



Merit-based Incentive Payment System (MIPS)

Alternative Payment Model (APM)
Performance Pathway (APP) Scoring
Guide for the 2021 Performance Year



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How to Use This Guide



Please Note: This guide provides a general summary about scoring for the Alternative Payment Model (APM) Performance Pathway (APP). It is for informational purposes only and does not intend to grant rights, impose obligations, or take the place of either the statute or regulations. We urge you to review the specific statutes, regulations, and other relevant materials for their complete and accurate contents. **This guide does not review reporting requirements or scoring policies for traditional Merit-based Incentive Payment System (MIPS).**

In this guide, we often use the term “individual” to refer to a MIPS eligible clinician participating in the program as an individual.

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Hyperlinks

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



Overview

COVID-19 and 2021 Participation

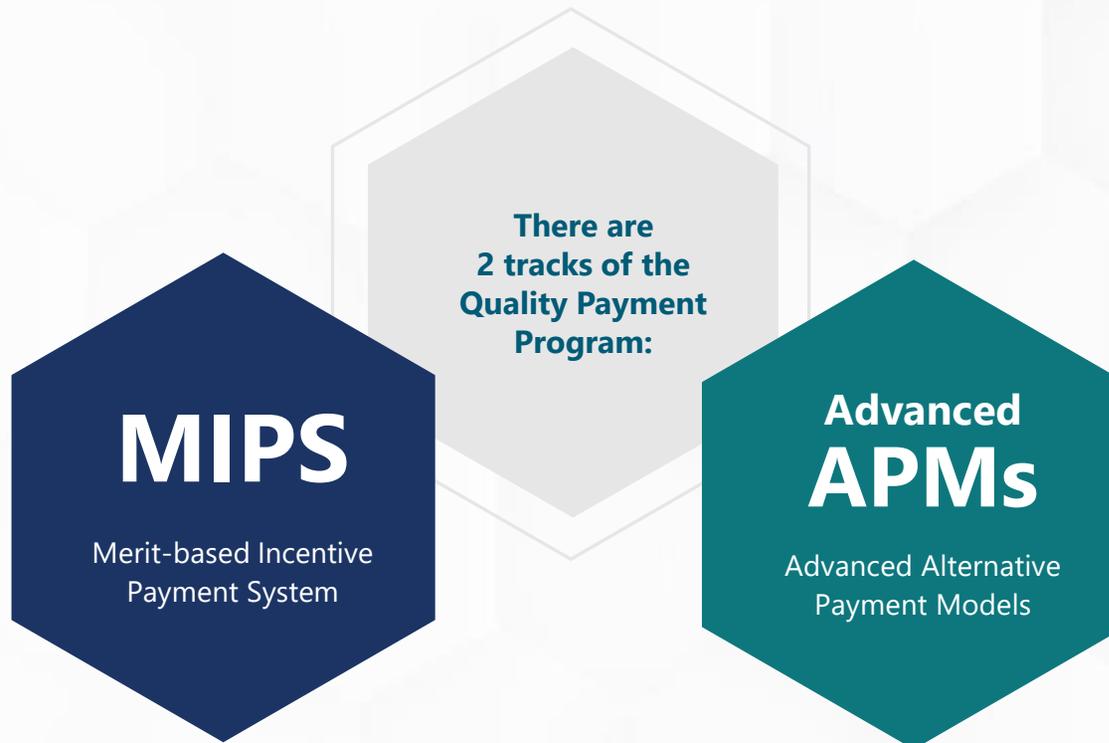
The 2019 Coronavirus (COVID-19) public health emergency continues to impact all clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2021 performance year, we'll continue to use our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, virtual groups, and APM Entities to [submit an application](#) requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency. The Extreme and Uncontrollable Circumstances application deadline for the 2021 performance year is December 31, 2021 at 8 p.m. ET.

Due to the anticipated need for continued COVID-19 clinical trials and data collection, MIPS eligible clinicians, groups, virtual groups, and APM Entities that meet the improvement activity criteria will be able to receive credit for the COVID-19 Clinical Reporting with or without Clinical Trial improvement activity for the 2021 performance year.

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

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides 2 participation tracks:



For performance years 2019-2022, Advanced APM participants who achieved Qualifying APM Participant (QP) status may have been eligible for a 5% Incentive Payment and excluded from MIPS. However, in December 2022, Congress announced it included a value-based care incentive in its year-end spending bill, allowing QPs to receive a 3.5% APM Incentive Payment for the 2023 performance year/2025 payment year.

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve Qualifying APM Participant (QP) status, you may be eligible for a 5% incentive payment and you will be excluded from MIPS.*

* Note: If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

What is the Alternative Payment Model (APM) Performance Pathway (APP)?

The APP is a MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs. To view the list of MIPS APMs, please go to the [Comprehensive List of APMs \(PDF\)](#).

The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. Performance is measured across 3 areas and accounts for the following percentages of the MIPS Final Score for MIPS APM participants reporting through the APP: quality (50%), improvement activities (20%), and Promoting Interoperability (30%).

- All MIPS APM participants who report through the APP in 2021 will automatically receive 100% for the improvement activities performance category score.
- In addition, under the APP the cost performance category is weighted at 0% of the MIPS Final Score, because all MIPS APM participants are already responsible for costs under their APMs.

The APP will be in effect starting January 1, 2021. It is an optional MIPS reporting and scoring pathway for MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the four snapshot dates (March 31, June 30, August 31, and December 31) during a performance period, starting in the 2021 MIPS performance period.

Who Can Report via the APP?

The APP can be reported by MIPS eligible individuals or groups that participate in MIPS APMs, or by APM Entities on behalf of their MIPS eligible clinicians. Virtual groups aren't eligible to report via the APP.

Accountable Care Organizations (ACOs) participating in the Shared Savings Program are required to report via the APP for the purpose of assessing their quality performance for that program. However, for the purposes of MIPS scoring, MIPS eligible clinicians participating in these ACOs, as well as the ACOs themselves, have the option of reporting traditional MIPS, outside the APP. MIPS eligible clinicians participating in ACOs can also choose to report the APP at the individual or group level, like all other MIPS APM participants.¹

Your final score determines whether you will receive a positive, neutral, or negative MIPS payment adjustment. The Centers for Medicare & Medicaid Services (CMS) will award the highest available score. For example, if your APM Entity reports via the APP and your group reports under traditional MIPS, you'll receive whichever of the 2 scores is higher.²

¹ Starting in 2021, the APP will be required for all Shared Savings Program ACOs. All quality data reported via the APP will be used to calculate Shared Savings Program scores, and quality measure scores between MIPS and Shared Savings Program will be identical.

² If you participate in a virtual group, you will receive a final score based on the performance of the virtual group, even if you have a higher score through another means of participation.



Getting Started: Reviewing MIPS Terms

Collection Type*

- **Collection Type** refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data. The following collection types apply to APP reporting:
 - Electronic clinical quality measures (eCQMs).
 - MIPS clinical quality measures (MIPS CQMs).
 - Medicare Part B Claims measures (available only to small practices).
 - CMS Web Interface measures (available only to Shared Savings Program ACOs).
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for MIPS Survey measure (available to groups and to APM Entities with 2 or more clinicians).
- [Appendix D](#) explains each of these collection types in further detail.

* The term "Collection Type" is unique to the Quality performance category and does not apply to the other performance categories.

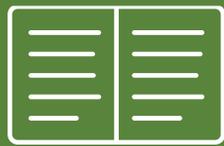
Getting Started: Reviewing MIPS Terms (Continued)

Submitter Type

- **Submitter Type** refers to the individual MIPS eligible clinician, group, APM Entity, or third-party intermediary (acting on behalf of a MIPS eligible clinician, group, or APM Entity) that submits data on measures for the quality and Promoting Interoperability performance categories for APP reporting.

Submission Type

- **Submission Type** is the mechanism by which the submitter type submits data to CMS:
 - Direct (transmitting data through a computer-to-computer interaction, such as an Application Programming Interface, or API).
 - Sign in and upload (attaching a file).
 - Sign in and attest (manually entering data).
 - Medicare Part B Claims.
 - CMS Web Interface.



APP: Quality Performance Category



What Are the Quality Performance Category Data Submission Requirements Under the APP?

Individual MIPS eligible clinicians, groups, and APM entities reporting the APP must submit 3 specific quality measures (as eQMs, MIPS CQMs, or Medicare Part B claims measures) and administer the CAHPS for MIPS Survey. In addition, there are 2 administrative claims measures that we'll automatically calculate for you.



50% of MIPS Score

Option 1: Quality Measures Set

<p>Quality ID: 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control</p>	<p>Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan</p>	<p>Quality ID: 236 Controlling High Blood Pressure</p>	<p>Quality ID: 321 CAHPS for MIPS <i>(Groups and APM entities only)</i></p>	<p>Quality ID: 479 Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups</p>	<p>Quality ID: TBD Risk Standardized All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs**</p>
<p>Collection Type:</p> <ul style="list-style-type: none"> eQCM MIPS CQM <p>Submitter Type:</p> <ul style="list-style-type: none"> MIPS EC Representative of a Practice APM Entity Third Party Intermediary 	<p>Collection Type:</p> <ul style="list-style-type: none"> eQCM MIPS CQM Medicare Part B Claims* <p>Submitter Type:</p> <ul style="list-style-type: none"> MIPS EC Representative of a Practice APM Entity Third Party Intermediary 	<p>Collection Type:</p> <ul style="list-style-type: none"> eQCM MIPS CQM Medicare Part B Claims* <p>Submitter Type:</p> <ul style="list-style-type: none"> MIPS EC Representative of a Practice APM Entity Third Party Intermediary 	<p>Collection Type:</p> <ul style="list-style-type: none"> CAHPS for MIPS Survey <p>Submitter Type:</p> <ul style="list-style-type: none"> Third Party Intermediary 	<p>Collection Type:</p> <ul style="list-style-type: none"> Administrative Claims <p>Submitter Type:</p> <ul style="list-style-type: none"> N/A 	<p>Collection Type:</p> <ul style="list-style-type: none"> Administrative Claims <p>Submitter Type:</p> <ul style="list-style-type: none"> N/A

*Medicare Part B Claims measures can only be reported by individuals, groups or APM Entities with a small practice designation. Note that Measure 001 is suppressed in 2021 for the Medicare Part B Claims collection type.

**The Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions measure is for ACOs only, for performance year 2021.

What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures instead of the 3 eQMs/MIPS CQMs/Medicare Part B Claims measures. Shared Savings Program ACOs that choose to report the CMS Web Interface measures must still administer the CAHPS for MIPS Survey and will be evaluated on 2 administrative claims measures. This alternative measure set is available only to Shared Savings Program ACOs.

Option 2: Quality Measures Set (Shared Savings Program ACOs only)

<p>Quality ID: 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control</p>	<p>Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan</p>	<p>Quality ID: 236 Controlling High Blood Pressure</p>	<p>Quality ID: 318 Falls: Screening for Future Fall Risk</p>	<p>Quality ID: 110 Preventive Care and Screening: Influenza Immunization</p>	<p>Quality ID: 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</p>
<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface 	<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface 	<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface 	<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface 	<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface 	<p>Collection Type:</p> <ul style="list-style-type: none"> • CMS Web Interface
<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO) 	<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO) 	<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO) 	<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO) 	<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO) 	<p>Submitter Type:</p> <ul style="list-style-type: none"> • APM Entity (ACO)

What Are the Quality Performance Category Data Submission Requirements Under the APP?

(Continued)

Option 2: Quality Measures Set (Shared Savings Program ACOs only) [continued]

Quality ID:

113

Colorectal Cancer Screening

Collection Type:

- CMS Web Interface

Submitter Type:

- APM Entity (ACO)

Quality ID:

112

Breast Cancer Screening

Collection Type:

- CMS Web Interface

Submitter Type:

- APM Entity (ACO)

Quality ID:

438

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Collection Type:

- CMS Web Interface

Submitter Type:

- APM Entity (ACO)

Quality ID:

370

Depression Remission at Twelve Months

Collection Type:

- CMS Web Interface

Submitter Type:

- APM Entity (ACO)

Quality ID:

321

CAHPS for MIPS

Collection Type:

- CAHPS for MIPS Survey

Submitter Type:

- Third Party Intermediary

Quality ID:

479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Collection Type:

- Administrative Claims

Submitter Type:

- N/A

Quality ID:

TBD

Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs

Collection Type:

- Administrative Claims

Submitter Type:

- N/A

Submitting APP Measures as Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs

What Are the Quality Measure Reporting Requirements for eQMs, MIPS CQMs, and Medicare Part B Claims Measures?

Quality measures have a 12-month performance period (January 1, 2021 – December 31, 2021).

To meet data completeness requirements, you must identify all of the measure's denominator eligible encounters **and** report performance data for at least 70% of these encounters.

Are you submitting quality measures through the CMS Web Interface? [Skip ahead.](#)

- When reporting eQMs and MIPS CQMs, your denominator eligible encounters **include your entire patient population**, not just your Medicare patient population.
- Medicare Part B Claims measures can only be reported by individuals, groups, and APM Entities with the small practice designation and are limited to Medicare patients.

Did you know? You can use multiple collection types when reporting Measures 001, 134, and 236. For example, you could report Measure 001 as an eQM and Measures 134 and 236 as MIPS CQMs.

What Does “Data Completeness” Mean?

“Data completeness” refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the entire eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the eligible population (denominator).

- For Medicare Part B Claims measures, we identify the eligible population (denominator) for you based on the claims you submit.
- For eQMs and MIPS CQMs, you (or your vendor) identify the eligible population in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (submitting only favorable performance data, commonly referred to as “cherry-picking”), would not be considered true, accurate, or complete and may subject you to audit.

Submitting APP Measures as Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs (Continued)

How are eQMs, MIPS CQMs, and Medicare Part B Claims Measures Assessed in the Quality Performance Category for the 2021 Performance Period?

Your performance on each quality measure is assessed against a benchmark to see how many points you earn for the measure.

Benchmarks are differentiated by collection type. Because the 3 APP measures can be reported through multiple collection types, different benchmarks will be used for scoring based on whether you report these measures as eQMs, MIPS CQMs, or Medicare Part B Claims measures (available to small practices only). Looking for information on CMS Web Interface measures? [Click here](#).

Whenever possible, we use historical data to establish benchmarks. Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years before the applicable performance period. The historical benchmarks for the 2021 MIPS performance period were established from quality data submitted for the 2019 MIPS performance period.

Did you know? If you submit eQMs, you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eQM data. The CEHRT used to collect the data must meet the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

For more information about the 2021 quality benchmarks, please review the [2021 Quality Benchmarks \(ZIP\)](#).

Submitting APP Measures as Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs (Continued)

What If a Quality Measure Doesn't Have a Historical Benchmark?

Measure 134 (Preventive Care and Screening: Screening for Depression and Follow-Up Plan) was suppressed for the eQm collection type in the 2019 performance period and therefore doesn't have a historical benchmark. We'll try to calculate a benchmark for this eQm based on 2021 performance data submitted.

We can calculate a performance period benchmark when 20 or more individuals, groups, virtual groups, or APM Entities submit the eQm collection type for Measure 134 (as part of APP or traditional MIPS reporting) and when the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured).
- Meets or exceeds the 70% data completeness criteria.
- Has a performance rate greater than 0%.

Individuals, groups, virtual groups, and APM Entities must be eligible for MIPS (that is, not voluntarily reporting) for their data to be used in the creation of a benchmark.

If we can't create a performance period benchmark, we'll exclude Measure 134 from quality scoring for any individual, group, or APM Entity that reports the measure for the APP as an eQm. (This is different than our scoring policies under traditional MIPS.)

Did you know? We suppressed Measure 134 in the 2019 performance period for the eQm collection type only due to the removal of Systematized Nomenclature of Medicine (SNOMED) codes. There are historical benchmarks for the MIPS CQM and Medicare Part B Claims measure collection types for Measure 134, because the specifications for these collection types don't include SNOMED codes.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

How Are Measures Scored?

If a measure can be reliably scored against a benchmark, it means:

- A benchmark is available.
- The volume of cases that you've submitted is sufficient (≥ 20 cases for most measures).
- You've met data completeness requirements (identified all denominator eligible encounters and submitted performance data for at least 70% of the denominator eligible encounters).

Did you know? In 2020, we established an alternate (flat) benchmarking methodology for scoring the following quality measures when we determine that their historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient:

- Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control ($>9\%$); and
- Measure 236: Controlling High Blood Pressure.

- We're suppressing the Medicare Part B claims collection type for Measure 001 due to coding issues. [Appendix E](#) describes how the coding issues affected this measure and how CMS applied its policy on measure suppression.
- We will use **flat benchmarks*** to score the Medicare Part B Claims and MIPS CQM collection types for Measure 236.
- We'll continue to use the **historical, performance-based benchmark** to score the MIPS CQM and eCQM collection types for Measure 001 and the eCQM collection type for Measure 236.

*In flat percentage benchmarks, any performance rate at or above 90% would be in the top decile, any performance rate between 80% and 89.99% would be in the second highest decile, and so on. (For inverse measures, this would be reversed – any performance rate at or below 10% would be in the top decile, any performance rate 10.01% and 20% would be in the second highest decile, and so on.)

The [2021 Quality Benchmarks \(ZIP\)](#) reflect these flat benchmarks.



Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Measure achievement points are based on your performance for a measure in comparison to a benchmark, exclusive of bonus points.

Measure Achievement Points

**3-10
points**

You'll receive between 3 and 10 achievement points for quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.

3 points
(small
practices only)

You'll receive 3 points for measures that don't meet data completeness requirements.

0
(0 out of 10
points)

You'll receive 0 points for measures that don't meet data completeness requirements. This doesn't apply to small practices (15 or fewer clinicians).

0
(0 out of 10
points)

You'll receive 0 points for measures that are required but unreported. (You must report performance data for the measure to be considered reported.)

N/A
(0 out of 0
points)

You won't be scored on measures without a benchmark or on measures that don't meet the case minimum for scoring, as long as you meet data completeness requirements.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Example: Assigning Measure Achievement Points

You submit Measure 236 (Controlling High Blood Pressure) as an eCQM with a 66.74% performance rate.

Step 1. Find the benchmark based on collection type for the measure.

- Achievement points are determined by mapping the performance rate to the [benchmark \(ZIP\)](#) for the measure, specific to collection type.
- Remember that Measure 236 is scored according to the flat benchmark methodology for Medicare Part B Claims and MIPS CQM, which is reflected in the [2021 Quality Benchmarks \(ZIP\)](#).

The following extract from the [2021 Quality Benchmarks \(ZIP\)](#) shows the range of performance rates associated with each decile for each collection type for Measure 236.

Measure Name	Measure ID #	Collection Type	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	Medicare Part B Claims	Intermediate Outcome	Y	20.00 – 20.99	30.00 – 39.99	40.00 – 40.99	50.00 – 50.99	60.00 – 60.99	70.00 – 70.99	80.00 – 80.99	≥90.00
Controlling High Blood Pressure	236	eCQM	Intermediate Outcome	Y	51.69 – 57.07	57.08 – 61.32	61.33 – 64.79	64.8 – 68.44	68.45 – 72.03	72.04 – 76.35	76.36 – 82.37	≥82.38
Controlling High Blood Pressure	236	MIPS CQM	Intermediate Outcome	Y	20.00 – 20.99	30.00 – 39.99	40.00 – 40.99	50.00 – 50.99	60.00 – 60.99	70.00 – 70.99	80.00 – 80.99	≥90.00

Submitting Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs (Continued)

Step 2. Calculate achievement points in a decile.

- Determine the decile that the performance rate falls in
- In this case, the measure performance rate is 66.74, which corresponds to Decile 6 (eligible for 6.0 – 6.9 points)

Measure Name	Controlling High Blood Pressure
Measure ID#	236
Collection Type	eQm
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 3	51.69 – 57.07
Decile 4	57.08 – 61.32
Decile 5	61.33 – 64.79
Decile 6	64.8 – 68.44
Decile 7	68.45 – 72.03
Decile 8	72.04 – 76.35
Decile 9	76.36 – 82.37
Decile 10	≥82.38

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Step 3. Apply the following formula based on the measure performance and decile range:

$$\begin{array}{c} \text{decile \#} \\ X \end{array} + \frac{\left[\begin{array}{c} q \\ \text{performance rate} \end{array} - \begin{array}{c} a \\ \text{bottom of decile range} \end{array} \right]}{\left[\begin{array}{c} b \\ \text{top of decile range} \end{array} - \begin{array}{c} a \\ \text{bottom of decile range} \end{array} \right]} = \text{Achievement Points}$$

NOTE: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

$$\begin{array}{c} \text{decile \#} \\ 6 \end{array} + \frac{\left[\begin{array}{c} 66.74 \\ - \end{array} \begin{array}{c} 64.8 \end{array} \right]}{\left[\begin{array}{c} 68.44 \\ - \end{array} \begin{array}{c} 64.8 \end{array} \right]} = 0.5329 = \begin{array}{c} 6.5 \end{array}$$

...which is rounded to 0.5

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Quality Measure Bonus Points

You can also earn bonus points in the quality performance category in addition to measure achievement points when reporting eCQMs, MIPS CQMs and Medicare Part B Claims measures.

High-Priority Bonus Points

The APP measure set includes 3 outcome and patient experience measures:

- Measure 001 (Diabetes: Hemoglobin A1c [HbA1c] Poor Control [>9%])
- Measure 236 (Controlling High Blood Pressure)
- Measure 321 (CAHPS for MIPS Survey)

Under MIPS, you earn 2 bonus points for each outcome or patient experience measure beyond the one that's required. These bonus points are capped at 10% of your quality denominator and are available for all collection types.

- You'll typically earn 4 bonus points for reporting Measures 001 and 236 and administering the CAHPS for MIPS Survey.
 - You must meet data completeness (70%) and case minimum requirements (20 cases) for Measures 001 and 236.
 - Measure 001 must have a performance rate less than 100% (this is an inverse measure, where a lower performance rate indicates better performance).
 - Measure 236 must have a performance rate greater than 0%.
- You'll typically earn 2 bonus points for reporting Measures 001 and 236 if you don't meet sampling requirements for the CAHPS for MIPS Survey.
 - You must meet data completeness (70%) and case minimum requirements (20 cases) for Measures 001 and 236.
 - Measure 001 must have a performance rate less than 100% (this is an inverse measure, where a lower performance rate indicates better performance).
 - Measure 236 must have a performance rate greater than 0%.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

End-to-End Electronic Reporting

You'll earn 1 bonus point for each of the 3 APP quality measures (Measures 001, 134, and 236) that's submitted as an eCQM. (Because these measures are available as eCQMs, you can't earn end-to-end electronic reporting bonus points for APP measures submitted as a MIPS CQM.) These bonus points are also capped at 10% of your quality denominator.

There are no data completeness, case minimum, or performance rate requirements for eCQMs to be eligible for these bonus points.

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

Data Aggregation and Multiple Submissions

If you submit the same quality measure multiple times through the **same collection type**, we'll use the most recently reported data you submitted for that specific measure. We won't aggregate measure-level performance data when the same measure is reported multiple times.

Let's look at an example:

- You uploaded a file with the 3 eCQMs in January. In February, your electronic health record (EHR) vendor contacts you about a measure calculation issue that they just fixed so you upload a new file with the 3 eCQMs.
- The eCQMs you uploaded in February overwrote the ones you submitted in January.

If you submit the same measure through **multiple collection types** (that is, as a MIPS CQM and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points for 2 collection types for the same measure.

Let's look at an example:

- You're working with a qualified registry to report the 3 APP measures as MIPS CQMs because your certified EHR technology is only coded for Measure 001. Your registry uploads a file of all 3 measures submitted as MIPS CQMs, and you upload a file with Measure 001 submitted as an eCQM.
- When scoring Measure 001, we'll use either the MIPS CQM or eCQM collection type — whichever results in more achievement points based on comparison to its benchmark.

Submitting Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs (Continued)

How Many Measure Points Can I Earn in the Quality Performance Category?

Maximum Points by Reporting Level	
Individuals	<ul style="list-style-type: none"> • 30 POINTS – For the 3 required quality measures: <ul style="list-style-type: none"> ○ The CAHPS for MIPS Survey can't be administered for individual clinicians. ○ The Hospital-wide, All-Cause Unplanned Readmission (HWR) measure doesn't apply to individual clinicians. ○ The Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCCs) for Shared Savings Program ACOs measure doesn't apply to individual clinicians.
Groups and APM Entities	<ul style="list-style-type: none"> • 50 POINTS – For the 3 required quality measures + CAHPS for MIPS Survey measure + HWR measure <ul style="list-style-type: none"> ○ The MCC measure doesn't apply to groups or non-ACO APM entities.
ACOs Reporting eQMs/MIPS CQMs	<ul style="list-style-type: none"> • 60 POINTS – For the 3 required quality measures + CAHPS for MIPS Survey measure + HWR measure + MCC measure

Note: The maximum number of measure points available is different from the quality performance category weight (the category weight identifies the number of points that the quality performance category can contribute to your MIPS final score). The total number of points for the quality performance category will be calculated as a percentage (for example, 55 out of 60 points would be 91.6%) and then multiplied by the category weight of 50% to determine the category score.

If you don't submit at least one required APP measure, you will receive zero points in this performance category unless you qualify for the performance category to be [reweighted](#).

Submitting Medicare Part B Claims Measures, eQMs, and/or MIPS CQMs (Continued)

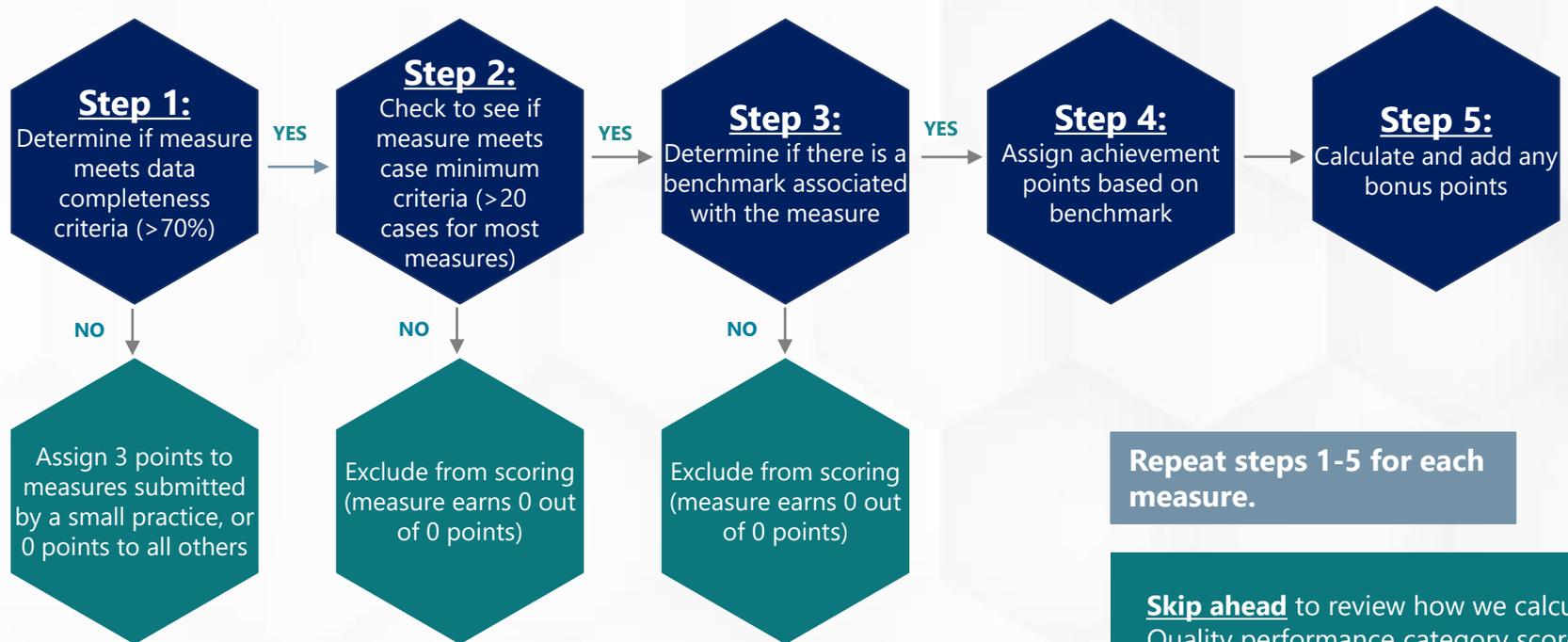
Can the Denominator (Maximum Number of Points) Be Lower Than the Maximum Points Available?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower.

IF...	THEN...
<p>There's no historical benchmark for one of the required APP measures and we can't calculate one based on data submitted for the performance period...</p>	<p>...we'll lower the denominator by 10 points for each measure without a benchmark.</p>
<p>You don't meet the case minimum for one or more measures...</p>	<p>...we'll lower the denominator by 10 points for each measure for which you don't meet the case minimum but do meet data completeness criteria.</p>
<p>Your group or APM Entity doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey...</p>	<p>...we'll lower the denominator by 10 points to account for your inability to administer the CAHPS for MIPS Survey measure.</p>
<p>You submit a measure(s) significantly impact by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available...</p> <p>NOTE: To the extent feasible, we will identify suppressed measures by the beginning of the submission period. (For example, we're suppressing the Medicare Part B Claims collection type for Measure 001 in PY 2021 due to coding issues.)</p>	<p>...we'll lower the denominator by 10 points for each impacted measure.</p> <p>Why? So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control.</p> <p>However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.</p>

Submitting Medicare Part B Claims Measures, eCQMs, and/or MIPS CQMs (Continued)

What Are the Steps for Scoring Medicare Part B Claims measures, eCQMs, and/or MIPS CQMs?



APP: Quality Performance Category

Submitting CMS Web Interface Measures (Shared Savings Program ACOs only)

How are the CMS Web Interface Measures Assessed in the Quality Performance Category When Reporting via the APP for the 2021 Performance Period?

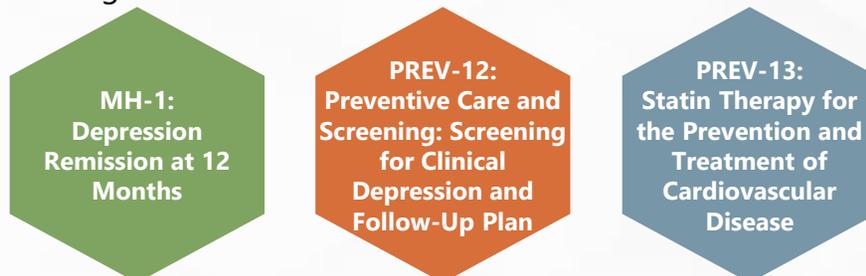
For the 2021 performance period, only Shared Savings Program ACOs may report CMS Web Interface measures. When you submit data for the 10 required measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. ACOs submitting their quality measures through the CMS Web Interface will be assessed against benchmarks established under the Shared Savings Program. The benchmarks used for the CMS Web Interface are identified in the [Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs \(PDF\)](#).

REMINDER: This guide focuses on scoring for the APP and doesn't address scoring policies for traditional MIPS.

What If a CMS Web Interface Measure Doesn't Have a Benchmark?

Unlike other collection types, we won't attempt to calculate a performance period benchmark if there isn't an existing benchmark for MIPS scoring. CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet reporting requirements for such measures.

The following CMS Web Interface measures don't have a benchmark for the 2021 performance period:



A total of 7 CMS Web Interface measures can be scored against a benchmark. Please note that we will identify any measures suppressed for the 2021 performance period at the end of the year.

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

Measure achievement points are based on your performance for a measure in comparison to a benchmark, not including bonus points.

Measure Achievement Points

3-10
points

You'll continue to receive between 3 and 10 achievement points for quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.

0
(0 out of 10
points)

You'll continue to receive 0 points (0 out of 10) for measures that don't meet data completeness requirements.

N/A
(0 out of 0
points)

You won't be scored on measures for which your sample is fewer than 20 Medicare patients, as long as you report on all the patients in the sample.

N/A
(0 out of 0
points)

You won't be scored on measures without a benchmark as long as you meet data completeness requirements.

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

- ACOs are required to submit all data for a minimum of the first 248 consecutively ranked patients for each measure (or 100% of the patients in the sample if fewer than 248 patients were assigned to a measure).
- For each patient that's skipped for a valid reason, your ACO must submit all data on the next consecutively ranked patient until the target sample of 248 is reached, or until the sample has been exhausted.

Submitting CMS Web Interface Measures (Continued)

Measure Bonus Points

You can earn one bonus point for each CMS Web Interface measure submitted, according to CMS Web Interface **end-to-end electronic reporting** criteria. For the 2021 performance period, this means submitting data collected in your CEHRT directly to CMS via the CMS Web Interface API or Excel upload.

Did you know?

- These bonus points are capped at 10% of the quality performance category denominator (or the total available measure achievement points).
- ACOs will also earn 2 bonus points for reporting the CAHPS for MIPS Survey measure in addition to the CMS Web Interface measures.

APP: Quality Performance Category

Submitting CMS Web Interface Measures (Continued)

How Many Measure Points Can I Earn in the Quality Performance Category?

- 100 POINTS for CMS Web Interface measures + Hospital-wide, All-Cause Unplanned Readmission measure + Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCC) for Shared Savings Program ACOs measure + CAHPS for MIPS Survey measure.

Note: The maximum number of measure points available is different from the quality performance category weight which is the number of points that the quality performance category can contribute to your MIPS final score. The total number of points for the quality performance category will be calculated as a percentage (for example, 85 out of 100 points would be 85%) and then multiplied by the category weight of 50% to determine the quality performance category score.

Skip ahead to review how we calculate the quality performance category score.

Submitting CMS Web Interface Measures (Continued)

Can the Denominator (Maximum Number of Achievement Points) Be Lower Than 100 Points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower.

IF...	THEN...
<p>You don't meet the case minimum for one or more measures...</p>	<p>...we'll lower the denominator by 10 points for each measure for which you don't meet the case minimum but do meet data completeness criteria</p>
<p>Your group or APM Entity doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey...</p>	<p>...we'll lower the denominator by 10 points to account for your inability to administer the CAHPS for MIPS Survey measure.</p>
<p>A CMS Web Interface measure is determined to be significantly affected by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results, and 9 months of consecutive, reliable data isn't available...</p> <p>NOTE: To the extent feasible, we will identify suppressed measures by the beginning of the submission period.</p>	<p>...we'll lower the denominator by 10 points for each affected measure.</p> <p>Why? So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control.</p> <p>However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.</p>

Submitting CMS Web Interface Measures (Continued)

What Are the Steps for Scoring CMS Web Interface Measures?



CAHPS for MIPS Survey

Groups and APM Entities reporting the APP are required to administer the CAHPS for MIPS Survey. Because they're required to report the APP, Shared Savings Program ACOs are automatically registered but groups and non-ACO APM Entities who choose to report the APP must register.

CAHPS for MIPS Survey Measure Scoring and Benchmarks

We established a benchmark for individual summary survey measures (SSM) in the CAHPS for MIPS Survey measure. These benchmarks were calculated using historical data from the 2019 performance period. Each SSM is awarded 3 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey measure score is calculated by the average number of points across all scored SSMs. Please review the 2021 historical CAHPS for MIPS benchmarks in the [2021 Quality Benchmarks \(ZIP\)](#).

Administrative Claims Measures

Two of the MIPS quality measures required by the APP will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- Hospital-wide, All-Cause Unplanned Readmission measure.
 - This measure has a case minimum of 200 cases and will apply to groups and APM Entities.
- Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs
 - This measure has a case minimum of 18 cases and is calculated only for ACOs.

Administrative Claims Measure Benchmarks

For the Hospital-wide, All-Cause Unplanned Readmission measure and Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs measure, we intend to calculate performance period benchmarks for the 2021 performance period.

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, and APM Entities

We use the following formula to calculate a quality score for individuals, groups, and APM entities that aren't a small practice:



A total of 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least one quality measure. (These bonus points are available to small practices through individual, group, and APM Entity participation.)

Your quality performance category score is then multiplied by the 50% quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

We use the following formula to calculate a quality score for individuals, groups, and APM entities with the small practice designation:



What Happens If a Shared Savings Program ACO Reports CMS Web Interface Measures and eQMs?

We would calculate scores for each measure set — one score for the 3 eQMs and one score for the 10 CMS Web Interface measures — and use whichever measure set resulted in the higher score for MIPS scoring.

*Total Available Measure Achievement Points = the number of required measures x 10

APP: Quality Performance Category

Calculating the Quality Performance Category Score (Continued)

What Is Improvement Scoring?

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

CMS determines eligibility for these additional percentage points when MIPS eligible clinicians meet the following criteria:

1. Full participation in the quality category for the current performance period:

- Submits a complete set of APP measures.
- All submitted measures must meet data completeness requirements.

2. Data sufficiency standard is met — that is, data is available and can be compared:

- There is a quality performance category achievement score (the score earned by measures based on performance, excluding bonus points) for the previous performance period (2020 performance period) and the current performance period (2021 performance period).
- Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did you know?

- Improvement scoring is not available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately before the current MIPS performance period.
- For example, if your performance year (PY) 2020 quality score is derived from facility-based measurement, you aren't eligible for improvement scoring in PY 2020 or PY 2021.



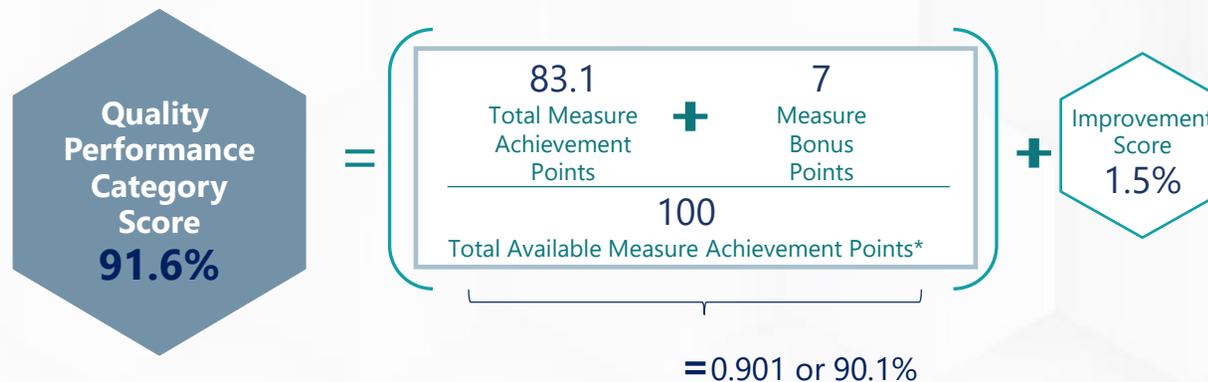
Calculating the Quality Performance Category Score (Continued)

Scoring Example

A Shared Saving Program ACO reported a full set of quality measures through the CMS Web Interface for 2020 and 2021. They earn 83.1 achievement points and 7 bonus points out of 100 possible points for the 2021 performance period.

They also qualify for improvement scoring because their achievement score showed improvement from last year.

- Their 2021 achievement score = $83.1/100 = 83.1\%$.
- Their 2020 achievement score = 72.2% .
- The increase in their achievement score = $83.1\% - 72.2\% = 10.9\%$.
- Their improvement score = $(10.9\% \div 72.2\%) \times 10 = 1.5\%$.



How Is My Quality Performance Category Score Calculated?

To determine how many points the quality performance category contributes to your final score, we multiply your quality performance category score by the quality performance category weight. Under the APP, we multiply your quality performance category score by 50% (the quality performance category weight under the APP).

Can the Quality Performance Category Be Reweighted?

There are a few scenarios that would allow the quality performance category to be reweighted.

- We continue to make our extreme and uncontrollable circumstances (EUC) policy available, and you may request performance category reweighting through the EUC application. Please check the [Quality Payment Program COVID-19 Response Fact Sheet \(PDF\)](#), [2021 MIPS Extreme and Uncontrollable Circumstances Exceptions Application User Guide \(PDF\)](#), or the [Exceptions Application](#) webpage for more information.
- In the rare instance that you can't meet the case minimum for any quality measures, you won't be scored on this performance category, and it will be reweighted to 0% of your final score. We anticipate that reweighting of the quality performance category will be rare.

Please see [Appendix A](#) for more information on the reweighting of the quality performance category, including the EUC policy.



APP: Improvement Activities Performance Category

APP: Improvement Activities Performance Category

What Are the Data Submission Requirements for the Improvement Activities Performance Category?

MIPS APM participants reporting via the APP don't need to submit any data for the improvement activities performance category for the 2021 performance period. Each year, we'll assign a score for the improvement activities performance category for each MIPS APM. All MIPS APM participants who report through the APP in 2021 will automatically receive 100% for the improvement activities performance category score (20 out of 20 points).

In future performance periods, if the assigned score for a MIPS APM doesn't represent the maximum improvement activities score, you can report additional improvement activities that will then be applied toward your score.

Improvement Activities



20% of MIPS Score



APP: Promoting Interoperability Performance Category

What Are the Data Submission Requirements for the Promoting Interoperability Performance Category?

There's a single set of measures and objectives you must report for the 2021 performance period, as outlined in the following table.

When you report on required measures that have a numerator/denominator, you must submit at least a "1" in the numerator if you don't claim an exclusion.

IMPORTANT: Promoting Interoperability data is always submitted at the individual or group level. If you're participating as an APM Entity such as a Shared Savings Program ACO, we'll calculate a score for the APM Entity as a weighted average of the scores received from individual and/or group submissions.



30% of MIPS Score

2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of the two are required for participation in this performance category.

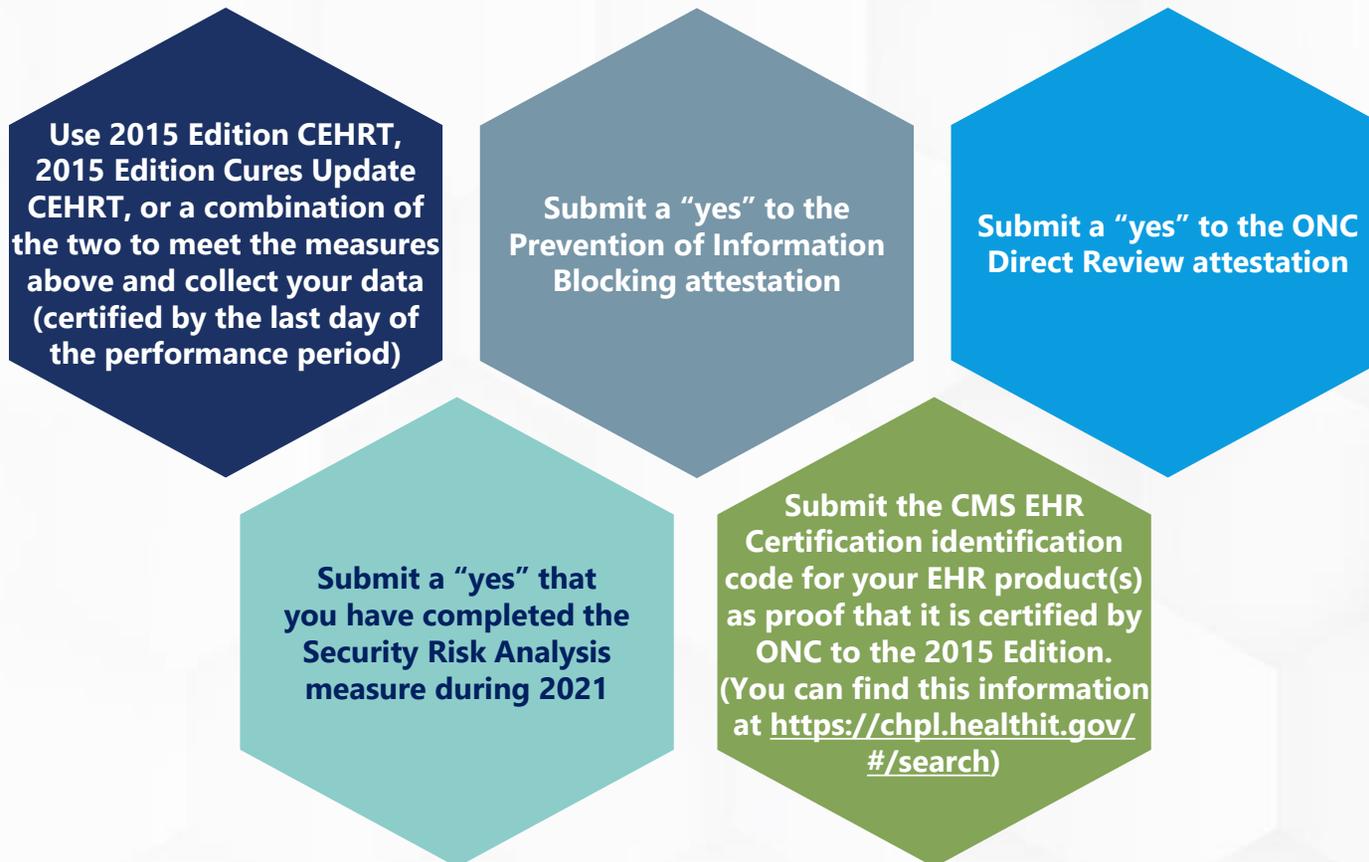
What Are the Data Submission Requirements for the Promoting Interoperability Performance Category? (Continued)

Objectives	Measures	Requirements
e-Prescribing	e-Prescribing	Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)	Optional measure cannot be reported if an exclusion is claimed for the required e-Prescribing measure
Health Information Exchange	Option 1 Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 is reported
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 is reported
	Option 2 NEW: HIE Bi-Directional Exchange*	Required (no exclusion available), unless option 1 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required (no exclusion available)
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting 	Required unless an exclusion(s) is claimed

* The HIE Bi-Directional Exchange measure is a new measure available for reporting in PY 2021. This measure serves as an **alternative** measure to the two existing, required HIE objectives. You're expected to report either option 1 (the two original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective. You would not submit both options.

What are the Data Submission Requirements for the Promoting Interoperability Performance Category? (Continued)

In addition to reporting the previously listed measures, you must:



If any of these requirements are **not met**, you'll get 0 points in the Promoting Interoperability performance category if you're participating as an individual MIPS eligible clinician or group. If you're participating as an APM Entity, then any clinician or group that fails to meet these criteria would contribute 0 points toward the Entity-level score.

Data Aggregation and Multiple Submissions

We recommend a single submission (file upload, API, **or** attestation; by you **or** a third party) to report your Promoting Interoperability data.

Any conflicting data submitted for a single measure or required attestation will result in a **score of 0** for individuals and groups in the Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score.

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021?

For the 2021 performance period, each required measure will be scored based on the performance data you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Query of PDMP measure (optional), Public Health and Clinical Data Exchange objective measures, and the new optional HIE Bi-Directional Exchange measure, which require a “yes” or “no” submission. Each measure will contribute to your total Promoting Interoperability performance category score.

NOTE: If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021? (Continued)

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance. For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure.

Below is an example featuring the Provide Patients Electronic Access to Their Health Information measure, which is worth 40 points.

Performance Rate

X

Total Possible Measure Points

=

Points Awarded Towards Your Total Promoting Interoperability Performance Category Score

Provide Patients Electronic Access to Their Health Information Measure Example:

$$\frac{187}{220}$$

Performance Rate

$$85\%$$

Performance Rate

$$\times 40 =$$

$$34$$

Points

Towards Your Total Promoting Interoperability Performance Score

When we calculate the performance rates, measure and objective scores, and the Promoting Interoperability performance category score, we generally round to the nearest whole number.

Example 1:

Score = 8.53

Round up to

}
9

Example 2:

Score = 8.33

Round down to

}
8

Note:

- The Query of Prescription Drug Monitoring Program (PDMP) bonus measure in the e-Prescribing objective will earn 10 points if submitted.
- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as at numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score.)

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2021? (Continued)

The available points for each measure in the Promoting Interoperability performance category are shown in the table below.

Objectives	Measures	Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing	Required	1 – 10 points	Numerator/Denominator
	<i>Bonus:</i> Query of PDMP	Optional	5 bonus points	Yes/No
Health Information Exchange	Option 1 Support Electronic Referral Loops by Sending Health Information Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required	1 – 20 points	Numerator/Denominator
		(unless option 2 is reported)	1 – 20 points	Numerator/Denominator
	Option 2 NEW: HIE Bi-Directional Exchange*	Required*	40 points	Yes/No
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required	1 – 40 points	Numerator/Denominator
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting 	Required	10 points for the entire objective	Yes/No

* The HIE Bi-Directional Exchange measure is a new measure available for reporting in PY 2021. This measure serves as an **alternative** measure to the two existing required HIE objectives. You're expected to report either option 1 (the two original HIE measures) or option 2 (the new HIE Bi-Directional Exchange measure) to satisfy the HIE objective. You wouldn't submit both options.

Scoring of the Public Health and Clinical Data Exchange Objective and HIE Bi-Directional Exchange Measure

The Public Health and Clinical Data Exchange objective and the new optional HIE Bi-Directional Exchange measure are scored differently, because these measures are submitted with a “Yes” or “No” instead of numerator and denominator values.

For the Public Health and Clinical Data Exchange objective, you’ll receive 10 points for this objective when:

You submit a “yes” to 2 measures in the objective*.

OR

You submit a “yes” to 1 measure and claim an exclusion for a second measure.

* You can report the same measure twice as long as you’re actively engaged with 2 different agencies or registries.

For the new HIE Bi-Directional Exchange measure (Option 2), you’ll receive 40 points for this measure when:

You submit a “yes” to participating in bi-directional exchange.

How Many Points Can I Earn in the Promoting Interoperability Performance Category?

While there are 110 total points available, individuals, groups, and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

Can the Denominator (Maximum Number of Points) Be Lower Than 100?

No; you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

Please see [Appendix D](#) for detailed information about how points are reallocated when an exclusion(s) is claimed.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

- When reporting the APP as an individual or group, we'll add the scores for each of the individual measures (or objectives) and then divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

REMINDER: You'll receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).

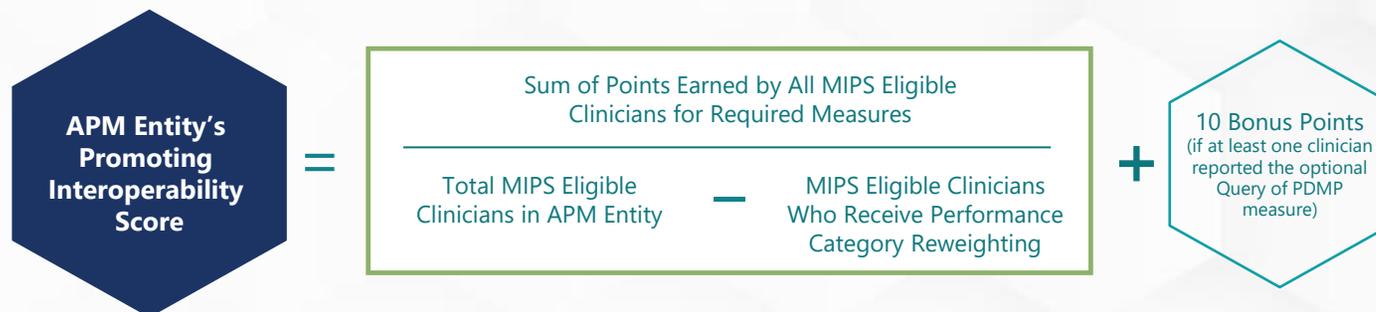
$$\text{Promoting Interoperability Performance Category Score} = \frac{\text{Total Points Earned for Completed Measures}}{\text{Total Possible Measure Points}}$$

How Is the Promoting Interoperability Performance Category Scored? (Continued)

APM Entity Participation

- When reporting the APP as an APM Entity, the MIPS eligible clinicians in the Entity still report their Promoting Interoperability measures as individuals or as a group. We score the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity.
- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- The APM Entity can also earn the 10 bonus points if at least one individual or group in the APM Entity reports the optional Query of PDMP measure, but the Promoting Interoperability performance category score can't exceed 100%.

REMINDER: You'll contribute 0 points toward your APM Entity's Promoting Interoperability performance category score if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).



Promoting Interoperability Performance Category Scoring Example

A Shared Savings Program ACO has 75 participants, but only 10 are MIPS eligible clinicians. The points assigned to each clinician are those earned through either individual or group reporting.

	Points for Required Measures (excluding bonus points)	Optional Query of PDMP Measure reported?
MIPS Eligible Clinician 1	87	Yes
MIPS Eligible Clinician 2	87	No
MIPS Eligible Clinician 3	77	Yes
MIPS Eligible Clinician 4	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 5	92	No
MIPS Eligible Clinician 6	85	Yes
MIPS Eligible Clinician 7	0 – didn't meet reporting requirements	No
MIPS Eligible Clinician 8	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 9	49	No
MIPS Eligible Clinician 10	82	Yes

Did you know? Only MIPS eligible clinicians are included when calculating the weighted average for the Promoting Interoperability score for an APM Entity.

$$\begin{array}{r}
 \text{Promoting Interoperability Performance Category Score} \\
 = \\
 \frac{87 + 87 + 77 + 92 + 85 + 0 + 49 + 82}{10 - 2} + 10 = 80.9\% \\
 \begin{array}{l}
 \text{Points from Required Measures} \\
 \text{Total MIPS ECs in APM Entity} \\
 \text{MIPS ECs Who Receive Reweighting} \\
 \text{Bonus Points from PDMP Measure}
 \end{array}
 \end{array}$$

Can the Promoting Interoperability Performance Category be Reweighted?

There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

Note that submitting Promoting Interoperability data will override any automatic or approved reweighting.

1. We continue to make our EUC policy available, and you may request reweighting for multiple performance categories through the EUC application. Please check the [Quality Payment Program COVID-19 Response Fact Sheet \(PDF\)](#), [2021 MIPS Extreme and Uncontrollable Circumstances Exception Application User Guides \(PDF\)](#), or the [Exceptions Application](#) webpage for more information.
2. An individual or group can submit a [Promoting Interoperability Hardship Exception Application \(PDF\)](#), citing one of the following specified reasons for review and approval:
 - Insufficient internet connectivity
 - Extreme and uncontrollable circumstances
 - Lack of control over the availability of CEHRT
 - Small practice
 - Decertified EHR

If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about [hardship exceptions](#).

3. You qualify for automatic reweighting of your individual score if you are any of the following (see the [QPP Participation Status Tool](#)):



Can the Promoting Interoperability Performance Category be Reweighted? (Continued)

An individual clinician's Promoting Interoperability performance category will be reweighted when the clinician:

- Has an approved hardship exception; OR
- Qualifies for automatic reweighting.

The image below is from the Other Reporting Factors section on the [QPP Participation Status Tool](#).

Other Reporting Factors

Learn more about [how other reporting factors are determined](#) and [special statuses](#).

Clinician Level	
SPECIAL STATUS Hospital-based	Yes

NOTE: If you have an approved exception or qualify for automatic reweighting, **we'll reweight the Promoting Interoperability category to 0% and redistribute 25% of the weight to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total)** so you can earn up to 100 points in your MIPS final score. However, you can still report Promoting Interoperability data if you want to. If you submit data on any of the measures for the Promoting Interoperability performance category as either an individual or a group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 30% of the final score.

How Does Reweighting Work If We're Participating as a Group?

A group's Promoting Interoperability performance category score will be reweighted when:

- The group has an approved hardship exception or qualifies for automatic reweighting; OR
- All of the MIPS eligible clinicians in the group individually qualify for reweighting (for any reason).

Just as with individual participation, groups who qualify for reweighting but submit data for this performance category will be scored just like any other clinician in MIPS, and their Promoting Interoperability performance category will be weighted at 25% of the final score.

The image below is from the Other Reporting Factors section on the [QPP Participation Status Tool](#).

Other Reporting Factors

Learn more about [how other reporting factors are determined](#) and [special statuses](#).

Clinician Level

SPECIAL STATUS Hospital-based	Yes
----------------------------------	-----

Practice Level

SPECIAL STATUS Hospital-based	Yes
----------------------------------	-----

NOTE: Groups are identified as non-patient facing or hospital-based when **more than 75%** of the MIPS eligible clinicians in the group have that status as individuals. These groups qualify for automatic reweighting.

How Does Reweighting Work If We're Participating as an APM Entity?

Individual MIPS eligible clinicians and groups in a MIPS APM that qualify for automatic reweighting or have an approved Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category.

They'll be excluded from the calculation when we determine the APM Entity's score but will still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire Entity for the 2021 performance period. This could occur when all of the clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

As with individuals and groups who report via the APP, APM Entities that qualify for reweighting will have the category reweighted to 0%, and CMS will redistribute the 25% of the weight to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total).



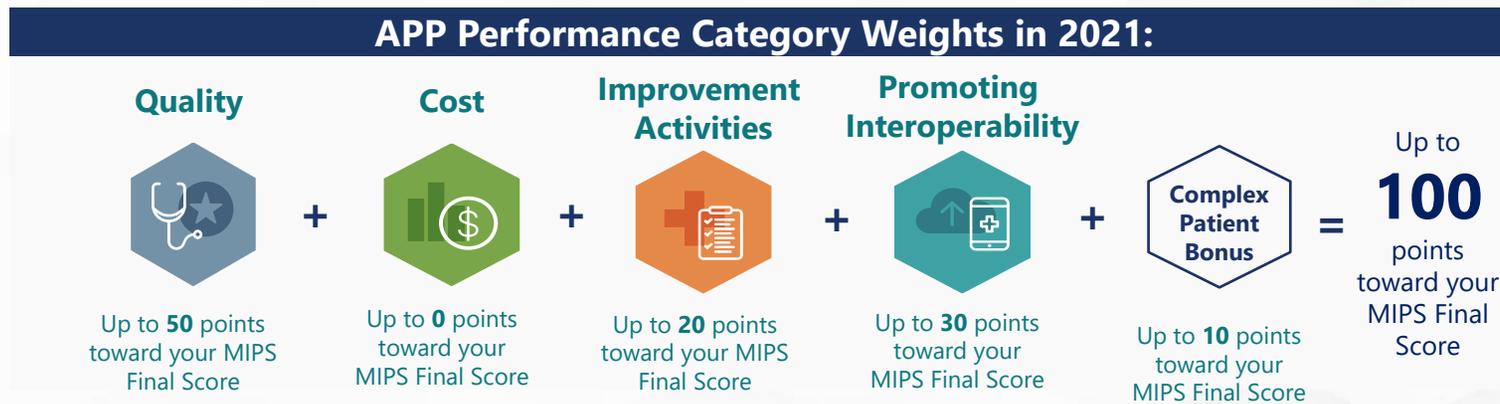


APP: MIPS Final Score

How Is My Final Score Calculated?

We multiply your performance category score by the category's weight, and then multiply that figure by 100, to determine the number of points that contribute to your final score for each performance category. To calculate your final score, we add the points for each performance category to any complex patient bonus you may have received.

APP Performance Category Weights in 2021:

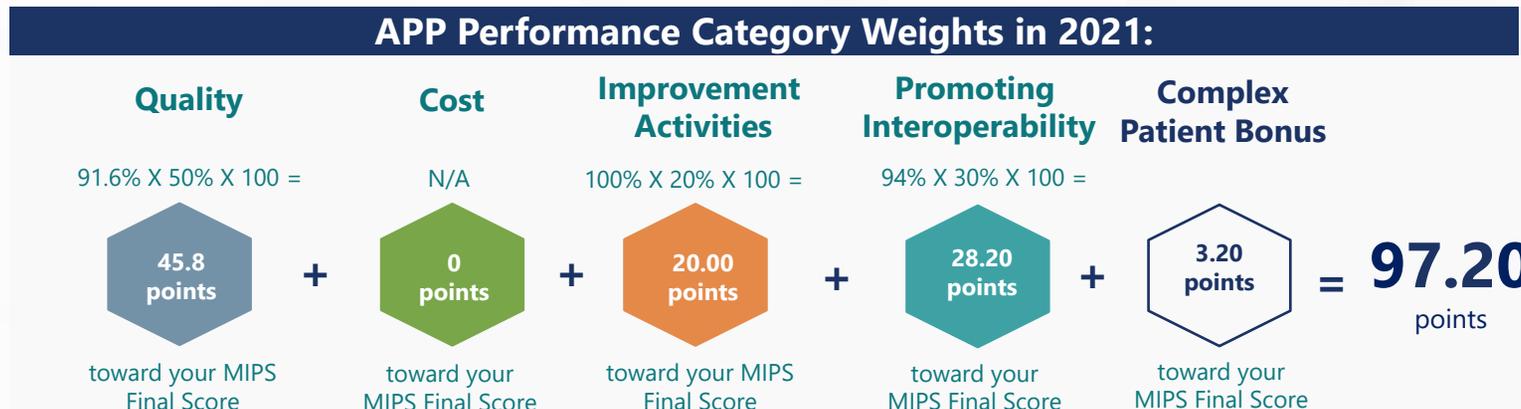


NOTE: The cost performance category is weighted at 0% of the MIPS Final Score for MIPS APM participants reporting through the APP, because all MIPS APM participants are already responsible for costs under their APMs.

Scoring Example

Below is an example of Comprehensive ESRD participants reporting as an APM Entity via the APP. Let's review how the final score is calculated:

APP Performance Category Weights in 2021:



The MIPS Final Score can't exceed 100 points

What is the Complex Patient Bonus?

The Complex Patient Bonus is added to the MIPS final score and is based on the overall medical complexity and social risk for the patients treated by a clinician or group. We recognize that challenges and additional costs can be associated with the care you provide to these patients. The Complex Patient Bonus awards up to 10 bonus points, which is added to your final score and is based on a combination of the average Hierarchical Condition Category (HCC) risk score of the Medicare patients you treat and the proportion of dually eligible patients you treat.

All individuals, groups, or APM Entities that care for complex patients and submit data for at least one MIPS performance category (quality, Promoting Interoperability, or improvement activities) are eligible for the complex patient bonus of up to 10 bonus points to their final score.

As finalized in the CY 2022 PFS Final Rule, we're doubling the complex patient bonus from 5 to 10 points for the 2021 performance year.

How is the Complex Patient Bonus Determined?

We use 2 indicators to measure patient complexity:

Medical complexity is measured by the average Hierarchical Condition Category (HCC) risk score of Medicare patients treated

AND

Social risk is measured by the proportion of patients treated who are dually eligible to receive Medicare and either full or partial Medicaid benefits

We calculate the HCC risk scores of Medicare patients and determine the proportion of dual eligible patients treated during the second 12-month segment (October 1, 2020 – September 30, 2021) of the MIPS determination period.

Each individual, group, or APM Entity will be evaluated for the complex patient bonus. You're not required to meet a minimum amount or percentage of medically complex or dually eligible patients in order to be scored for the complex patient bonus.

How is a Clinician's HCC Risk Score Determined?

A beneficiary's risk score is based on:

- Age and gender.
- Diagnoses from the previous year.
- Whether they are eligible for Medicaid, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home).

How is my Proportion of Dual Eligible Patients Determined?

- We'll calculate the number of your dually eligible patients using claims data from October 1, 2020, to September 30, 2021.
- We'll calculate the proportion as: the number unique patients who are dually eligible for Medicare and Medicaid seen by the MIPS eligible clinician to all unique Medicare patients seen by the MIPS eligible clinician during this time period.

How is the Complex Patient Bonus Calculated?

As finalized in the CY 2022 PFS Final Rule, we're doubling the complex patient bonus from 5 to 10 points for the 2021 performance year.

$$\left(\frac{\text{[sum of all risk scores for the unique beneficiaries treated*]}}{\text{[number of unique beneficiaries treated]}} + \left(\frac{\text{[unique patients treated who were dually eligible for Medicare and full- and partial-benefit Medicaid]}}{\text{[unique Medicare beneficiaries treated]}} \times 5 \right) \right) \times 2 = \text{Complex Patient Bonus}$$

For PY 2021

*Unique beneficiaries and patients (both dually-eligible and HCC) must be treated between 10/1/20 and 9/30/21 to be included in the Complex Patient Bonus calculation.

When participating as an individual or group: The complex patient bonus is calculated for individual MIPS eligible clinicians and groups by adding the dual eligible ratio (multiplied by 5) to the beneficiary weighted-average HCC risk score. This sum will be multiplied by 2 for the 2021 performance year.

When participating as an APM Entity: The complex patient bonus is calculated for APM Entities by adding the beneficiary weighted-average HCC risk score for all MIPS eligible clinicians to the average dual eligible ratio for all MIPS eligible clinicians, multiplied by 5. This sum will be multiplied by 2 for the 2021 performance year. This calculation will be made, if technically feasible, for Taxpayer Identification Numbers (TINs) in a virtual group or APM Entity.



APP: MIPS Final Score and Payment Adjustment

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(s), but in most cases we can't project what this correlation will be. **Why?** MIPS is required by law to be a budget-neutral program. Generally, this means that the amount of the payment adjustments will depend on the overall participation and performance of clinicians in the program for a certain year. The table below illustrates how 2021 MIPS final scores will correlate to 2023 MIPS payment adjustments for MIPS eligible clinicians.

Final Score	Payment Adjustment
85.00 – 100.00 points (Additional performance threshold = 85.00 points)	<ul style="list-style-type: none">• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)• Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
60.01 – 84.99 points	<ul style="list-style-type: none">• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)• Not eligible for additional adjustment for exceptional performance
60.00 points (Performance threshold = 60.00 points)	<ul style="list-style-type: none">• Neutral MIPS payment adjustment (0%)
15.01 – 59.99 points	<ul style="list-style-type: none">• Negative MIPS payment adjustment (between -9% and 0%)
0 – 15.00 points	<ul style="list-style-type: none">• Negative MIPS payment adjustment of -9%

How Does My MIPS Final Score Determine My Payment Adjustment? (Continued)

The MIPS payment adjustments have two components. The first component applies to all MIPS eligible clinicians. The second is an additional payment adjustment for exceptional performance that applies only to those MIPS eligible clinicians with a final score of 85 points or higher.

- 1. MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality. Clinicians with a final score at the performance threshold of 60 points earn a neutral adjustment. Clinicians with a final score above the performance threshold of 60 points earn a positive adjustment (subject to a scaling factor). Clinicians with a final score below the performance threshold of 60 points will be subject to a negative adjustment. The maximum negative adjustment is -9%. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments, and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.
- 2. Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 85 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled; it will depend on the scores and the number of clinicians receiving a score of 85 points or higher.

Did you know? The 2022 performance year/2024 payment year will be the last year the additional payment adjustment for exceptional performance is available.



FAQs

What happens if your ACO doesn't report quality measures?

If you're a MIPS eligible clinician participating in a Shared Savings Program ACO (or any MIPS APM) and your APM Entity doesn't report quality measures to MIPS on your behalf, you would receive a quality performance category score of 0 points and a final score below the performance threshold of 60 points, resulting in a negative payment adjustment, unless you report as an individual or group via the APP or traditional MIPS. We encourage individuals and groups that participate in Shared Savings ACOs to reach out to their APM Entity during the performance period to determine whether the ACO will report data on their behalf. But regardless of the APM Entity's decision to report on behalf of its participants, individuals or groups of MIPS eligible clinicians who participate in MIPS APMs may choose to report via the APP or traditional MIPS.

Why might a clinician or group choose to report separately from their Entity?

An individual or group of MIPS eligible clinicians may choose to report via the APP or traditional MIPS separately from their APM Entity if they believe they are likely to receive a more favorable MIPS final score from individual or group participation. As noted, CMS will award the higher MIPS final score to clinicians and to groups who report to MIPS at different levels.

Why might an individual or group choose to report via the APP?

An individual or group of MIPS eligible clinicians might choose to report via the APP if:

1. They believe they'll receive a higher score by reporting at the individual or group level than at the APM Entity level;
2. They want to streamline their data collection and reporting; or
3. Their APM Entity has indicated that it will not report to MIPS on their behalf.

We encourage individuals and groups who participate in MIPS APMs to reach out to their APM Entity during the performance period to confirm that the Entity will report data on their behalf.

Do we need to tell CMS what we're reporting the APP or traditional MIPS in advance of the submission period?

No. MIPS APM participants aren't required to state their intention to report via the APP or traditional MIPS before the data submission period. You'll identify your reporting option (APP or traditional MIPS) when you sign in to qpp.cms.gov to submit your data.





Resources, Glossary, and Version History

Resources

The following resources are available on the [QPP Resource Library](#) :

- **General:**

- [PY2021 APM Performance Pathway Toolkit \(ZIP\)](#)
- [2021 Group Participation Guide \(PDF\)](#)
- [2021 MIPS Eligibility & Participation User Guide \(PDF\)](#)
- [2021 Eligibility & Participation Quick Start Guide \(PDF\)](#)

- **Quality:**

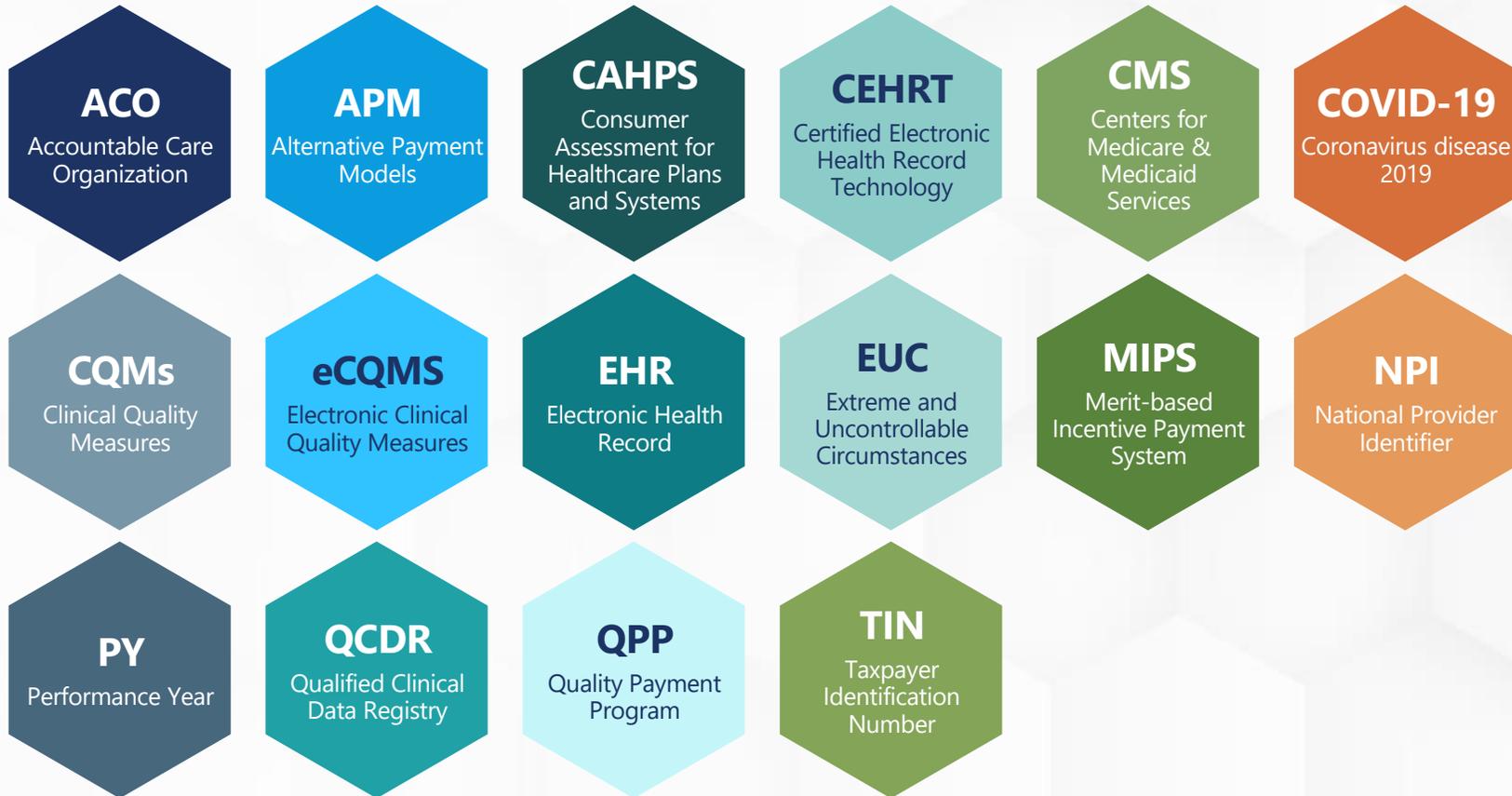
- [2021 Quality Benchmarks \(ZIP\)](#)
- [Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs \(PDF\)](#)
- [2021 CAHPS for MIPS Overview Fact Sheet \(PDF\)](#)
- [2021 Electronic Clinical Quality Measures \(eCQMs\) Specifications \(link to eCQI Resource Center\)](#)
- [2021 Medicare Part B Claims Measure Specifications \(ZIP\)](#)
- [2021 MIPS Clinical Quality Measure Specifications \(ZIP\)](#)
- [2021 CMS Web Interface Measure Specifications \(ZIP\)](#)
- [2021 Hospital-Wide All-Cause Readmission Measure \(ZIP\)](#)

- **Promoting Interoperability:**

- [2021 MIPS Promoting Interoperability User Guide \(PDF\)](#)
- [2021 Promoting Interoperability Quick Start Guide \(PDF\)](#)
- [2021 Promoting Interoperability Measure Specifications \(ZIP\)](#)



Glossary



Version History

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

Date	Description
02/17/2023	Added call-out box about APM Incentive Payment in performance year 2023 on slide 7.
04/28/2022	Updated slides 59-62 to reflect that the complex patient bonus is doubled from 5 to 10 points for the 2021 performance year, as finalized in the CY 2022 PFS Final Rule.
04/28/2022	Revised slide 36 to update the case minimum for Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs.
08/26/2021	Original posting



Appendices

Appendix A: Reweighting the Performance Categories

APP Performance Category Weight Redistribution: Individual, Group, and APM Entity Participation

The table below outlines the performance category weights under the APP for individuals, groups, and APM Entities when performance categories are reweighted to 0% based on any circumstances described throughout this guide.

Performance Category Redistribution for the 2021 Performance Year/2023 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
Standard Weighting				
General weighting for all performance categories	50%	0%	20%	30%
Reweighting 1 Performance Category				
No Promoting Interoperability: PI → Quality and IA	75%	0%	25%	0%
No Quality: Quality → IA and PI	0%	0%	25%	75%

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

Appendix B: End-to-End Electronic Reporting (eCQMs)

The table below outlines the submission options for submitting eCQMs that meet the criteria for earning end-to-end electronic reporting bonus points.

Collection Type	Submission Type	Format/Specification	Specification Indicators	Benchmark
eCQM	Sign In and Upload	QRDA III	N/A	eCQM
eCQM	Direct Sign In and Upload	QPP JSON	'submissionMethod=electronicHealthRecord'	eCQM

Under the APP, end-to-end electronic bonus points are only available for APP measures reported as eCQMs.

Why? Because all of the APP measures have an eCQM equivalent, APP measures submitted as MIPS CQMs aren't eligible for end-to-end electronic reporting bonus points.

If you're reporting a mixture of eCQMs and MIPS CQMs using the QPP JSON format, you must submit these types as separate [measurement sets](#):

- One measurement set of eCQMs (indicate EHR as the submission method); and
- A separate measurement set of MIPS CQMs (indicate Registry as the submission method).

Please see the Submission API documentation in the [Developer Tools](#) section of the QPP website for the most current information.

Appendix C: Reallocation of Points for Promoting Interoperability Measure(s)

When an Exclusion is Claimed

The table below outlines where points are redistributed when an exclusion is claimed.

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed...
e-Prescribing	e-Prescribing	Yes	...the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: <ul style="list-style-type: none"> • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)	N/A	N/A
Health Information Exchange	Option 1 Support Electronic Referral Loops by Sending Health Information	Yes	...the 20 points are redistributed to the Provide Patients Electronic Access to the Health Information
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	...the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2 NEW: HIE Bi-Directional Exchange	No	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No	N/A
Public Health and Clinical Data Exchange	Report to 2 different public health agencies or clinical data registries for any of the following: <ul style="list-style-type: none"> • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting 	Yes	...the 10 points are still available in this objective if you claim one exclusion and submit a “yes” attestation for one of the 5 measures in the objective. ...the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim two exclusions.

Appendix D: Quality Measure Collection Types

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
Electronic Clinical Quality Measures (eQMs)	2021 eCQM Specifications (ZIP) 2021 eCQM Flows (ZIP)	<p>You can report eQMs if you use technology that meets the 2015 Edition Certified Electronic Health Record Technology (CEHRT) criteria, the 2015 Edition Cures Update criteria, or a combination of both.</p> <p>You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification.</p> <p>If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted.</p> <p>eQMs can be reported in combination with Medicare Part B Claims measures, MIPS CQMs, and the CAHPS for MIPS Survey measure.</p>	<ul style="list-style-type: none"> • Individuals • Groups • APM Entities
MIPS Clinical Quality Measures (MIPS CQMs)	2021 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	<p>MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians.</p> <p>If you chose this collection type, you may choose to work with a Qualified Registry, QCDR, or Health IT vendor to support your data collection and submission. To see the lists of CMS approved Qualified Registries and QCDRs, visit the QPP Resource Library.</p> <p>MIPS CQMs can be reported in combination with Medicare Part B Claims measures, eQMs, and the CAHPS for MIPS Survey measure.</p>	<ul style="list-style-type: none"> • Individuals • Groups • APM Entities

Appendix D: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
Medicare Part B Claims Measures	2021 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP) 2021 Part B Claims Reporting Quick Start Guide (PDF)	<p>Medicare Part B Claims measures are always reported with the clinician’s individual (rendering) National Provider Identifier (NPI), even when participating as a group, virtual group, or APM Entity.</p> <p>Medicare Part B Claims measures can be reported in combination with eQMs, MIPS CQMs, and the CAHPS for MIPS Survey measure.</p>	<ul style="list-style-type: none"> • Individuals [Clinicians in small practices (fewer than 16 clinicians) only] • Groups [Small practices (fewer than 16 clinicians) only] • APM Entities (fewer than 16 clinicians in the APM Entity)
CMS Web Interface	2021 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)	<p>If you want to report through the CMS Web Interface, groups, virtual groups, and APM Entities must register between April 1, 2021 and June 30, 2021. (Registration not required for Shared Savings Program ACOs.)</p> <p>Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare patients for each measure within the application.</p>	<ul style="list-style-type: none"> • Groups (registered groups with 25 or more clinicians) • APM Entities (ACOs and registered APM Entities with 25 or more clinicians)

Appendix D: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?
CAHPS for MIPS Survey Measure	2021 CAHPS for MIPS Survey Overview Fact Sheet (PDF)	<p>Groups, virtual groups and APM Entities can register between April 1, 2021 and June 30, 2021 to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience and care within a group, virtual group or APM Entity.</p> <p>This survey must be administered by a CMS Approved Survey Vendor (PDF).</p>	<ul style="list-style-type: none"> • Groups (registered groups with 2 or more clinicians) • APM Entities (registered APM Entities with 25 or more clinicians)

Appendix E: Suppression of Measure 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

As announced on June 30, 2021, CMS will suppress the Medicare Part B claims-based submission of Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) for the 2021 performance period. In January 2021, new Current Procedural Terminology (CPT) Category II Quality Data Codes were introduced as numerator options within the measure specification but were not activated within CMS systems and therefore not usable for the 2021 performance period. Stakeholders expressed concerns that reporting these codes has resulted in rejected claims due to the inactive status.

Per CMS policy, for each measure that is submitted, if applicable, and impacted by significant changes, performance is based on data for 9 consecutive months of the applicable CY performance period. If such data are not available or may result in patient harm or misleading results, the measure is excluded from a MIPS eligible clinician's total measure achievement points and total available measure achievement points. For purposes of this paragraph (b)(1)(vii)(A), "significant changes" means changes to a measure that are outside the control of the clinician and its agents and that CMS determines may result in patient harm or misleading results. Significant changes include, but are not limited to, changes to codes (such as ICD-10, CPT, or HCPCS codes), clinical guidelines, or measure specifications. CMS will publish on the CMS website a list of all measures scored under this paragraph (b)(1)(vii)(A) as soon as technically feasible, but by no later than the beginning of the data submission period at § 414.1325(e)(1).

Therefore, CMS will suppress the Medicare Part B claims collection type for QID 001 and the measure will not be scored. For each suppressed measure that's submitted for the 2021 performance period, the total available measure achievement points will be reduced by 10 points*. MIPS eligible clinicians, groups, or APM entities do not need to submit any additional documentation or resubmit rejected claims solely for the purpose of adding a quality data code for the 2021 performance period.