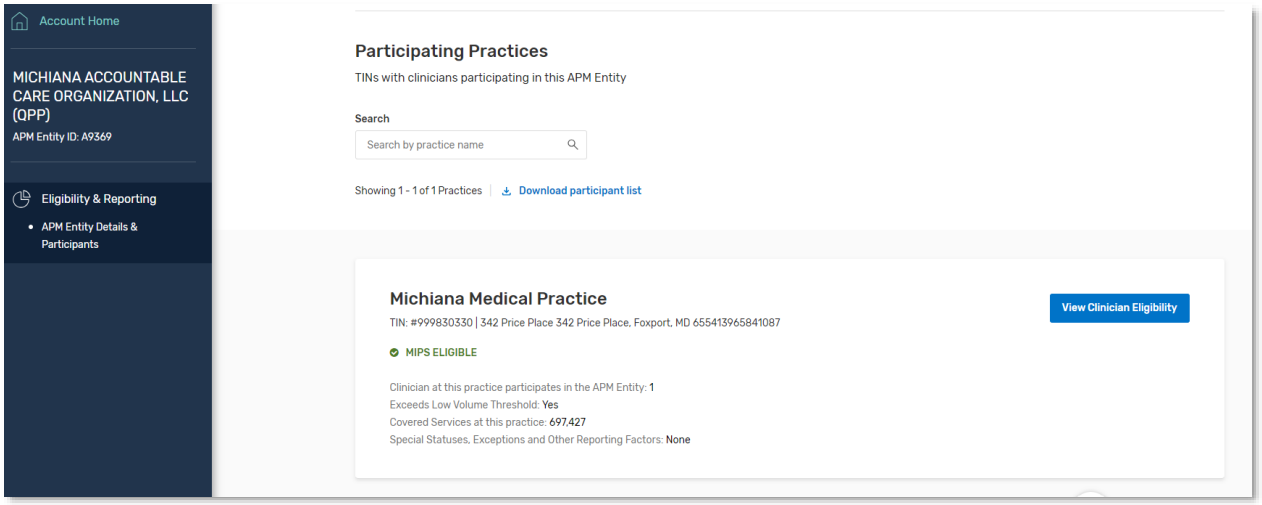
Important: Make sure to filter column G – "Clinician Status in APM Entity" – by the following:

- "This clinician was **not** actively participating in the APM Entity on any snapshot date. This clinician is not eligible to report via the APP and will not be included in QP determinations. This clinician must report through traditional MIPS, unless otherwise exempt."

MIPS eligible clinicians with this status aren't eligible to receive the APM Entity's final score or the associated payment adjustment.



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



What Should We Expect to See in Feedback?

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

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

Can Individual Clinicians View Our APM Entity Feedback?

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

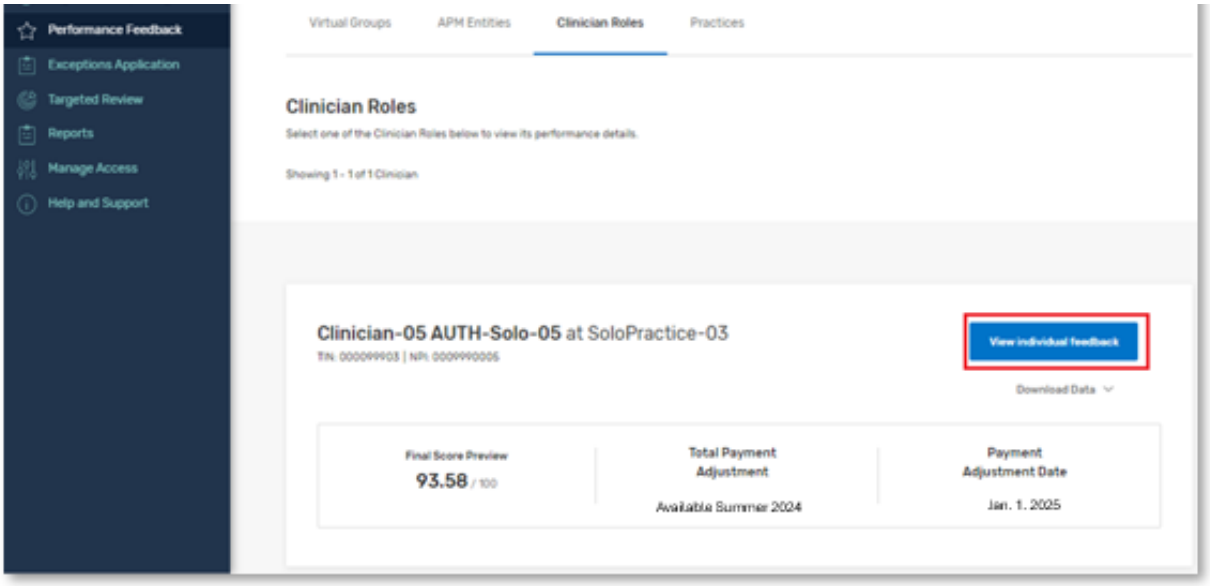
Representatives of Shared Savings Program ACO Participant TINs and practices with clinicians receiving their APM Entity's final score **won't** be able to access the APM Entity's performance feedback unless they have been approved as a staff user for the APM Entity.

Navigating Into Performance Feedback: Individual Clinicians

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

You'll see a list of all your associated organizations (practices, APM Entities, and virtual groups).

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



Continue with these Frequently Asked Questions or skip ahead to the Final Score Overview section.

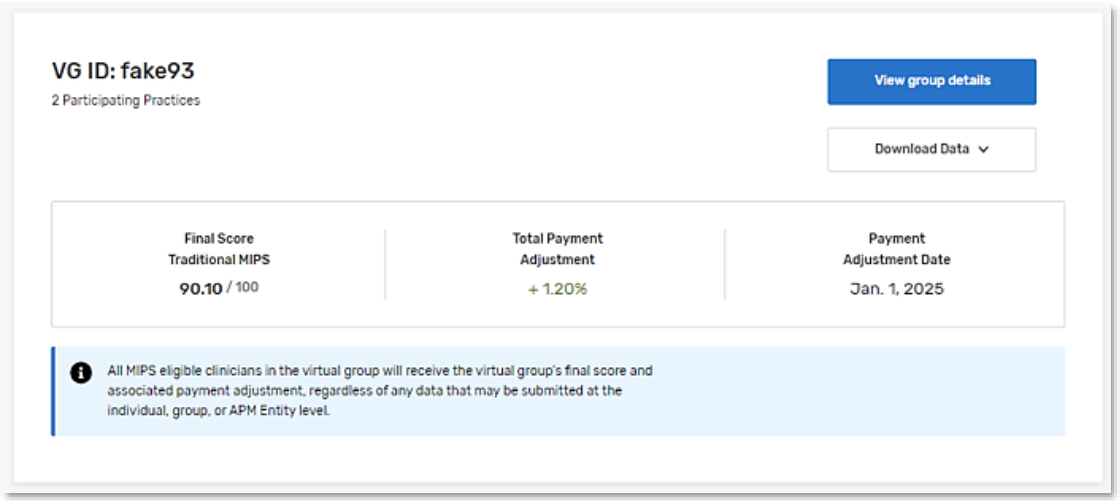
How Do I Identify My Associated Organizations in Performance Feedback?

You should see the same associations on the **Performance Feedback** tab as you see for the 2023 performance year in the QPP Participation Status Tool or on the Eligibility & Reporting page when you sign in to the QPP website. Click "**View Individual Feedback**" to view your final score as well as any individual data submitted on your behalf.

Navigating Into Performance Feedback: Virtual Group Representatives

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

Select **View Group Details** to access virtual group-level performance feedback.



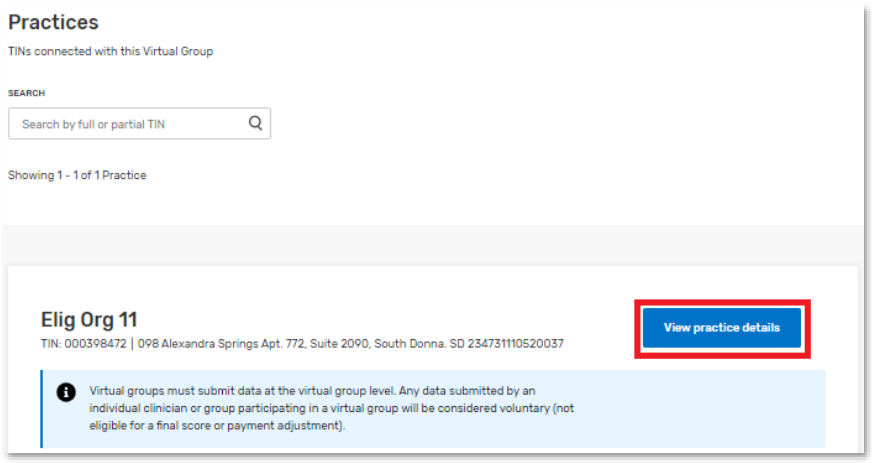
Continue with these Frequently Asked Questions or skip ahead to the Final Score Overview section.

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

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

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

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



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

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

Overview: Final Score and Payment Adjustment

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

- Your final score.
- Your score and the weight for each MIPS performance category.
- Your payment adjustment information*.

***REMINDER:** There's a **single payment adjustment** beginning with the 2023 performance year/2025 payment year. The Congressional funding for the additional adjustment for exceptional performance expired after the 2022 performance year/2024 payment year.

How Is Our Final Score Determined?

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

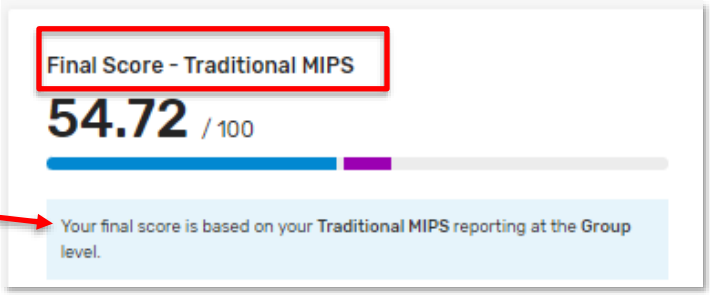
Your final score is associated with a MIPS reporting option and participation option.

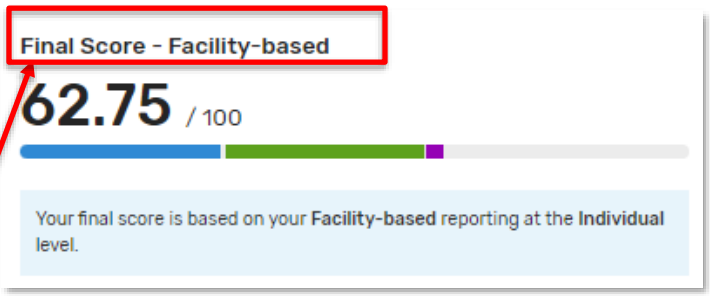
The Final Score card will identify both.

There are 3 MIPS reporting options:

- Traditional MIPS*
- APM Performance Pathway (APP)
- MIPS Value Pathways (MVPs).

***Facility-based clinicians and groups** are eligible to receive quality and cost scores in traditional MIPS based on their facility's Total Performance Score in the Hospital Value-Based Purchasing Program. These clinicians and groups will see their final score attributed to "Facility-based." You can learn more about facility-based scoring in the 2023 Facility-based Quick Start Guide (PDF, 730KB).





Note: If a clinician participated in MIPS multiple ways — for example, your practice reported traditional MIPS at the group level and the clinician also reported an MVP as an individual — we'll assign the highest score that could be attributed to the clinician under that TIN/NPI combination.

- Users with access to an APM Entity can only access performance feedback and the final score for the APM Entity. They won't see if the participating clinicians have a higher score from individual or group participation.
- Users with access to a practice (TIN) can only access performance feedback and the final scores from individual, group, and subgroup participation. They won't see if clinicians have a higher score from APM Entity or virtual group participation.

We Participated in Multiple Ways. How Did You Determine Which Final Score and Payment Adjustment to Attribute to Our Clinicians?

While clinicians can participate in multiple ways under a single TIN/NPI combination, they'll only have one final score and associated payment adjustment under that TIN/NPI combination.

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

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

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

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

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment, **but in most cases, we can't project what this correlation will be with some exceptions noted in the table below**.

> **Why?** MIPS is required by law to be a budget-neutral program, which generally means that the size of payment adjustments depends on the overall participation and performance of clinicians in the program for that year.

REMINDER!

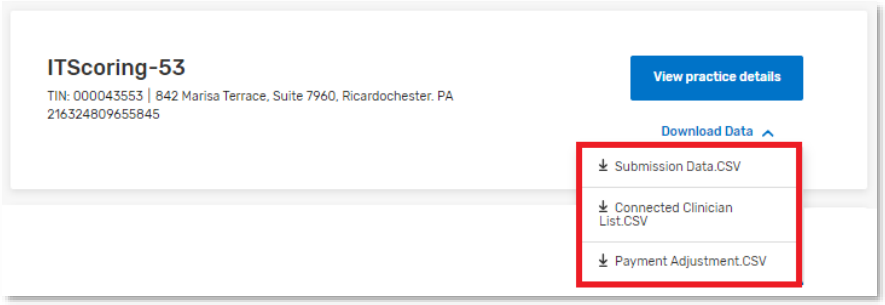
There's no longer an additional adjustment for exceptional performance. Congressional funding for this additional adjustment expired after the 2022 performance year (2024 payment year).

Final Score	Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (greater than -9% and less than 0%)
75.00 points (Performance threshold)	Neutral payment adjustment (0%)
75.01 –100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

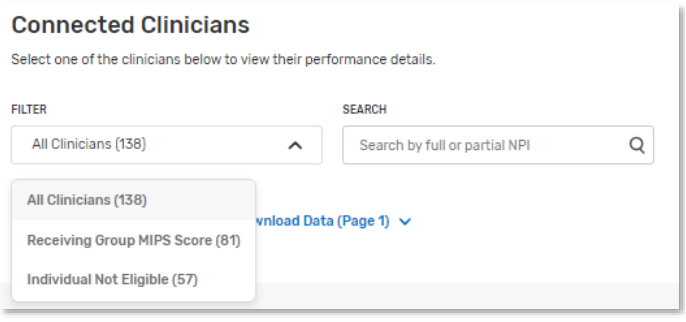
- When more MIPS eligible clinicians have a final score above the performance threshold, we see **lower positive adjustments** because there are fewer MIPS eligible clinicians receiving a negative adjustment and relatively more MIPS eligible clinicians receiving a positive MIPS payment adjustment.
- When more MIPS eligible clinicians have a final score below the performance threshold, we see **higher positive adjustments** because there are more MIPS eligible clinicians receiving a negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians receiving positive MIPS payment adjustments.

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

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

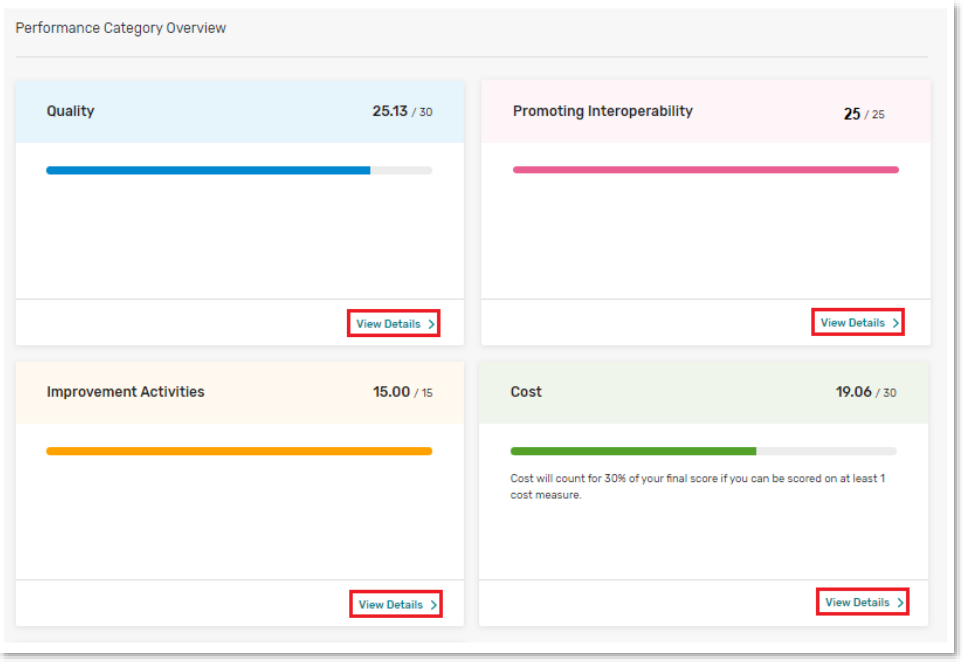


You can also filter your Connected Clinicians list by final score information once you've clicked **View Practice Details.** The list defaults to showing **All Clinicians.** There are multiple reports you can choose from (not all are shown in the image below).



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

You can access the scoring details for each performance category by clicking "**View Details**" on the Performance Category Overview cards below.



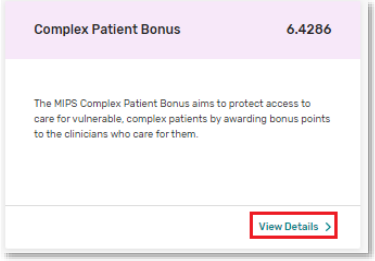
What Is the Complex Patient Bonus?

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

- **Medical Complexity.** This component uses the Hierarchical Condition Categories (HCC) Risk Scores of your patient population. These scores are assigned to each Medicare patient based on the severity of their acute or chronic conditions and are an indicator of medical complexity.
- **Social Risk.** This component uses the Dual Eligibility Ratio of your patient population. Dual Eligibility is a common indicator of social risk and refers to patients who are eligible for both Medicare and full- or partial-benefits under Medicaid.

How Is the Complex Patient Bonus Calculated?

To learn about these calculations, click **View Details** on the Complex Patient Bonus card or review the 2023 Complex Patient Bonus Fact Sheet (PDF, 394KB).



Why Am I Not Eligible for the Complex Patient Bonus?

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

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

Did you know?

We'll display the complex patient bonus (if it can be calculated) for informational purposes for practices that were (1) eligible for MIPS at the group level **and** (2) didn't report as a group **and** (3) had either Administrative Claims Quality Measures or Items and Services data available for informational purposes.

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

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

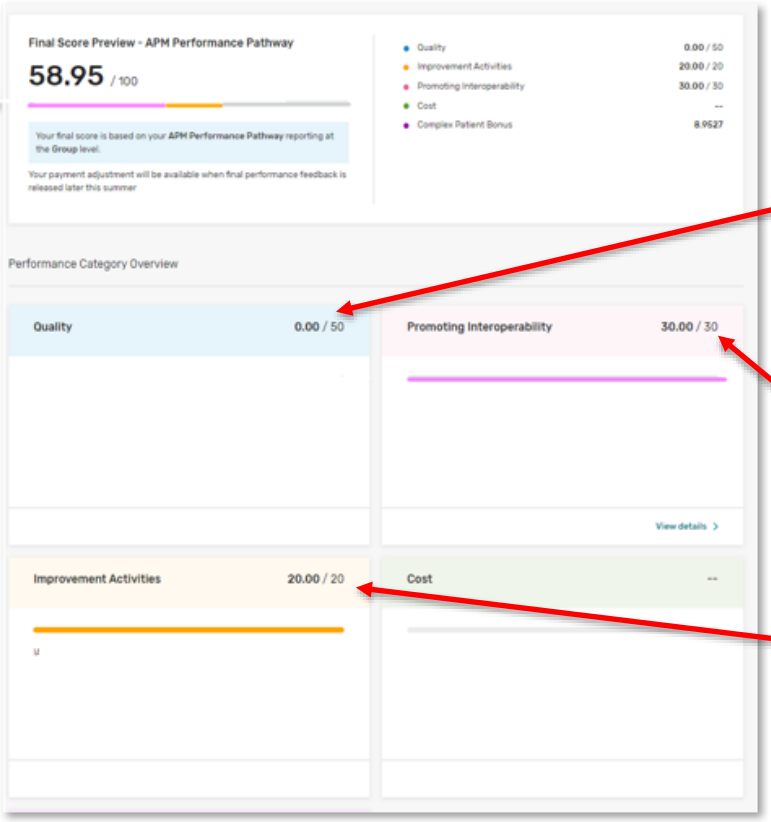
- Appendix A reviews reweighting for individual clinicians under the automatic Extreme and Uncontrollable Circumstances (EUC) policy.
- Appendix B reviews the performance category weight redistribution when 1 or more performance categories are reweighted.

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

Participant TINs (accessing their feedback on the QPP website through the Staff User or Security Official roles for the practice) can only see the data they reported at the group or individual level. You see a quality score of zero because the ACO, not the group or individual, reported the APP quality measures.

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

Here's an example of what a Participant TIN might see if they submitted Promoting Interoperability data as a group on behalf of their MIPS eligible clinician in the ACO:



You'll see 0 points in Quality unless you reported the APP quality measures as a group.

If you reported Promoting Interoperability data as a group, you'll see a score based on the data your group submitted – please note that **this isn't the ACO's score** for the performance category.

Automatic full credit for Improvement Activities when data is submitted for the APP in another performance category.

As a reminder, the MIPS eligible clinicians in the ACO will receive the highest final score and associated payment adjustment that could be attributed to their TIN/NPI combination. Please reach out to your ACO coordinator for more information about the ACO's final score.

Quality

Reporting Option	Details
Traditional MIPS	Details are available for the measures **submitted** and automatically calculated via **administrative claims**
MVPs	Details are available for the measures **submitted** and automatically calculated via **administrative claims**
APP	Details are available for the measures **submitted** and automatically calculated via **administrative claims**

If your Final Score indicates "Facility-based," skip ahead.

Each of the 3 MIPS reporting options has distinct measure reporting requirements that are reflected on the Quality details page of performance feedback.

- **Traditional MIPS**
  - You submit 6 measures (any available in the MIPS quality measure inventory) or a complete specialty set.
  - We automatically calculate 4 administrative claims measures; you'll be scored on the measures for which you meet the requirements.

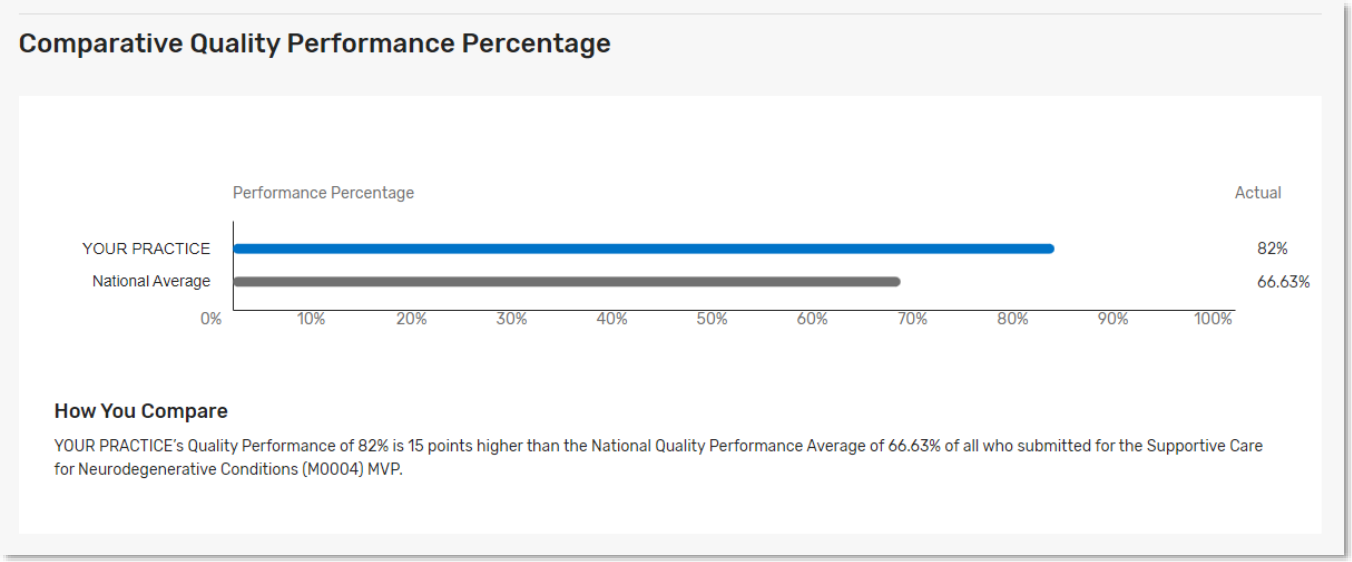
- **MVPs**
  - You submit 4 measures (selected from those available in the MVP you register for) or 3 measures (if you selected an outcomes-based administrative claims-based measure* in your MVP registration).
  - We automatically calculate the population health (administrative claims) measure you selected during registration; you'll be scored on the measure if you meet the requirements.

  *If you selected an outcomes-based measure as 1 of your 4 required measures (separate from the population health measure), you'll receive 0 points if you don't meet the measure requirements.

- **APP**
  - You report the 3 required measures or (Shared Savings Program ACOs only) the 10 CMS Web Interface measures.
  - You administer the CAHPS for MIPS Survey.
  - We automatically calculate 2 administrative claims measures; you'll be scored on the measures for which you meet the requirements.

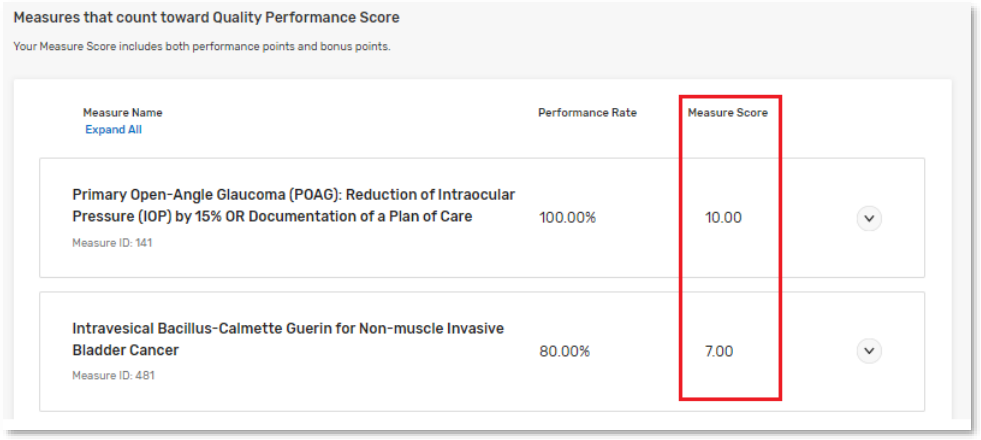
Comparative Quality Feedback (MVP Reporting Only)

Individual clinicians, groups, subgroups and APM Entities who received a final score from the MVP reporting option can see how their quality score compared to all other MVP participants who reported the same MVP.

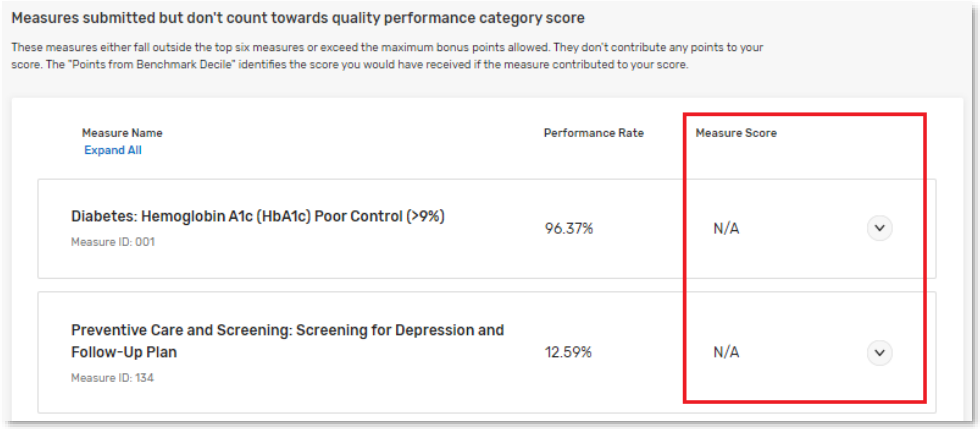


On the quality page, you may see your submitted quality measures displayed in up to 3 groups:

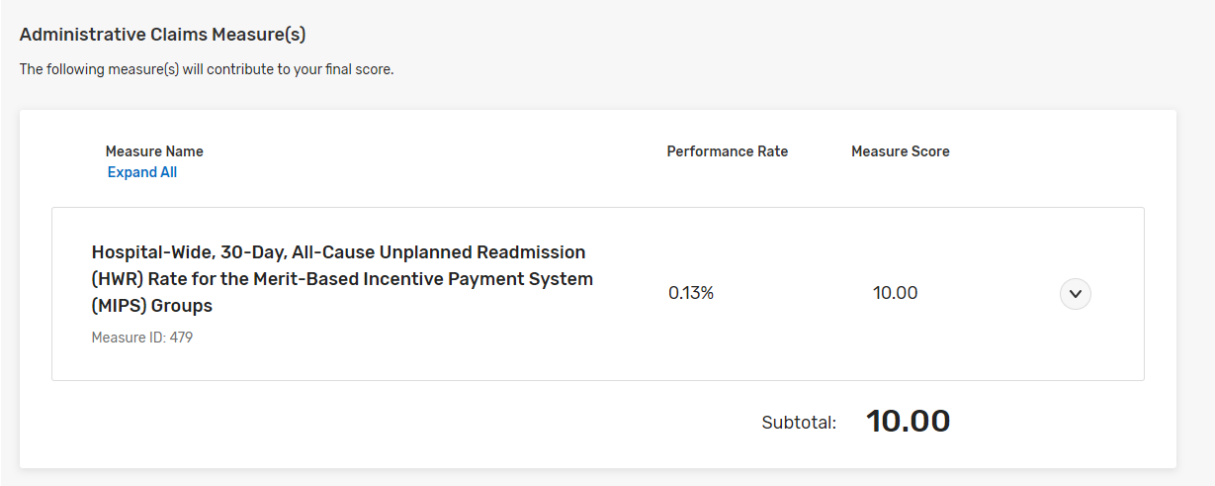
1. Measures whose performance points and bonus points count toward your quality performance category score. The measure score will display the points earned based on comparison to its benchmark.



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

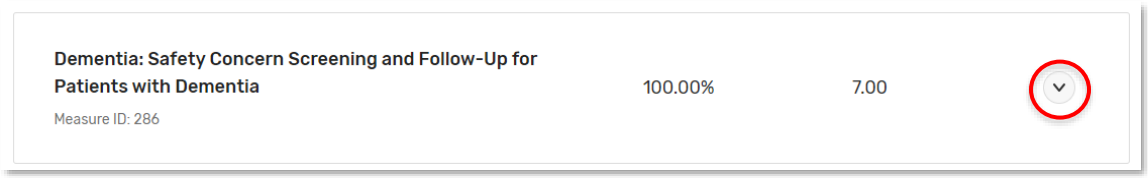


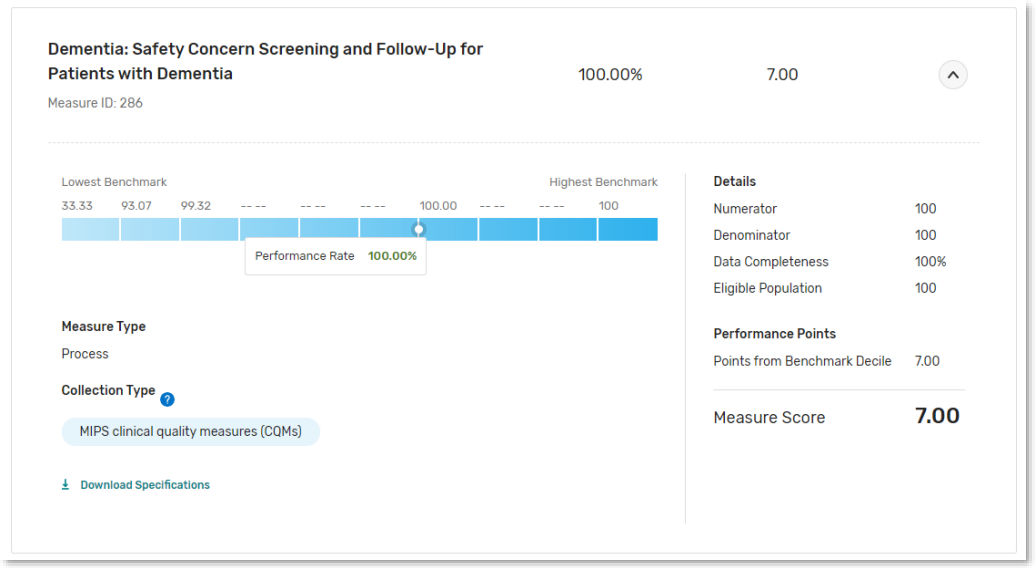
3. **Administrative Claims Measures.** You'll only see the administrative claims measures for which you received a score (if any). Refer to Appendix D for more information about the administrative claims' measures available in the 2023 performance year.



How Can I Access Details About the Measures I Submitted?

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





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

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

There are 6 measures required for traditional MIPS and 4 measures required for MVP reporting. (You can't submit measures outside of the prescribed measure set when reporting the APP.)

When determining which measures are included:

- We'll select the highest scoring outcome measure.
  - If you didn't have an outcome measure available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 (traditional MIPS)/3 (MVP) highest scoring measures.
- If you didn't submit an outcome or high priority measure, we selected your next highest scoring measure, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

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

Example: You submit 7 measures, and your 2 lowest scoring measures (after the outcome measure) were Measure 102 (Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients) and Measure 250 (Radical Prostatectomy Pathology Reporting), both earning 1 point. The Avoidance of Overuse of Bone Scan measure will be included in the top 6 because its measure ID (102) has a lower value than the Radical Prostatectomy Pathology Reporting measure (250).

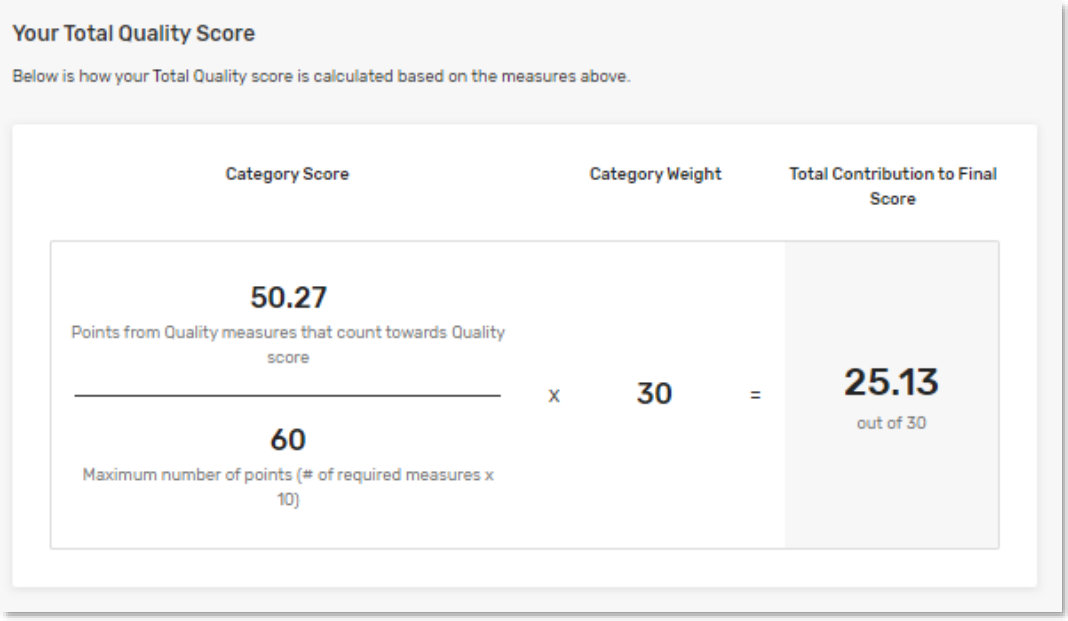
If you submit the same measure through multiple collection types — for example, as a Medicare Part B claims measure and as an electronic clinical quality measure (eCQM) — we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2 versions of the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

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

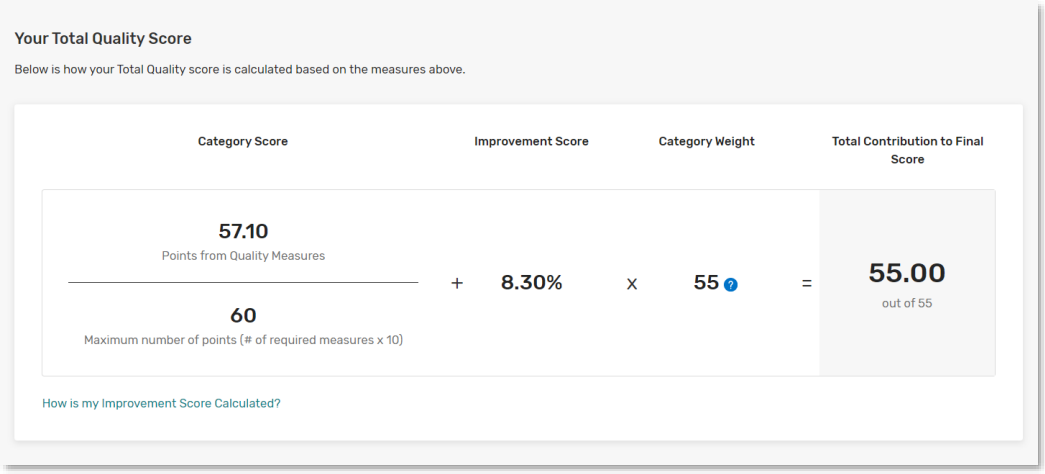
We included your **highest scoring** quality measures. Please note that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85% performance rate, 1 measure may earn 7 points while the other measure earns 10 points, based on the benchmarks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

How Do You Determine How Many Points Quality Contributes to Our Final Score?

At the bottom of the Quality page, you can see how we arrived at the points contributing to your final score. Generally speaking, we divide the points you earned (including small practice bonus points) by the available points [(# of required measures **+** # of administrative claims measures that are automatically calculated) **x** 10] and multiply the percentage by the category weight.



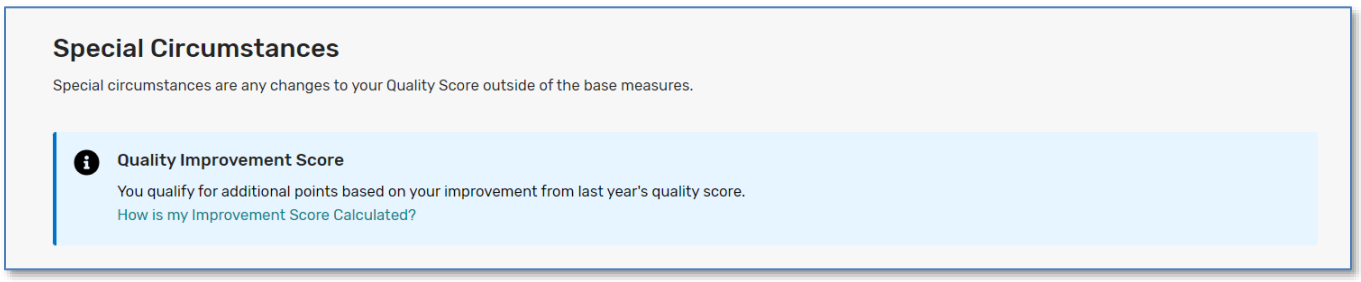
If you qualify for quality improvement scoring, we'll add that to your category score before multiplying it by the category weight.



What Is Quality Improvement Scoring?

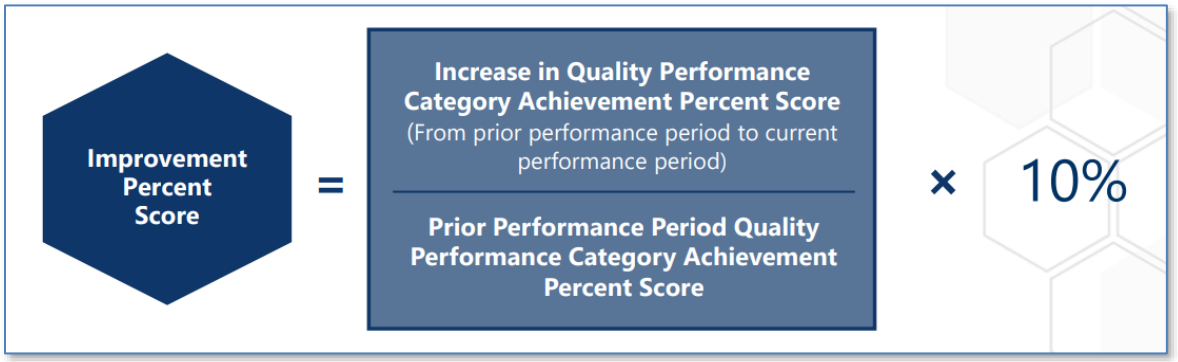
MIPS eligible clinicians can earn up to 10 additional percentage points in the quality performance category based on the rate of their improvement from the previous year.
The improvement score — calculated at the category level and representing improvement in achievement from one year to the next — may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

You'll see the following indicator at the top of the quality page if you're receiving quality improvement scoring.



How Is Quality Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2022) performance year to the quality performance category achievement score for the current (2023) performance year.

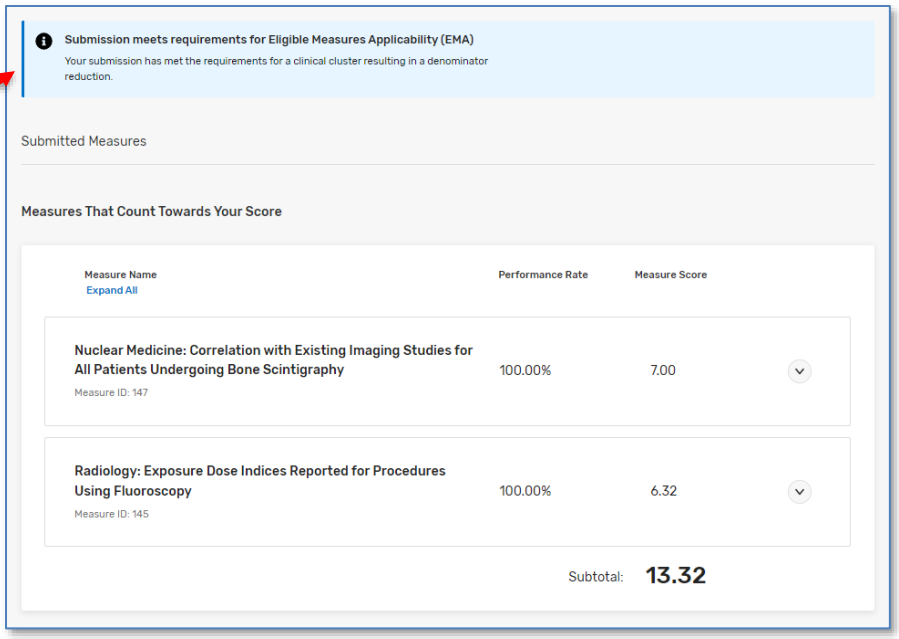


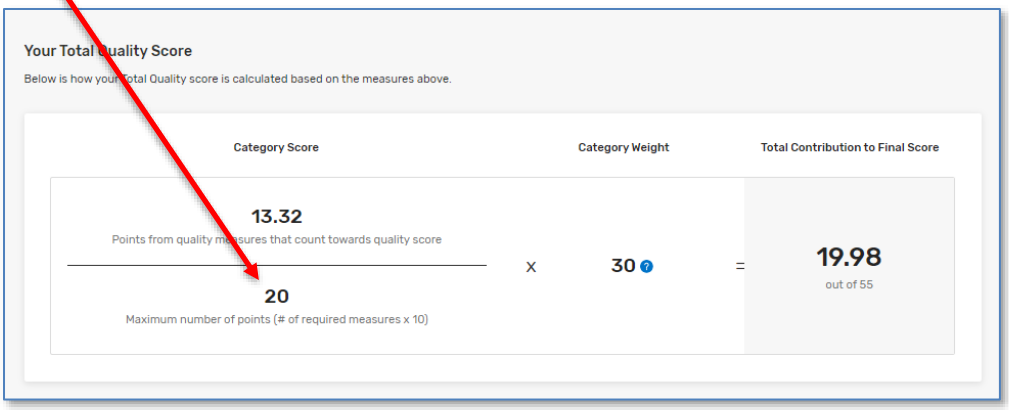
I Reported Traditional MIPS and Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures [CQMs]) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

Clinicians who don't have 6 available quality measures and who report Medicare Part B claims measures or MIPS CQMs may qualify for the EMA process. This process checks for unreported, clinically related measures and can result in a denominator reduction in the quality performance category. Learn more about this process in the 2023 EMA and Denominator Reduction Guide (PDF, 687 KB).

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

When you see this message, you should also see a reduced denominator (fewer measures required).

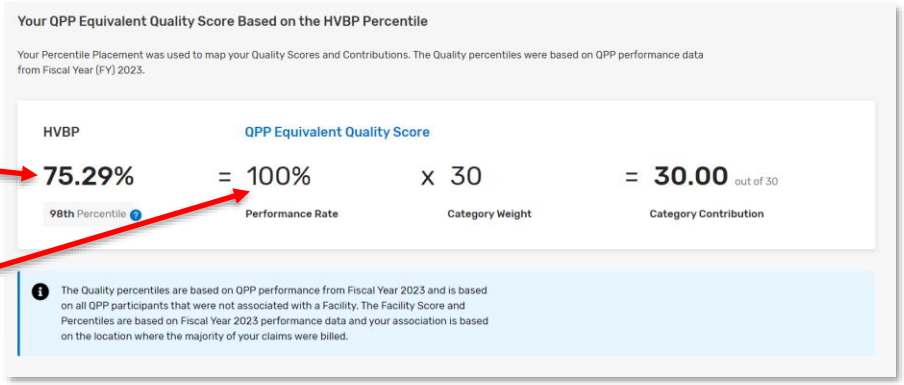




Facility-based Quality Score

If your quality and cost scores are derived from facility-based scoring, you won't see measure details. Instead, you'll see your facility's **Hospital VBP Program score and associated percentile** and the **MIPS equivalent (unweighted) quality score** based on the Hospital VBP Program score's percentile.

The MIPS equivalent score is multiplied by the **category weight** to arrive at the quality **points contributing to your final score.**

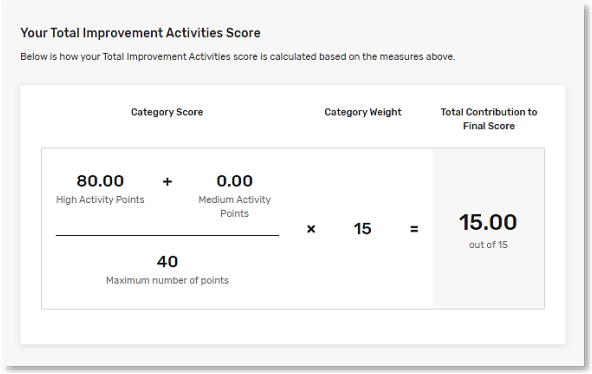


Improvement Activities

Reporting Option	Details
Traditional MIPS	Details are available for the reported activities
MVPs	Details are available for the reported activities
APP	N/A – automatic full credit in this performance category

The Improvement Activities page will display the name, weight, and points received for each activity you attested to completing. 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.



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

If you're a MIPS eligible clinician practicing in a certified patient-centered medical home, including the medical home model, or a comparable specialty practice, **you earn full credit for the improvement activities performance category as long you attested to this during the submission period.** If you didn't attest to participating in a certified, patient-centered medical home, then you didn't receive the credit.

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

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

Promoting Interoperability

Reporting Option	Details
Traditional MIPS	Available based on measures submitted
MVPs	Available based on measures submitted
APP	Available based on measures submitted (either through the details page or via download for APM Entities scored through the "PI Rollup.")

The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed. **All 3 MIPS reporting options have the same requirements for this performance category.**

Beginning with the 2023 performance year, APM Entities – such as Shared Savings Program ACOs – had the option to report Promoting Interoperability data at the APM Entity level or at the individual and group level.

- When the APM Entity submits Promoting Interoperability data, the Entity will be scored on the Entity-level data, even if data is also submitted by individuals and groups within the Entity.

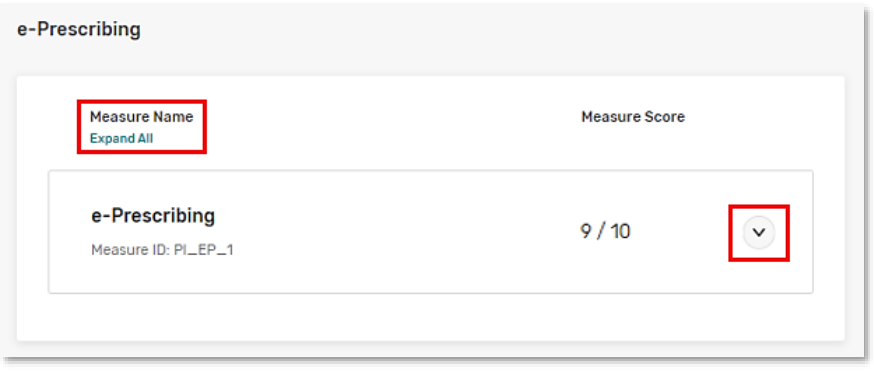
How Are Measures Scored?

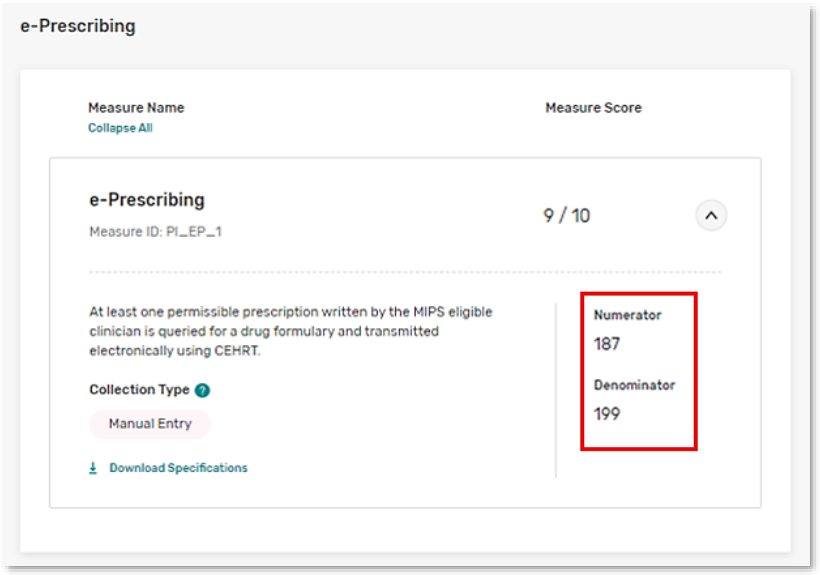
Each required, scored measure is worth a specified number of points, though the maximum points per measure could change based on reporting exclusions for other measures.

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

How Do I Find Measure Details?

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

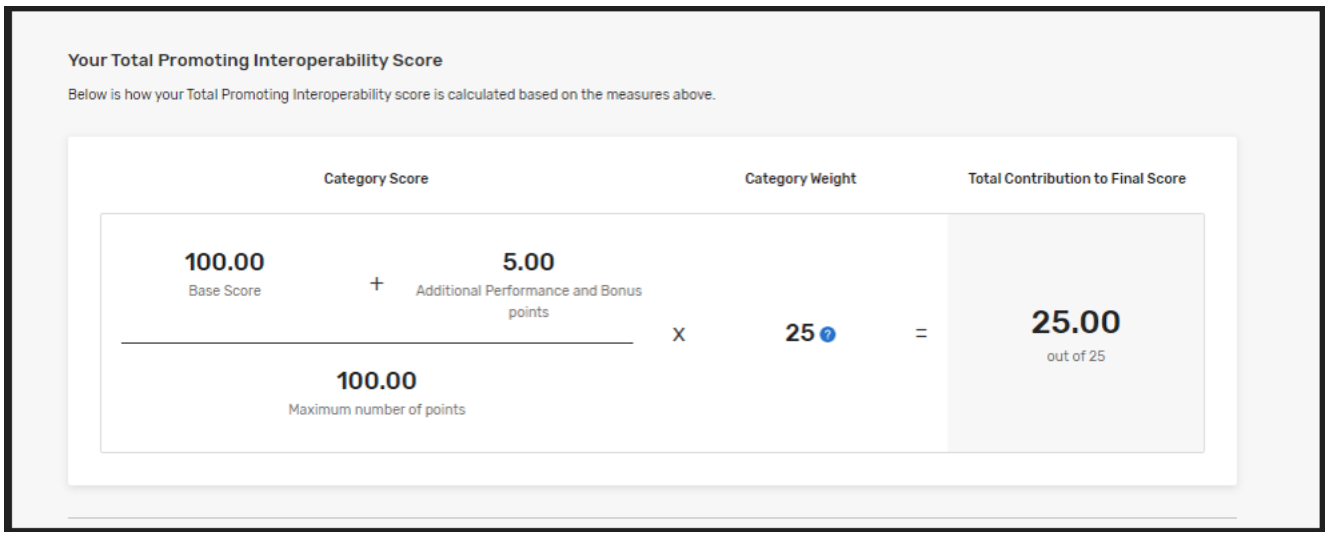




How Was Our Promoting Interoperability Score Calculated?

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

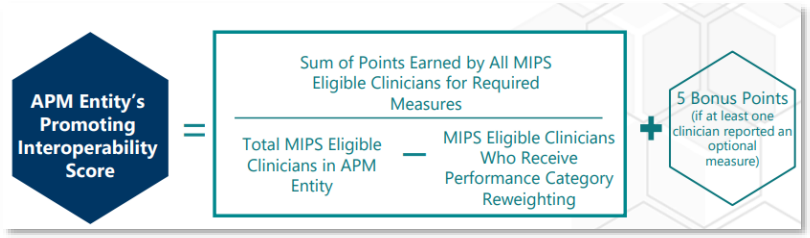
We divided the points earned by 100 (the maximum number of points available); then we multiplied that number by the category weight.



We're an APM Entity (e.g., a Shared Savings Program ACO) and Our MIPS Eligible Clinicians Reported Promoting Interoperability Data As Individuals and Groups. How Was Our Score Calculated for the ACO as a Whole?

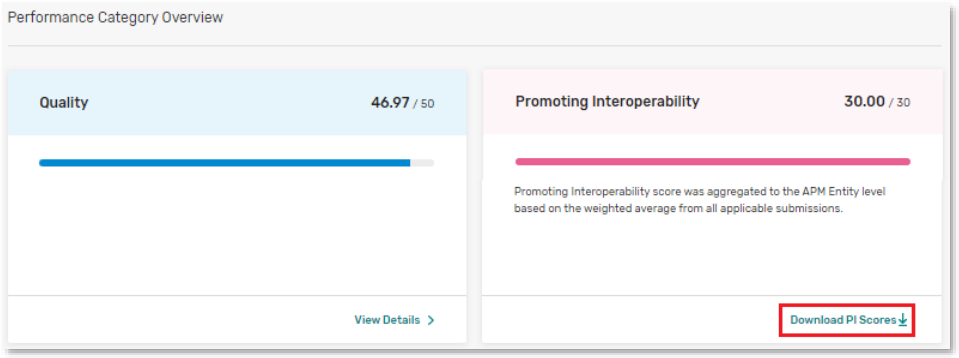
We scored the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity. (This is sometimes referred to as the "PI rollup.")

- When reporting this category at the individual and group level, we identify the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- We'll calculate a score for the APM Entity as a weighted average of the scores that MIPS eligible clinicians in the Entity receive from individual and group submissions.
- The APM Entity received 5 bonus points if at least one individual or group in the APM Entity reported any of the optional measures within the Public Health and Clinical Data Exchange objective), but the Promoting Interoperability performance category score can't exceed 100%.



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

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



Why Did I Receive a Performance Category Score of 0 Out of 25 Points When I Qualified for Reweighting?

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

Note: If you didn't submit data and received a performance category score of 0 out of 25 points but should've qualified for reweighting based on your clinician type, special status, and/or exception status, please contact the QPP Service Center for assistance.

Why Did I Receive a Performance Category Score of 0 Out of 25 Points When I Submitted All of My Data?

If you reported Promoting Interoperability data through multiple submission types (for example, manual entry and file upload) and there was any conflicting data, you received a score of 0 out of 25 points for the performance category.

What Is a CEHRT ID?

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

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

Cost

Reporting Option	Details
Traditional MIPS	Details available for scored measures (automatically calculated).
MVPs	Details available for scored measures (automatically calculated).
APP	N/A – cost performance category isn't applicable

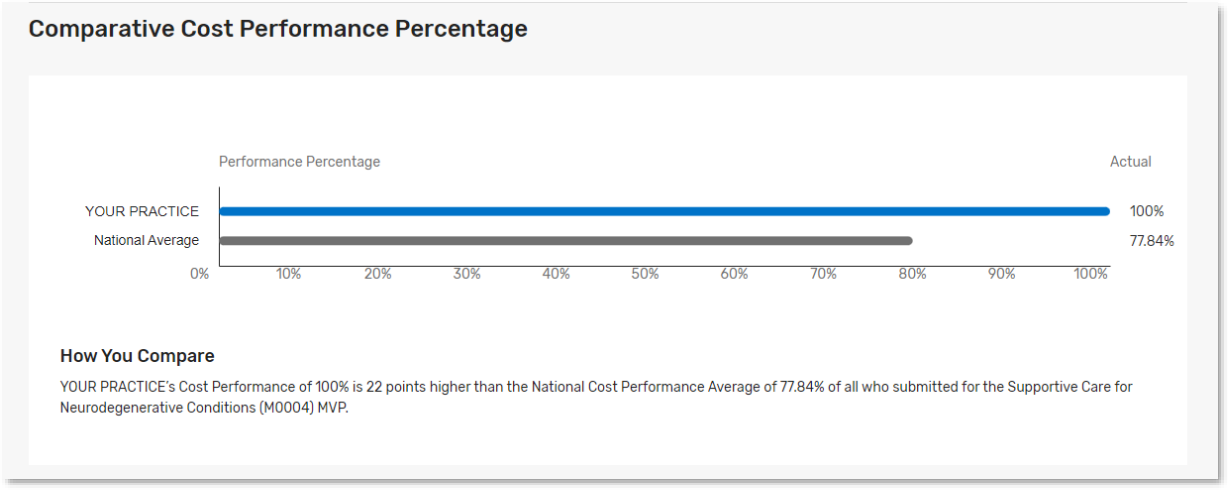
If your Final Score displays "Facility-based," skip ahead.

Each of the 3 MIPS reporting options has different cost measure options.

- **Traditional MIPS**
  - We automatically calculate all cost measures in the MIPS inventory; you'll be scored on the measures for which you meet the requirements.
- **MVPs**
  - We automatically calculate the cost measures in the MVP you registered for; you'll be scored on the measures for which you meet the requirements.
- **APP**
  - Cost isn't measured under the APM Performance Pathway.

Comparative Cost Feedback (MVP Reporting Only)

Individual clinicians, groups, subgroups and APM Entities who received a final score from the MVP reporting option can see how their cost score compared to all other MVP participants who reported the same MVP.



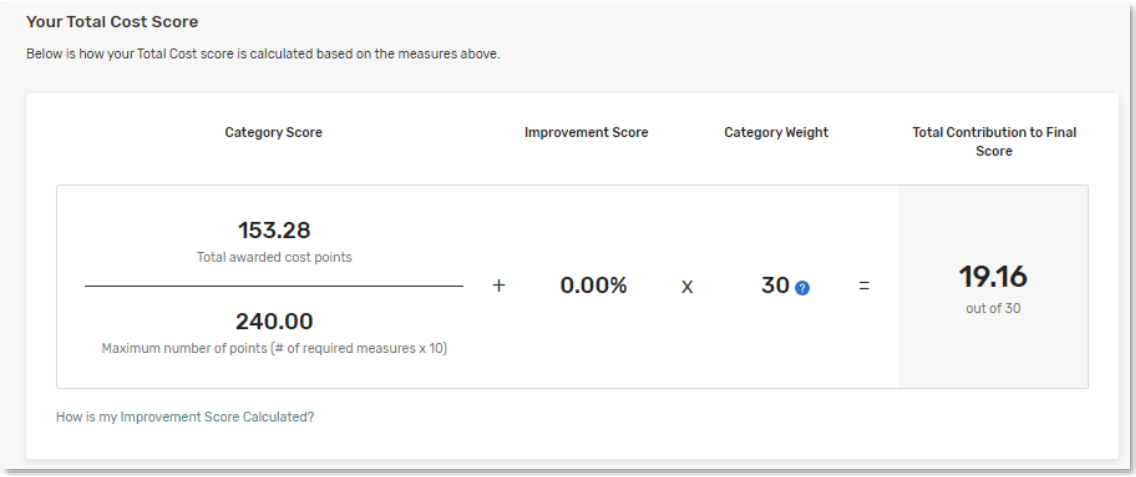
How is the Cost Performance Category Score Determined?

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

- We sum the points earned for each of the cost measures you could be scored on and divide that by the maximum number of points available (10 x the number of measures you could be scored on.)
- We add improvement scoring (beginning with the 2023 performance period).
- We then multiply that by 30% performance category weight.

In the example below, the organization reported traditional MIPS and could be scored on all 24 cost measures available for scoring in the 2023 performance period.

As a reminder, the Simple Pneumonia with Hospitalization measure was announced as excluded via QPP listserv on 5/28/2024. Learn more in this fact sheet (PDF, 190KB).



What Is Cost Improvement Scoring?

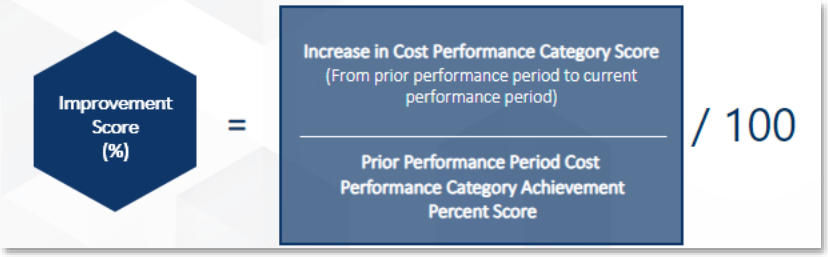
You can earn up to 1 additional percentage point in the cost performance category based on your rate of improvement from the previous year.

The improvement score — calculated at the category level and representing improvement in achievement from one year to the next — may not total more than 1 percentage point. If CMS can't compare data between 2 performance periods, or there's no improvement, the improvement score will be 0%. The improvement score can't be negative.

- You'll see an indicator at the top of the cost page if you're receiving cost improvement scoring.

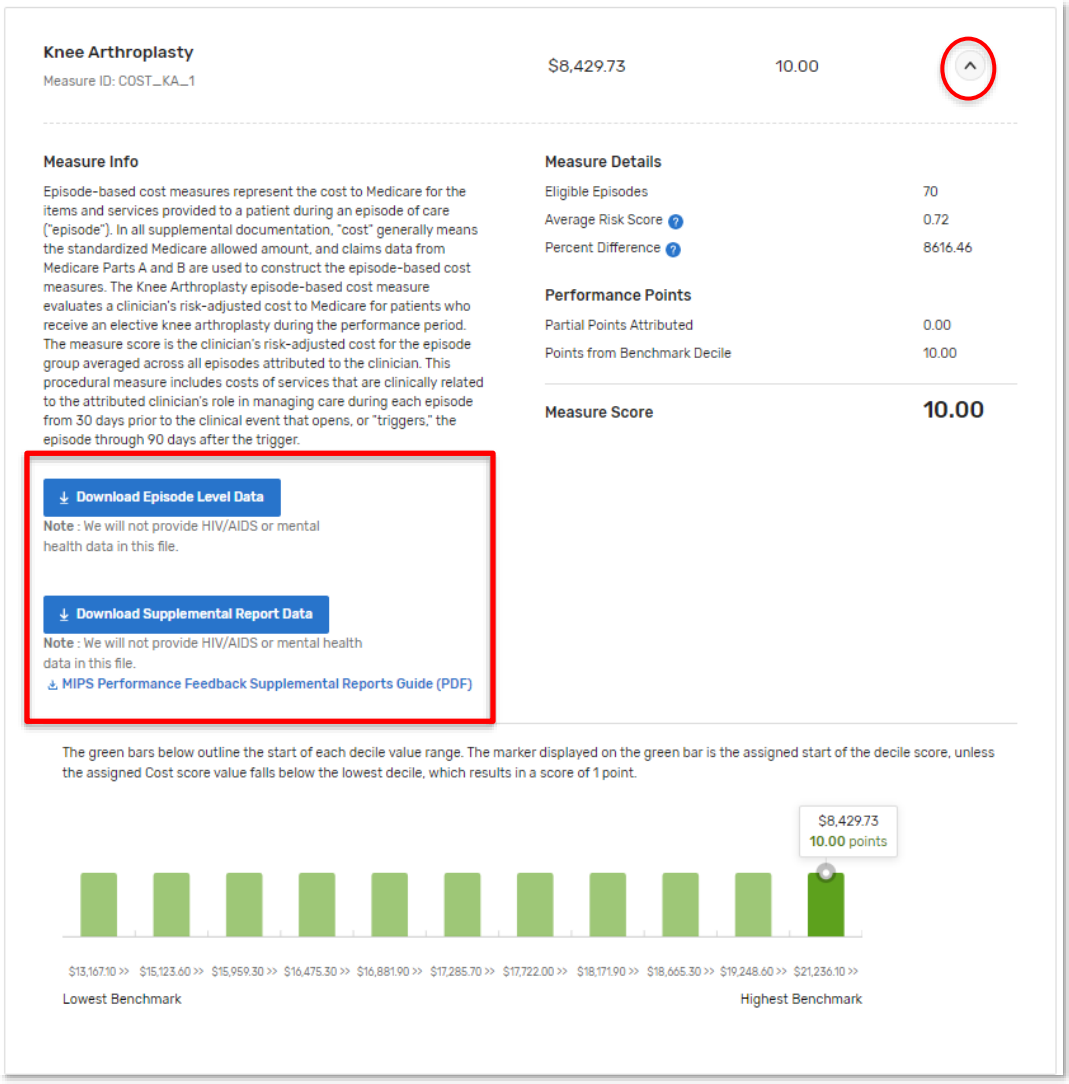
How Is Cost Improvement Scoring Calculated?

Similar to quality improvement scoring, cost improvement scoring is calculated by comparing the cost performance category score from the previous (2022) performance period to the cost performance category score for the current (2023) performance period. However, cost improvement scoring is capped at one percentage point. (See graphic on next page.)



Where Can I Find More Detailed Information about the Cost Measures I Was Scored on?

We've released supplemental cost measure reports. These reports are available for every cost measure on which you could be scored. Click the arrow to open the measure details and access these reports. Review the 2023 MIPS Performance Feedback Supplemental Reports Guide (PDF, 824KB) for more information about the data included in these reports; this guide can also be accessed in the measure details.



Why Don't I See Any Cost Measure Information?

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

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

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

At a High Level, How Can I Interpret My Score (Expressed as a Dollar Value) on a MIPS Cost Measure?

A cost measure score represents how a clinician performs relative to their peers. A clinician or group receives more MIPS points on a cost measure if their average observed (i.e., actual) spending is lower than the expected spending (predicted through risk adjustment), relative to their peers.

- For episode-based cost measures and the MSPB Clinician measure, clinicians are scored based on their average cost per episode after applying adjustments.
- For the TPCC measure, clinicians are scored based on their average cost per beneficiary after applying adjustments.

All cost measures used standardized payment data, so factors such as geographic variation in reimbursement do not influence cost performance. All cost measures also use risk adjustment to help account for factors outside of attributed clinicians' control that can influence the cost of care, such as the patient's age or preexisting comorbidities.

Risk adjustment factors include comorbidities derived from the CMS Hierarchical Condition Category (HCC) model, plus measure-specific factors tailored to the condition or procedure being assessed by that particular cost measure. For some measures, a specialty adjustment is also applied. The risk adjustment model predicts the cost for a given episode of care or beneficiary ("expected cost"), which is then compared to the actual ("observed") costs for an episode or beneficiary to get a ratio of observed to expected costs. This ratio is averaged across all episodes or beneficiaries attributed to a clinician during a performance period and is multiplied by the national observed mean cost to generate a dollar figure referred to as an average cost per episode or per beneficiary. This score is then translated into points in the cost performance category based on the measure's performance deciles.

Please see the 2023 MIPS Cost User Guide (PDF, 1MB) for a summary of how the cost measures are scored.

How Can I Use My 2023 Performance Year Supplemental or Patient-level Cost Measure Reports to Address or Improve My Cost Category Performance in Future Performance Years?

Cost measures assess costs directly related to treatment choices, as well as the costs of other services such as costs associated with clinically related adverse outcomes or complications. Clinicians can consider the appropriate use of treatment services, such as office visits, testing and imaging, and medications. Additionally, clinicians can influence the costs of care by providing high-quality care, such as having an appropriate care plan, following clinical guidelines, conducting proactive monitoring, reconciling medications, engaging in care coordination, and providing patient education. These treatment choices can affect the likelihood and severity of

costly adverse outcomes, like emergency department visits, hospitalizations and readmissions, post-acute care, and other treatment for complications, which can contribute to a clinician's cost performance score.

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

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

What Can I Do During the Current Performance Year to Ensure My MIPS Cost Measure Performance Is Accurately Assessed?

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

You may also review the measure specifications to see which services and costs are included in the measure; this information is available in the 2024 MIPS Cost Measure Codes Lists (ZIP, 10 MB) and the 2024 MIPS Cost Measure Information Forms (ZIP, 37 MB), which are both available in the QPP Resource Library.

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

Why Did My 2023 Performance Year Episode-based Cost Measure Score Change So Much Compared to My 2022 Performance Year Score for the Same Measure?

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

Additional information on the 2023 MIPS cost measures can be found in the 2023 MIPS Cost User Guide (PDF, 1MB) in the QPP Resource Library.

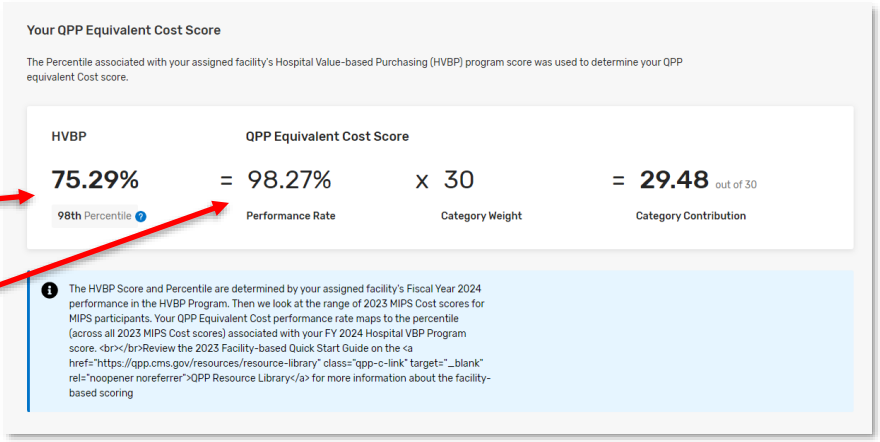
Can a Clinician Be Scored on an Episode-based Cost Measure if That Clinician Isn't Individually Attributed Episodes for the Measure?

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

Facility-based Cost Score

If your quality and cost scores are derived from facility-based scoring, you won't see measure details. Instead, you'll see your facility's **Hospital VBP Program score and associated percentile** and the **MIPS equivalent (unweighted) cost score** based on the Hospital VBP Program score's percentile.

The MIPS equivalent score is multiplied by the **category weight** to arrive at the quality points contributing to your final score.



Items and Services

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

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

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

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

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

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

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

What Is a CPT Code?

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

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

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

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

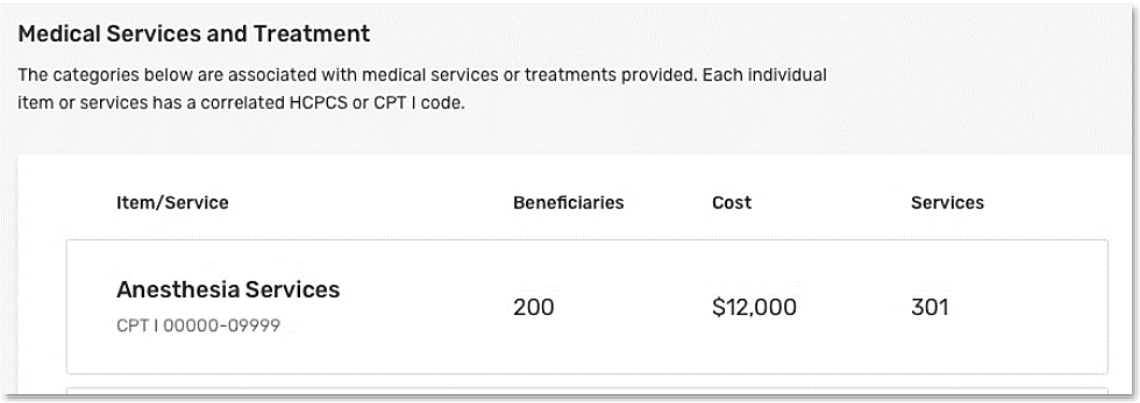
HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS	
00000-09999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital, maternity care, and delivery system
60000-69999	Endocrine, nervous, eye and ocular adnexa, auditory system
70000-79999	Radiology services
80000-89999	Pathology and laboratory services
90000-99999	Evaluation and management services
Level 2 HCPCS	
HCPCS A	Transportation services including ambulance, medical & surgical supplies
HCPCS B	Enteral and parenteral therapy
HCPCS C	Temporary codes for use with outpatient prospective payment system
HCPCS E	Durable medical equipment (DME)
HCPCS G	Procedures or professional services (temporary codes)
HCPCS H	Alcohol and drug abuse treatment services or rehabilitative services

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

HCPCS Code	Definition of HCPCS Code Ranges
HCPCS J	Drugs administered other than oral method, chemotherapy drugs
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS U	Codes for Coronavirus lab tests
HCPCS V	Vision, hearing and speech-language pathology services

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

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Types 71 and 72) billed with dates of services between January 1, 2023, and December 31, 2023, and received by CMS within 60 days of December 31, 2023 (a "60-day runout").



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

For individual clinicians, this number includes all unique Part B-enrolled patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during CY 2022 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2023.

For groups, this number includes all Part B-enrolled patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2023 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2023.

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

The cost reflected in the Items and Services section of performance feedback is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines with dates of service 1/1/-2023 – 12/31/2023. These numbers are raw allowed charge amounts and aren't payment-standardized, risk-adjusted, or specialty adjusted.

For individual clinicians, the number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during CY 2023 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any provider during CY 2023.

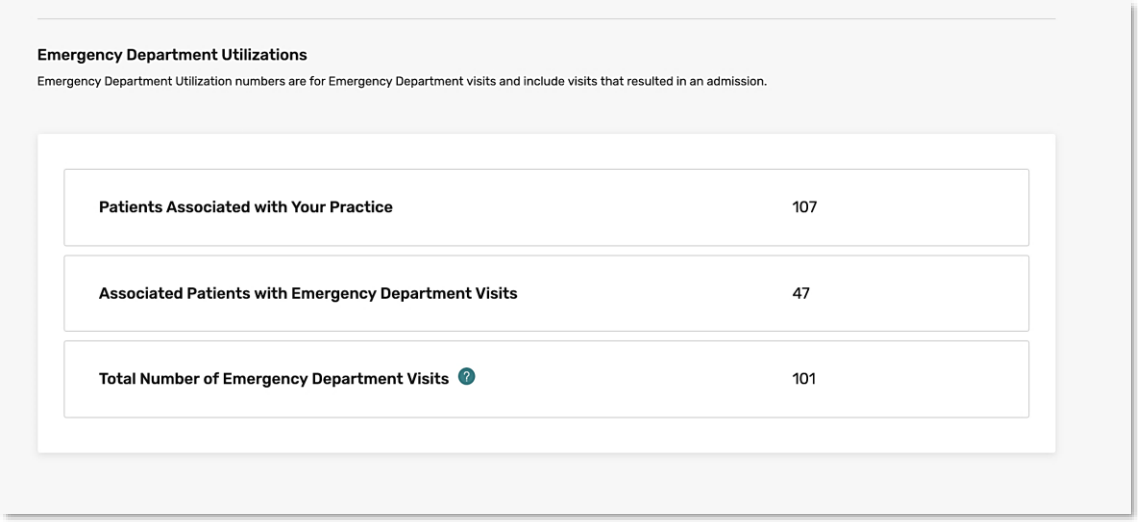
For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2023 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any clinician during CY 2023.

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

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from the individual clinician (identified by TIN/NPI) during
CY 2023 AND received at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2023.

For groups, this number is the sum of all Part B-enrolled patients' service unit quantity counts on professional claim lines with positive allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN/NPI) who reassigned their billing rights to the group (identified by TIN) during CY 2023 AND at least one qualifying service (identified by the relevant CPT code within the designated range) from any clinician during CY 2023.

Emergency Department Utilization



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

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

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

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

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

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

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

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

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

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

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

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

This metric reflects the number of attributed patients who also had an ED visit in CY 2023. An ED visit is defined as any CY 2023 claim with a claim line containing any of the following ED revenue center codes: 0450 – 0459 and/or 0981.

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

The figure reflects the actual number of ED visits across all attributed patients in CY 2023.

Where Can I Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during nonpeak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing 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 on the Quality Payment Program Resource Library.

Version History

Date	Change Description
08/12/2024	Original Posting

Appendix A: Automatic Extreme and Uncontrollable Circumstances (EUC) Policy

Performance Category Weights and Payment Adjustment Based on Individual Data Submission

The table below illustrates the 2023 performance category reweighting policies under the MIPS automatic EUC policy that apply to clinicians participating as individuals. Learn more in this fact sheet (PDF, 364KB).

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

Appendix B: Performance Category Reweighting

Table 1. Performance Category Weight Redistribution (Excluding Small Practices)

Table 1 outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances, including the Extreme and Uncontrollable Circumstances policy.

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Performance Category Redistribution for the 2023 Performance Year/2025 MIPS Payment Year				
Reweighting Scenario	**Quality**	**Cost**	**Improvement Activities (IA)**	**Promoting Interoperability (PI)**
No Reweighting Needed				
General weighting for all 4 performance categories	30%	30%	15%	25%
Reweighting 1 Performance Category				
No Cost: Cost → Quality and PI	55%	0%	15%	30%
No Promoting Interoperability: PI → Quality	55%	30%	15%	0%
No Quality: Quality → PI	0%	30%	15%	55%
No Improvement Activities: IA → Quality	45%	30%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability Cost and PI → Quality	85%	0%	15%	0%
No Cost and No Quality Cost and Quality → PI	0%	0%	15%	85%
No Cost and No Improvement Activities Cost and IA → Quality and PI	70%	0%	0%	30%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	0%	50%	50%	0%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	70%	30%	0%	0%
No Quality and No Improvement Activities Quality and IA → PI	0%	30%	0%	70%

Table 2. Performance Category Weight Redistribution (Small Practices)

Table 2 reviews the performance category redistribution policies that apply to small practices in the 2023 performance year.

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix C: Performance Feedback Based on Access

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

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

With This Access	You CAN	You CAN'T
(QCDR or Qualified Registry)		○ Data collected and calculated by CMS on behalf of your clients.
Clinician Role	✓ View and download your performance feedback and view final scores applicable to each of your TIN/NPI combinations. ✓ View and download payment adjustment data.	**X** View performance feedback for other clinicians.
Staff User or Security Official for a **Virtual Group**	✓ View and download virtual group-level performance feedback. ✓ View and download payment adjustment data. ✓ Access patient-level reports for administrative claims cost and quality measures.	**X** View performance feedback about data submitted by individuals or practices in your virtual group.

Appendix D: Administrative Claims Measures

- **Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System.**
  - This measure is automatically calculated for groups, virtual groups, and APM Entities that include at least 1 cardiologist and meet the case minimum (21 cases).
  - Review the measure specification (ZIP, 743KB).
    - Included in traditional MIPS.
    - Available as 1 of the 4 required measures in MVP reporting.
    - Not included in APP reporting.

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

- **Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).**
  - This measure is automatically calculated for individuals, groups, virtual groups, and APM Entities that meet the case minimum (25 cases).
  - Review the measure specification (ZIP, 1.9 MB).
    - Included in traditional MIPS.
    - Available as 1 of the 4 required measures in MVP reporting.
    - Not included in APP reporting.

- **Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
  - This measure is automatically calculated for groups, virtual groups, and APM Entities with at least 16 eligible clinicians that meet the case minimum (18 cases).
  - Review the measure specification (ZIP, 25.5 MB).
    - Included in traditional MIPS.
    - Available as a population health measure in MVP reporting.
    - Included in APP reporting.

Appendix E: Cost Measures with Scoring Changes

The following measures have MIPS scoring changes due to changes in clinical guidelines during the 2023 performance period, or because specifications were determined during or after the performance period to have substantive changes.

Cost Measure ID/Name	Impact on Scoring, Submission, and Feedback Expectations
COST_SPH_1/ Simple Pneumonia with Hospitalization	This measure will be excluded from scoring and won't contribute to the MIPS cost performance category score. This measure won't be included in performance feedback.

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

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

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

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

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

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

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

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

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

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