Quality Payment PROGRAM

2020 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2022 Payment Adjustment FAQs

Purpose

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

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

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Have questions about a particular topic?

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

Before You Begin

If you don't already have a HCQIS Authorized Roles and Profile (HARP) account or access to your organization on qpp.cms.gov, 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)

Please note that due to a mandatory federal-wide security update, you'll need a CMS supported version of Firefox or Chrome to access qpp.cms.gov. You may encounter errors if you use a different web browser.

- **Please update your browser to the least version of Firefox or Chrome**

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:

- Measure-level performance data and scores
- Activity-level scores
- Performance category-level scores and weights
- Final score
- Payment adjustment information

Who Receives Performance Feedback and Payment Adjustment Information?

- **MIPS eligible clinicians** (including those who opted-in to MIPS participation during the submission period) will receive performance feedback and payment adjustment information for **each associated practice at which they were eligible.**
- **Practices that were eligible and submitted data as a group** (including those who opted-in to MIPS participation during the submission period) will receive performance feedback and payment adjustment information.
- **Virtual groups** will receive performance feedback and payment adjustment information.
- **Alternative Payment Model (APM) Entities and clinicians scored under the APM scoring standard** will receive performance feedback and payment adjustment information.
- Clinicians and groups that **voluntarily reported** won't receive a payment adjustment but will have limited performance feedback, as long as they are found in our eligibility information (i.e., billed Medicare Part B claims under that Tax Identification Number (TIN) or Tax Identification Number/National Provider Identifier (TIN/NPI) combination between 10/1/2019 and 9/30/2020).

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

Who Doesn't Receive Performance Feedback?

- Qualifying APM Participants (QPs)
- Partial QPs who didn't elect to participate in MIPS

How Do I Access Performance Feedback?

- Sign in to qpp.cms.gov
- Select Performance Feedback from the home page
- Select your organization (Practice, APM Entity, Virtual Group)
    - Practice representatives can access both individual and group feedback through the practice organization.

What If There's an Error with Our Performance Feedback and Payment Adjustment?

If you believe there's an error in your performance feedback and payment adjustment, you can request a Targeted Review. More information on that process is available in the 2020 Targeted Review Guide (PDF).

COVID-19's Impact on 2020 Performance Feedback and 2022 MIPS Payment Adjustments

We continue to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We're applying the **MIPS automatic extreme and uncontrollable circumstances (EUC) policy** to all individual MIPS eligible clinicians for the 2020 performance period. This policy only applies to clinicians participating in MIPS as individuals.

- Clinicians who didn't submit any data, or who only submitted data in one performance category, will automatically receive a neutral payment adjustment in 2022.
- Any performance category for which an individual clinician didn't submit data is weighted at 0% for performance year (PY) 2020.
- Appendix A outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.

We also reopened our EUC **application** to groups, virtual groups, and APM Entities.

- Approved applications will reweight performance categories to 0% unless data was submitted. **For PY 2020, approved applications didn't void previously submitted data.**
- Appendix B outlines performance category weights and payment adjustment implications based on the performance categories selected in approved applications.

Finally, we **reweighted the cost performance category** from 15% to 0% for the 2020 performance period **for all MIPS eligible clinicians** regardless of participation as an individual, group, virtual group or APM Entity. The 15% cost performance category weight will be redistributed to other performance categories.

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How Does the Neutral Payment Adjustment Assigned to All MIPS Eligible Clinicians Who Didn't Submit Data Affect the 2022 Payment Adjustment For Those Who Did Submit Data?

The MIPS automatic extreme and uncontrollable policy doesn't affect the Quality Payment Program's budget neutrality requirement. MIPS payment adjustments are required by law to be budget neutral. Generally stated, this means that the projected negative payment adjustments must be balanced by the projected positive payment adjustments. We understand that a lower-than-expected positive payment adjustment may be disappointing; however it's critical that we support every clinician's ability to focus on caring for patients impacted by the COVID-19 pandemic.

Accessing Performance Feedback

How Can I Access My/Our MIPS Performance Feedback?

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

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

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

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

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

I'm a Clinician. What Is the Best Way For Me To Access My Performance Feedback and Payment Adjustment?

We've added a **Clinician role** that 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 the APM scoring standard.

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

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Can Third Party Intermediaries Access Performance Feedback?

Performance feedback can only be accessed by authorized group or practice representatives. CMS doesn't grant direct access to performance feedback for third party intermediaries (including Qualified Registries and QCDRs) because it will contain sensitive information, including payment and beneficiary 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:

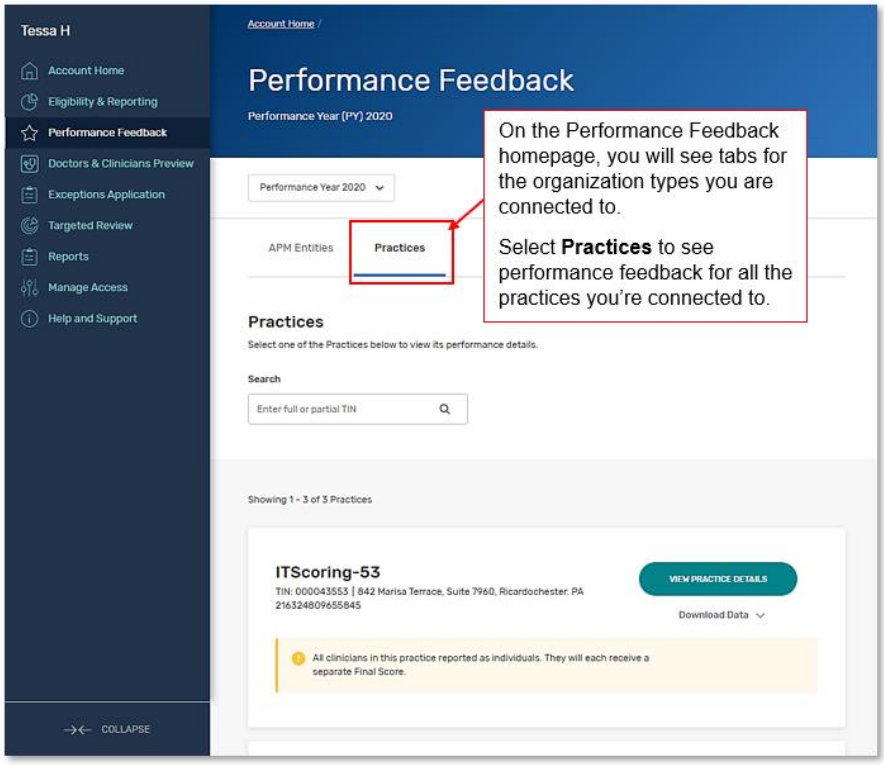
- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims. (**Reminder:** We didn't calculate these measures for anyone in PY 2020.)
- Patient-level reports for the administrative claims' measures. (These won't be available in PY 2020.)
- Final score information.
- Payment adjustment information.

To view their clients' performance feedback, third party intermediaries need a Quality Payment Program (QPP) account and must submit a request for a role for each practice (TIN), virtual group, or APM Entity they represent. The Security Official for each organization would then need to approve the request, authorizing the third party intermediary to access performance feedback. If the request is approved, they would be able to access their client's performance feedback.

Navigating Into Performance Feedback: Practice Representatives

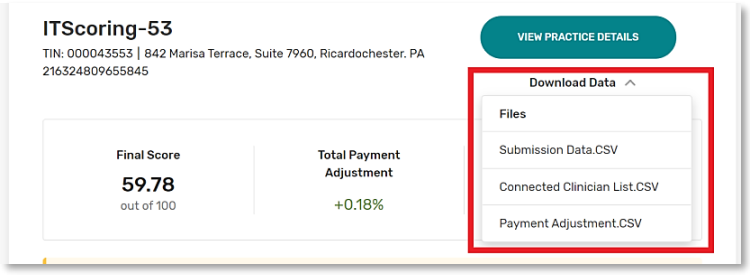
This section assumes you have either the Staff User or Security Official role for a **Practice** organization. (This is distinct from access to a Virtual Group and/or APM Entity organization.)

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



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

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



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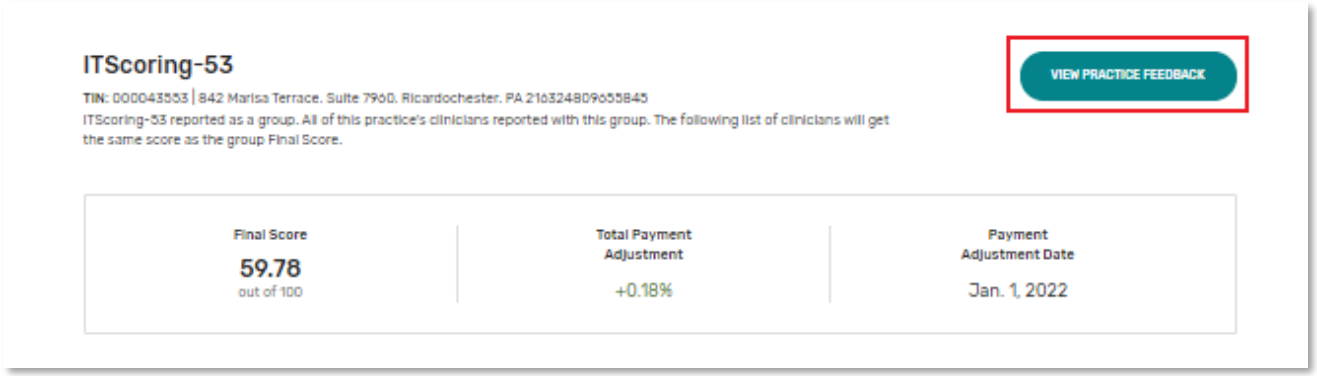
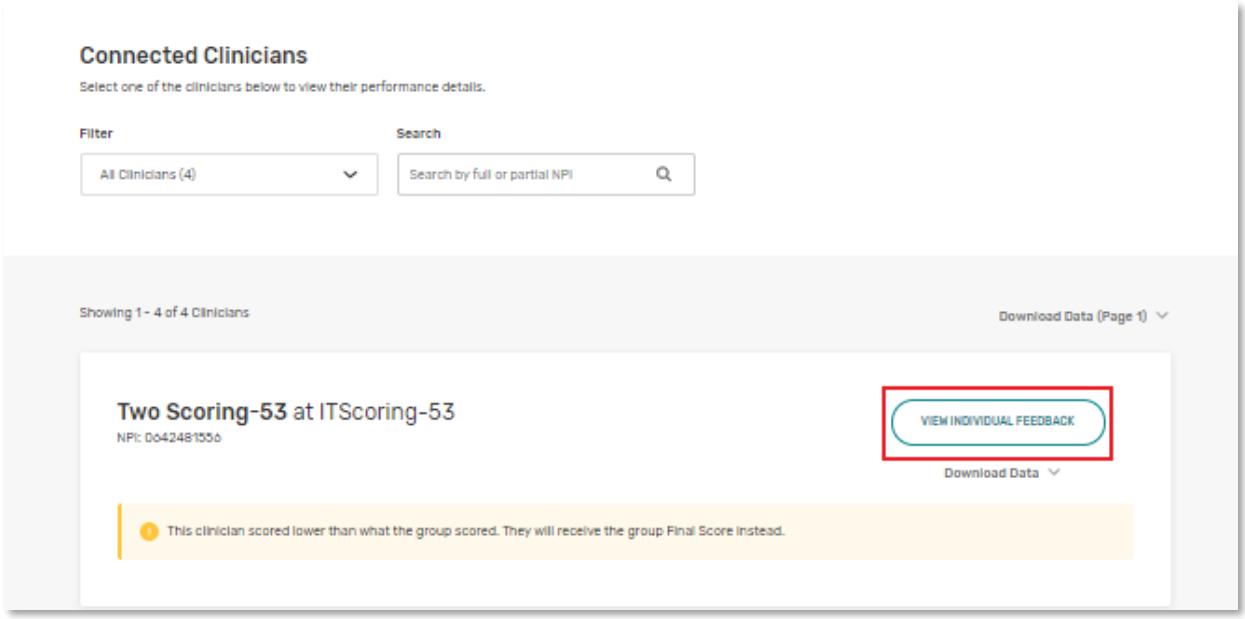
Select **View Practice Feedback** to the right of the practice's name to access performance feedback and payment adjustment information based on **group participation** (aggregated data for all clinicians).



Select **View Individual Feedback** to the right of the clinician's name to access performance feedback and payment adjustment information based on **individual participation** (an individual clinician's data.)



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

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

If your practice didn't submit data as a group for PY 2020, you'll see a message indicating that your clinicians only reported as individuals:

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

You can **View Individual Feedback** for each Connected Clinician.

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

Connected clinicians are all of the clinicians (NPIs) associated with your practice (TIN) through Medicare Part B claims billed between 10/1/2019 and 9/30/2020 regardless of their individual MIPS eligibility. This list appears when you select '**Performance Feedback**' (from the home page or left-hand navigation), under the link to any group level feedback. Clinicians who started billing claims under your TIN between 10/1/2020 and 12/31/2020 will appear in the Payment Adjustment CSV download.

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

You'll see final performance feedback based on the data your practice submitted to QPP at the group or individual level.

Final MIPS APM performance feedback is available to the APM Entity and to the individual clinicians scored under the APM scoring standard (with the appropriate permissions).

No APM scoring information will be available to **Practice** representatives (including Accountable Care Organizations (ACO) Participant TINs) with clinicians scored under the APM scoring standard.

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 final 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).

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.

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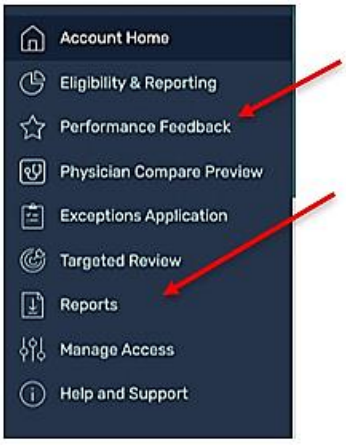
What's the Difference Between the Performance Feedback and Reports Tabs?

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



You'll access your 2020 MIPS performance feedback through the **Performance Feedback** tab.

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

- 2020 CAHPS for MIPS Survey Detail Reports.
- Historical CMS Web Interface reports for groups that have reported quality measures through the CMS Web Interface in previous years.

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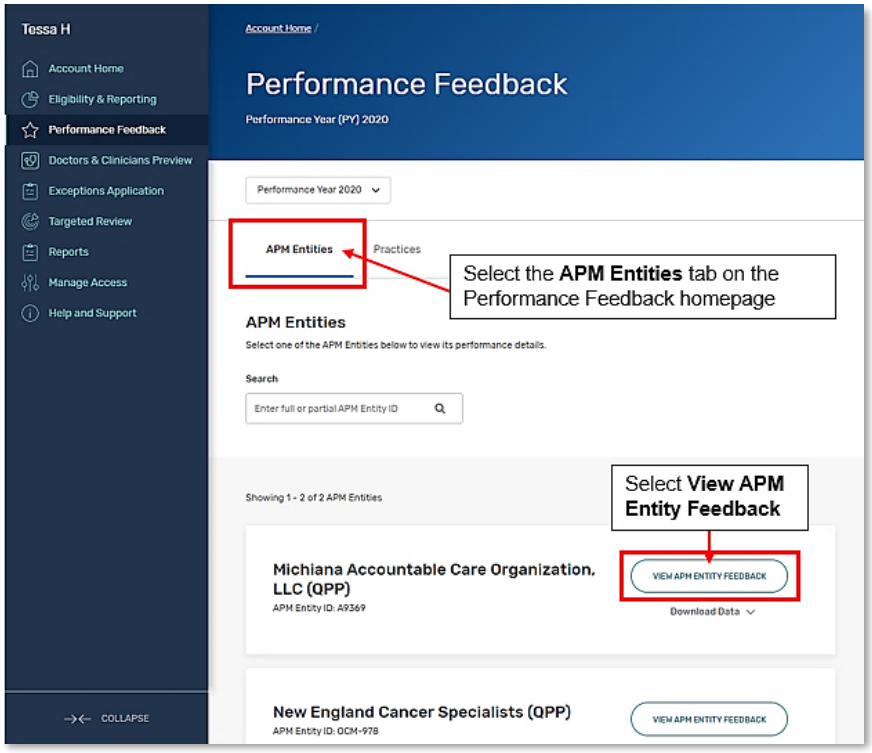
Navigating into Performance Feedback: APM Entity Representatives

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

The following models are able to review 2020 MIPS performance feedback, based on the APM scoring standard, if applicable and available:

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

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



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Continue with these Frequently Asked Questions or Skip Ahead to walk through the rest of your feedback. You can also click here for more information about which performance categories are included in your performance feedback, based on your model.

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.

- Once you land on the Participating Practices screen, you can click on "**Download participant list**" for a list of all Participating Practices and Clinicians associated with the APM Entity.
- You can also click "**Clinician Eligibility**" for any of the practices to view the clinicians within that practice.

What Should We Expect to See in Feedback?

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

- Payment adjustment information.
- 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 OR a report of the individual and/or group quality performance category scores that contributed to the APM Entity's quality score.
- Model specific information is available here.

Can Individual Clinicians View Our APM Entity Feedback?

Yes. Final MIPS APM performance feedback and payment adjustment information is available to the APM Entity and to the individual clinicians scored under the APM scoring standard. The individual clinician will need to be approved for the clinician role or be approved as a staff user by the APM Entity.

Representatives of participant TINs and practices with clinicians scored under the APM scoring standard **won't** be able to access the APM Entity's performance feedback unless they have been approved as a staff user by the APM Entity.

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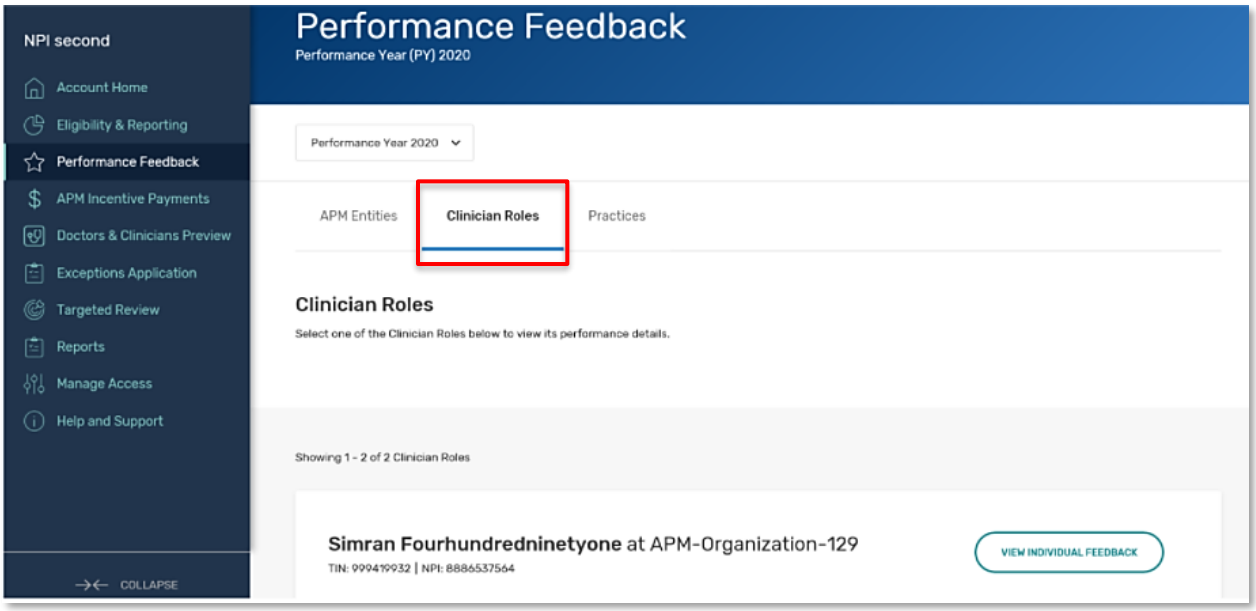
Navigating into Performance Feedback: Individual Clinicians

Note: This section assumes you have the Clinician role. (This is different from the Staff User role for a Practice, APM Entity or Virtual Groups).

From the performance feedback page, 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 and payment adjustment information associated with this organization. Your feedback at an organization may be based on individual, group or MIPS APM participation.



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

How Do I Identify My Associated Organizations in Performance Feedback?

You should see the same associations on the Performance Feedback tab as you see for PY 2020 in the QPP Participation Status Tool. Click **View Individual Feedback** to see performance feedback, including your final score and payment adjustment, as well as any individual data you may have submitted.

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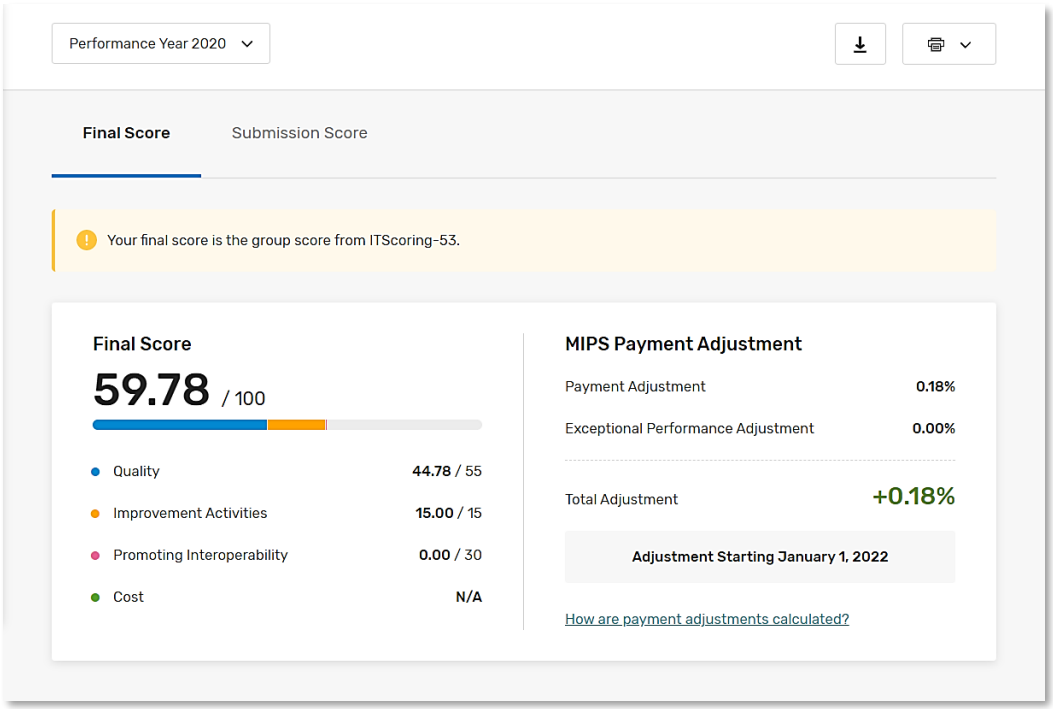
I Have the Clinician Role and See Both a Final Score and a Submission Score in My Individual Feedback. What's The Difference?

These tabs appear for clinicians who submitted individual data in addition to (or as part of) the data used to determine their final score. (If there is only one submission associated with your TIN/NPI combination, you won't see these tabs and will only see performance feedback for the data used to determine your final score.)

- The **Final Score** tab provides feedback on the data that will be used to determine your payment adjustment under that TIN/NPI combination.
- The **Submission Score** tab provides feedback on individual data you submitted (or was submitted on your behalf) under that TIN/NPI combination.

Let's look at an example. This clinician is in a practice that reported as a group and she also reported some data as an individual.

- The **Final Score** tab displays the group's final score and performance feedback because that's the higher of the 2 scores attributed to her under this TIN/NPI combination.
- The **Submission Score** tab will display performance feedback based on any individual (TIN/NPI level) data she submitted.



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I'm a MIPS APM Participant and Scored Under the APM Scoring Standard. What Should I Expect to See?

Once you have the Clinician role, you'll be able to see the payment adjustment plus the APM Entity's final score, APM Entity's MIPS performance category scores (quality, improvement activities, Promoting Interoperability as applicable), your individual Promoting Interoperability score, and your individual quality score (if you reported quality separate from the Entity).

You'll also be able to see scoring information for individual quality measures if you participate in a Medicare Shared Savings Program ACO, Next Generation ACO or other APM Entity that submitted quality measures to QPP.

If you participate in multiple MIPS APMs, you'll be able to view MIPS performance feedback for each APM Entity for which you were included on the MIPS APM participation list (based on APM snapshot dates). Your MIPS payment adjustment will be based on the APM Entity with the highest payment adjustment. You can also contact the Quality Payment Program to find out how the MIPS payment adjustment will apply to them.

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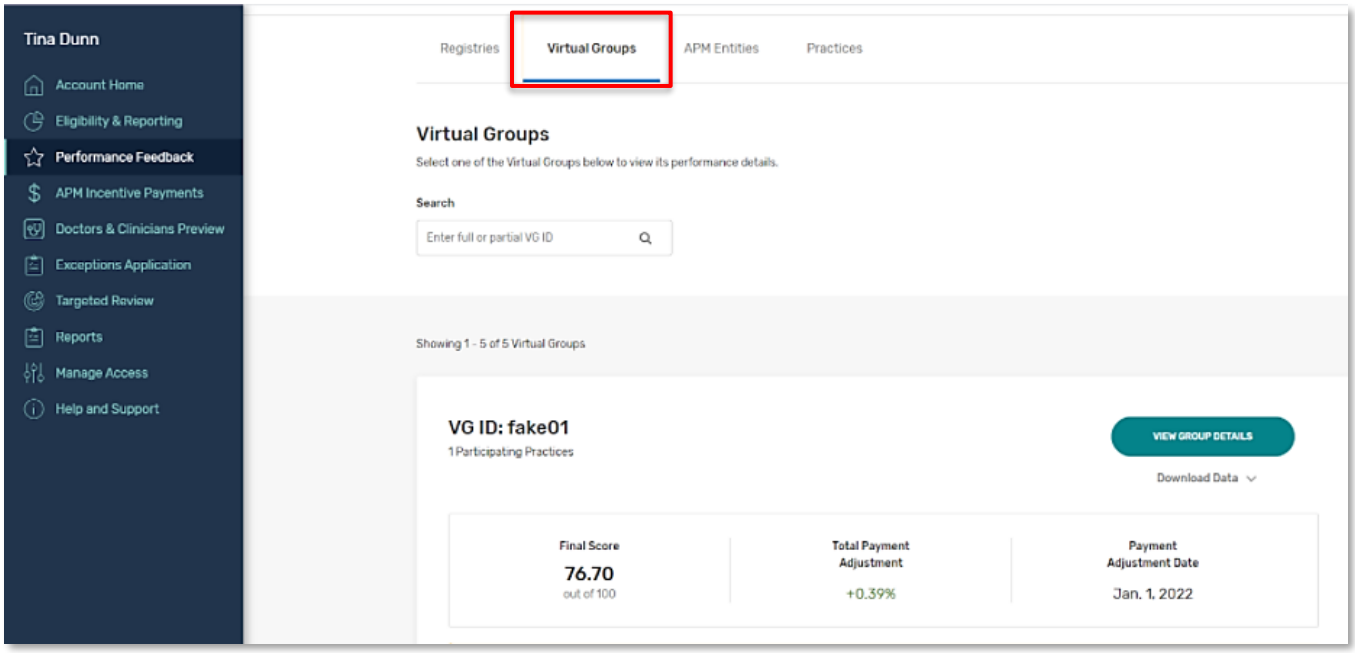
Navigating Performance Feedback: Virtual Group Representatives

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

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



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

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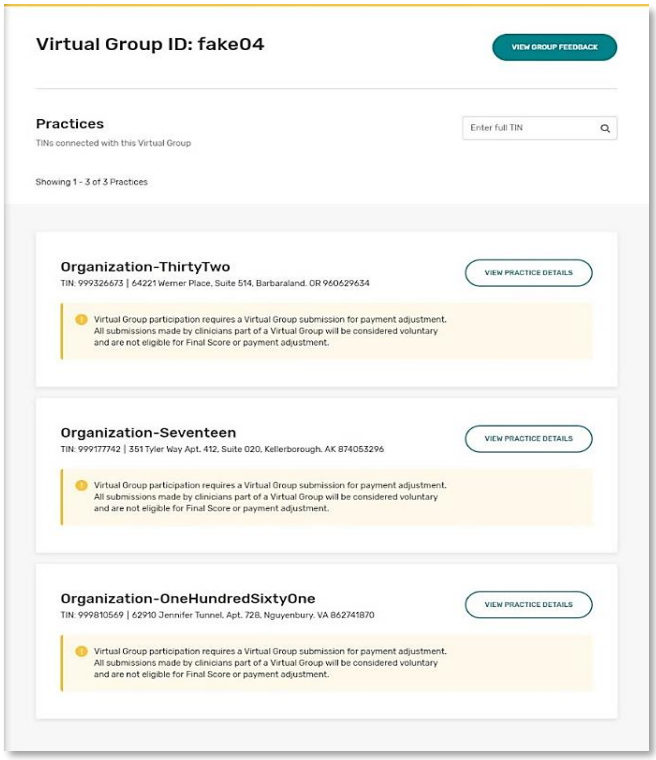
Can the Practices and/or Solo Practitioners Who Participate in Our Virtual Group Access Our Performance Feedback?

Yes, but only if they have an approved Staff User role for your virtual group. This means they 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).

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

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



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

You'll see performance feedback based on the data you submitted to QPP at the virtual group level. MIPS APM performance feedback is available to the APM Entity and to the individual clinicians scored under the APM scoring standard. No APM scoring information will be available to a virtual group with clinicians scored under the APM scoring standard.

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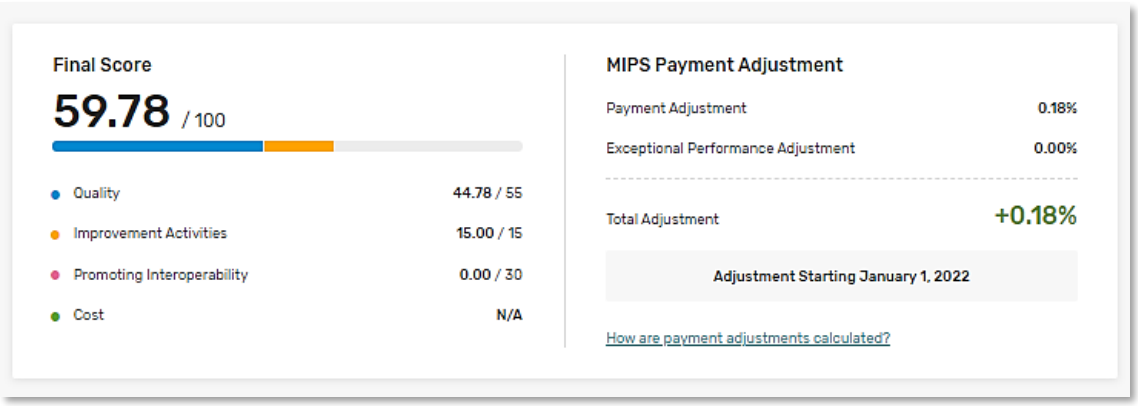
Overview: Final Score and Payment Adjustment

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

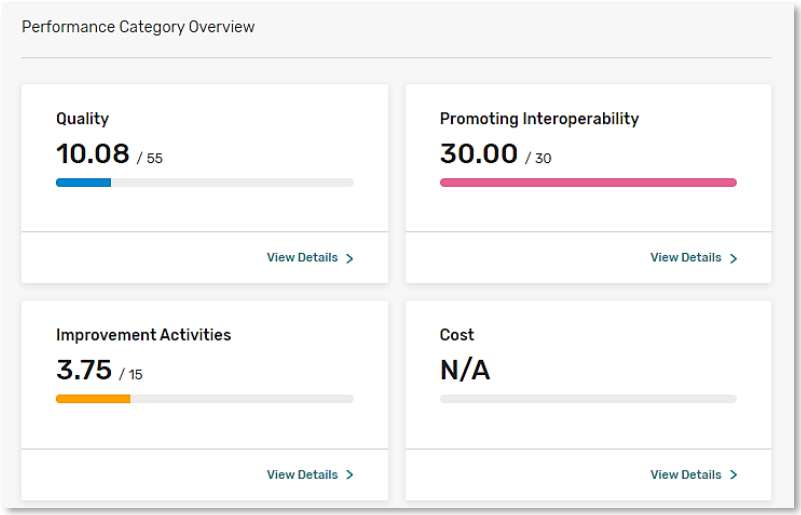
- Your final score
- Your score and the weight for each MIPS performance category
- Your payment adjustment(s) information

How Is Our Final Score Determined?

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



Note: Bonus points awarded for the complex patient bonus will display under the cost performance category as **Additional Bonus Points**.



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Who Gets the 2022 MIPS Payment Adjustment(s) That I See in Performance Feedback?

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

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

Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI is scored under the APM scoring standard and has more than one APM Entity final score.	The highest of the APM Entity final scores.
TIN/NPI has an APM Entity final score and any other final score (individual, group, or virtual group).	APM Entity final score.
TIN/NPI has virtual group final score and an individual or group final score.	Virtual group final score.
TIN/NPI has a group final score and an individual final score.	The higher of the two final scores (either group or individual).

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

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

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How Does My Payment Adjustment Relate to My Final Score?

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

Final Score	Payment Adjustment
85.00 – 100.00 points (Additional performance threshold = 85.00 points)	• 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)
45.01 – 84.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
45.00 points (Performance threshold = 45.00 points)	Neutral MIPS payment adjustment (0%)
11.26 – 44.99	Negative MIPS payment adjustment (between 0% and -9%)
0 – 11.25 points	Negative MIPS payment adjustment of -9%

Why Is Our Payment Adjustment Low When Our Final Score Is High?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires MIPS to be a budget neutral program, which, generally stated, means that the projected negative adjustments must be balanced by the projected positive adjustments. The magnitude of the payment adjustment amount is influenced by 2factors: The performance threshold and the distribution of final scores in comparison to the performance threshold in a given year. (The low-volume threshold, which is used to determine eligibility for the program, doesn't factor into the magnitude of the payment adjustment.)

The modest positive payment adjustment you see is a result of high participation rates in combination with a high percentage of participating clinicians earning a final score well above the relatively low performance threshold of 45 points. With many clinicians successfully participating, the distribution of positive adjustments is spread across many more people. This year's distribution was further affected by the flexibilities we introduced to reduce burden on those clinicians on the front lines of the COVID-19 response. By extending the automatic extreme and uncontrollable circumstances policy to all MIPS eligible clinicians, clinicians who didn't submit any data will receive a neutral payment adjustment instead of the maximum negative adjustment.

We understand that a lower-than-expected positive payment adjustment may be disappointing; however, it's critical that we support every clinician's ability to focus on caring for patients impacted by the COVID-19 pandemic.

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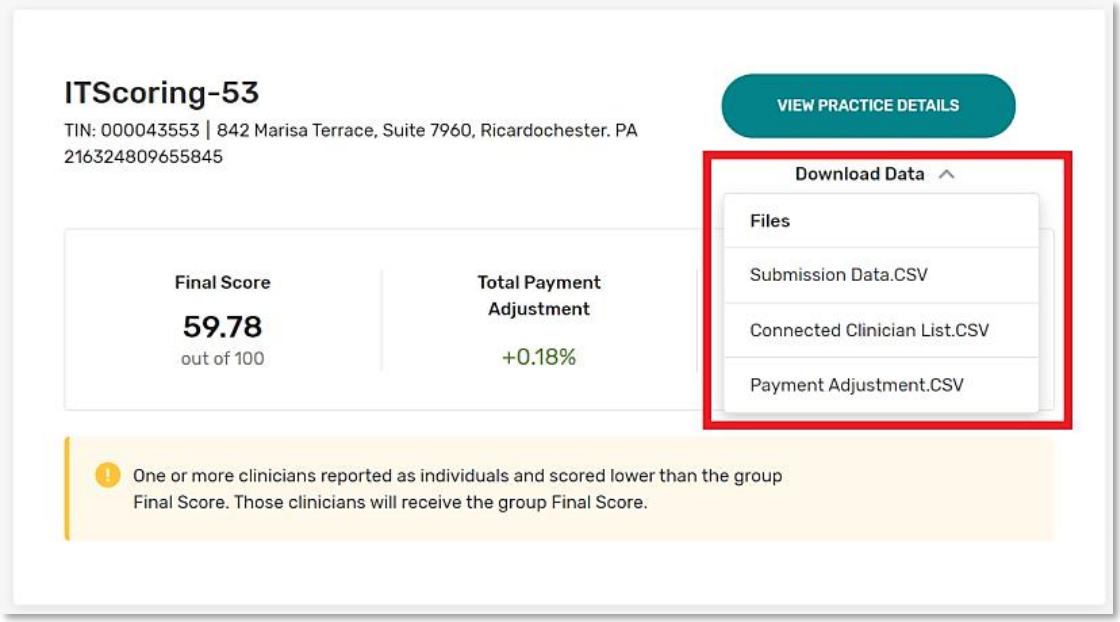
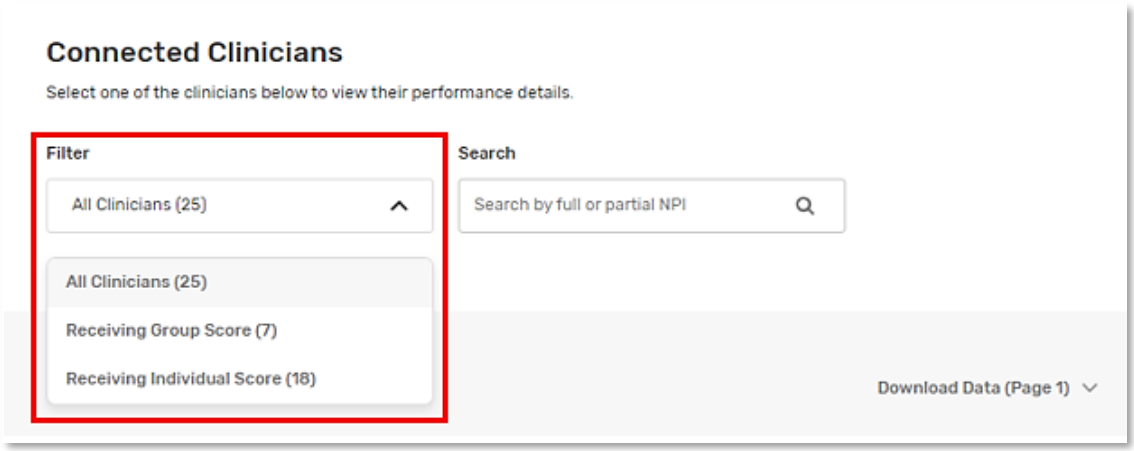
Is There a Way for Me to See a List of The Final Scores and Payment Adjustments for All the MIPS Eligible Clinicians in My Practice?

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**.



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Receiving Individual Score

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

Receiving Group Score

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

Receiving APM Score (not shown in image on the previous page)

- Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the APM Entity reporting under the APM scoring standard.

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

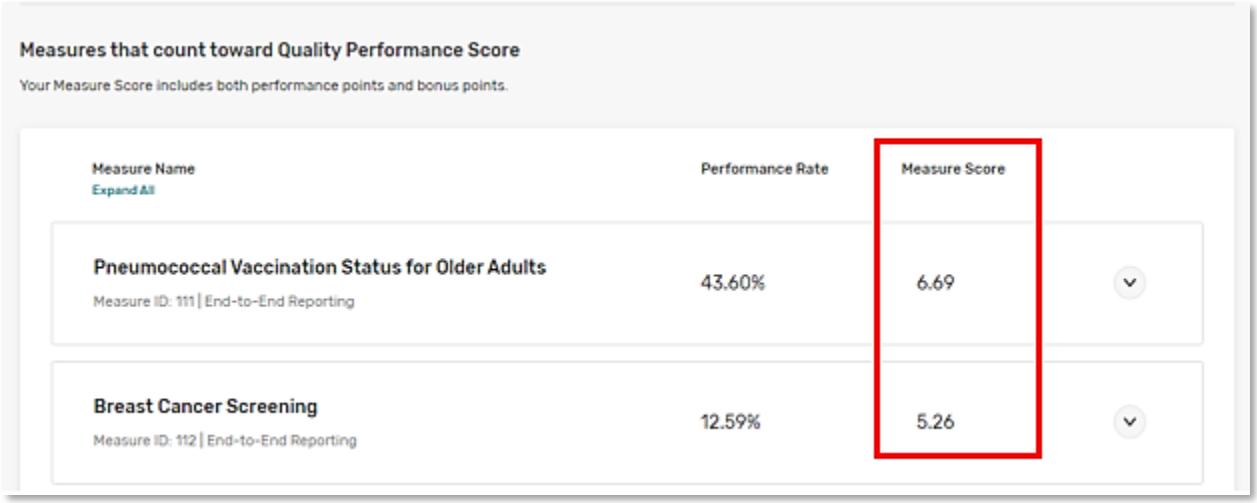
When you see N/A instead of a score for a performance category, this means that the category was reweighted to 0% of your final score.

- MIPS eligible clinicians who submitted some data as individuals will see "N/A" for every performance category for which they didn't submit data (due to the automatic EUC triggered by the COVID-19 pandemic).
- Groups and virtual groups will see "N/A" for every performance category they selected in an approved COVID-19 EUC application, unless data was submitted for that category. Unlike PY 2019, data submission overrode reweighting from an approved EUC application.

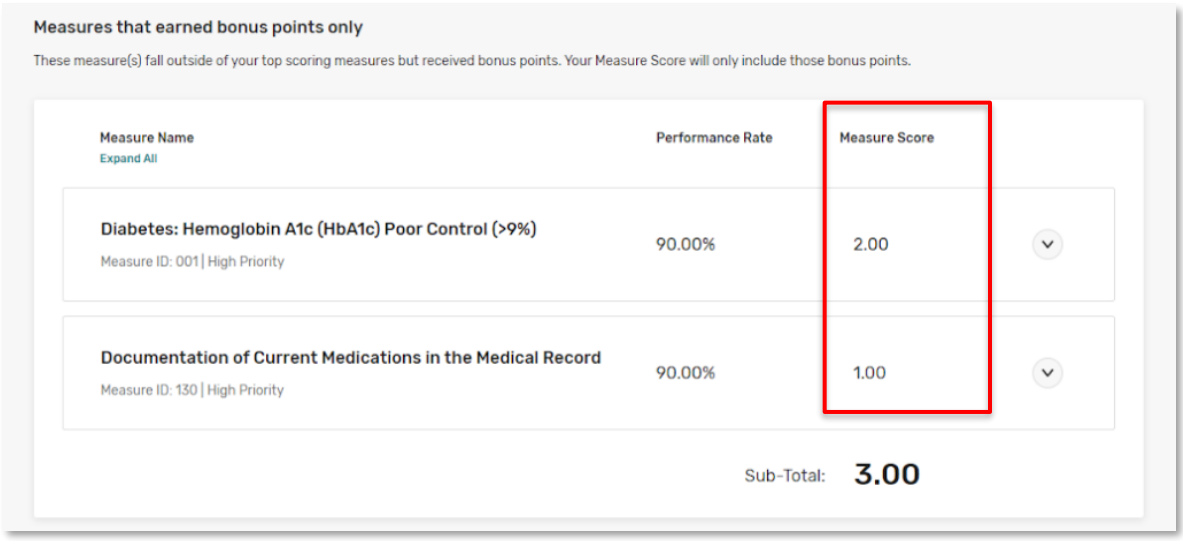
Quality

When you navigate into the quality section, you may see quality measures divided 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 sum of your performance and bonus points.



2. Measures whose bonus points contribute to your Quality performance category score. You'll see the bonus points earned by these measures.



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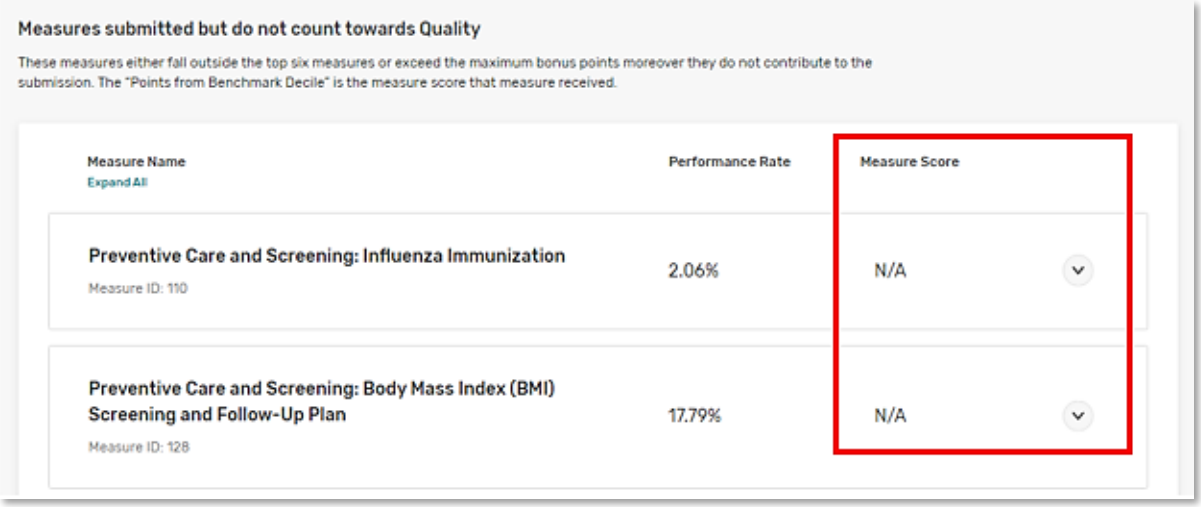
3. Measures that contribute zero points to your quality performance category score. You'll see "N/A" in the measure score.



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

If you submitted more than 6 measures, only 6 of those measures will contribute measure achievement points to your quality performance category score. However, we'll include any bonus points from the remaining measures, as long as you haven't exceeded the 10% cap for the applicable bonus.

When determining which measures are included in the top 6:

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

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

Example: You submit 7 measures, and your 2 lowest scoring measures (after the required outcome measure) were the Colorectal Cancer Screening and Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measures, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top 6 because its measure ID (113) has a lower value than the Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure (320).

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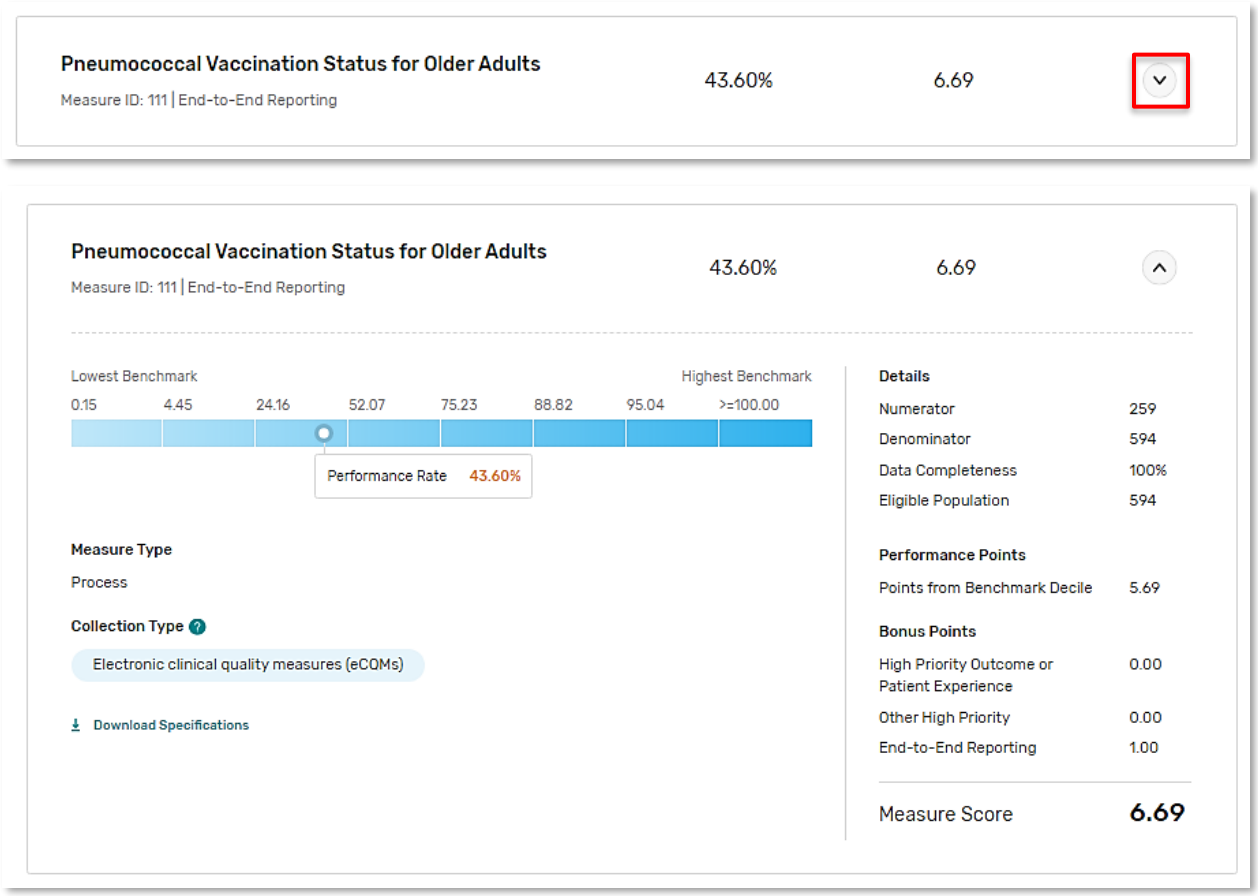
If you submit the same measure through multiple collection types—example, as a Medicare Part B claims measure and as an eCQM—we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2versions of the same measure count towards your quality performance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

What Does It Mean When I See a Measure Score Of "--:?

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

How Can I Access Details About the Measures I Submitted?

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



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

We included your highest **scoring** quality measures. Remember 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 earns 10 points, based on the benchmarks for each measure.

I Reported 6 Measures and They All Had Benchmarks. Why Was I Only Scored on Five of Them?

There are a small number of quality measures whose scoring was impacted by:

- Changes to clinical guidelines during the performance period.
- ICD-10-CM code changes during the performance period.
- Specification changes that were later determined to be substantive.

In some cases, the performance period was truncated to 9 months. More frequently, the measure was suppressed from scoring. This means the measure wasn't scored and your quality denominator – the maximum number of points available – was reduced by 10 points.

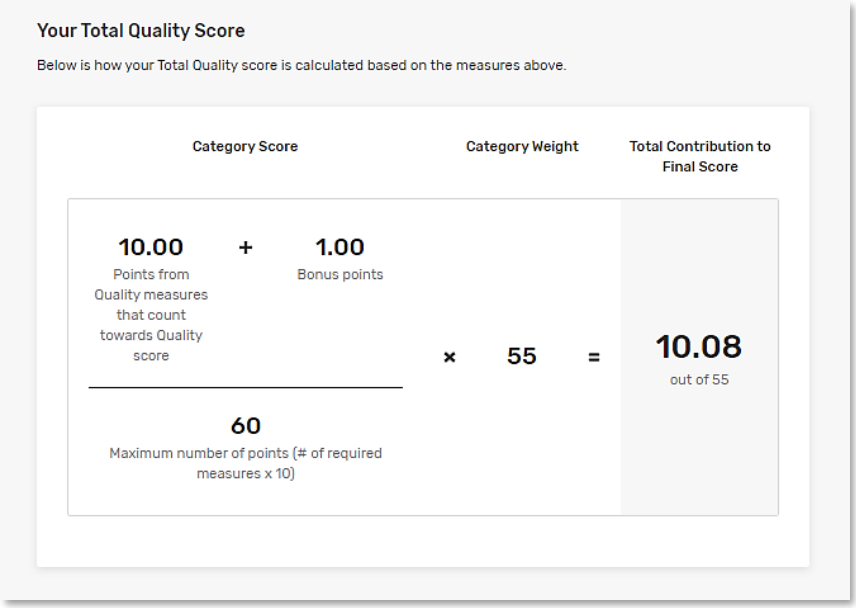
For a complete list of these impacted measures (and their collection types), refer to Appendix D.

How Do You Calculate My Quality Performance Category Score?

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

We divide the sum of your achievement and bonus points by the maximum number of points available in the quality performance category, and add that number to your improvement percent score, if applicable.

Finally, we multiply that number by the category weight.



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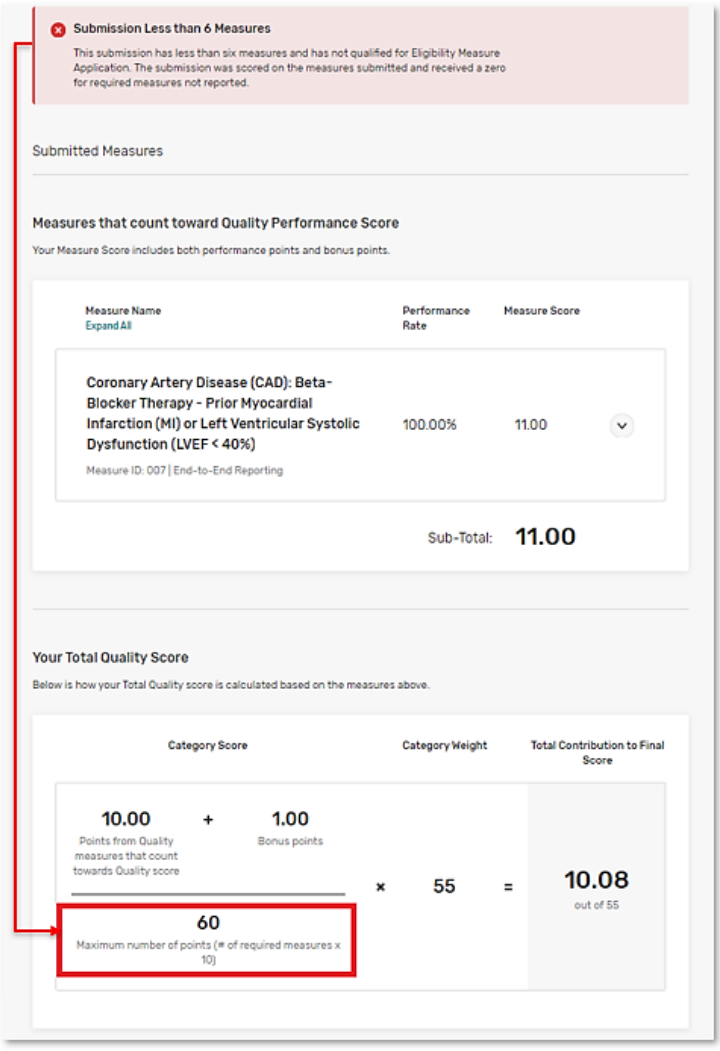
I Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures (CQMs)) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

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

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

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



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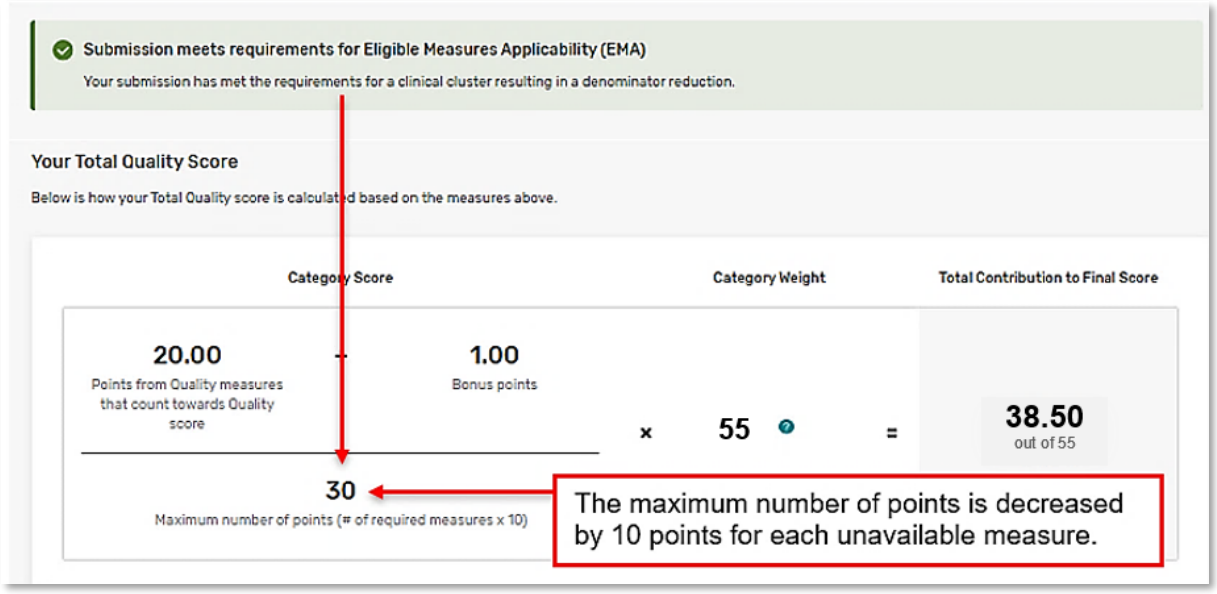
Submission (MIPS CQMs) Qualifies For Denominator Reduction



If you submitted all available Medicare Part B claims measures or MIPS clinical quality measures (CQMs) and were still scored out of 60 Total Possible Points (or 70 if you participated as a group and were scored on the All-Cause Hospital Readmission measure), you may want to request a targeted review so we can take another look.

Where Can I Find Information on the All-Cause Hospital Readmission (ACR) Measure for Our Group?

For the 2020 performance period, groups, and virtual groups with 16 or more eligible clinicians were to be scored on the All-Cause Hospital Readmission measure if they met the case minimum of 200 patients for the measure. However, CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure won't be scored or be attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

You can also review the information in Appendix D.

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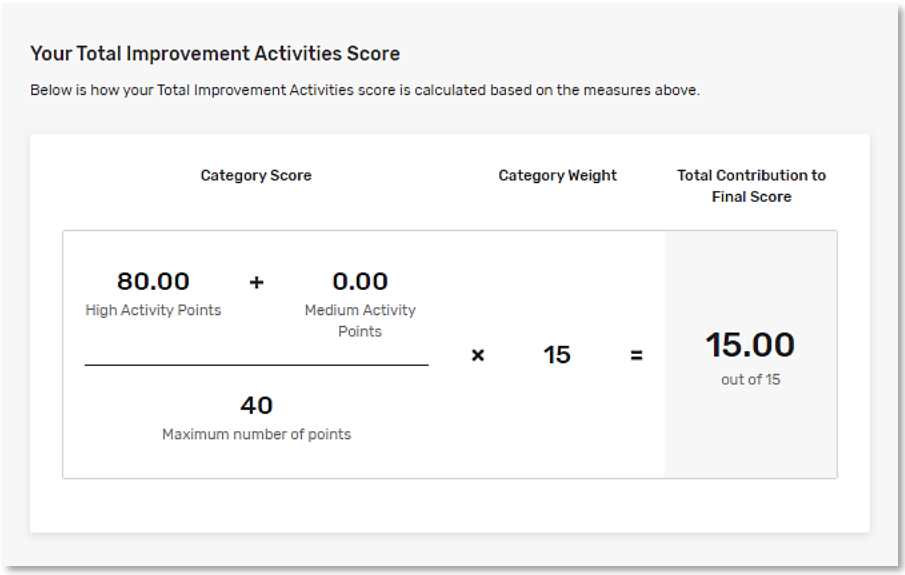
Improvement Activities

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

We divide the sum of the points earned for your medium and high weighted activities by 40 (the maximum number of points available), then we multiply that number by the category weight.



We Are 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 Medical Homes 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**.

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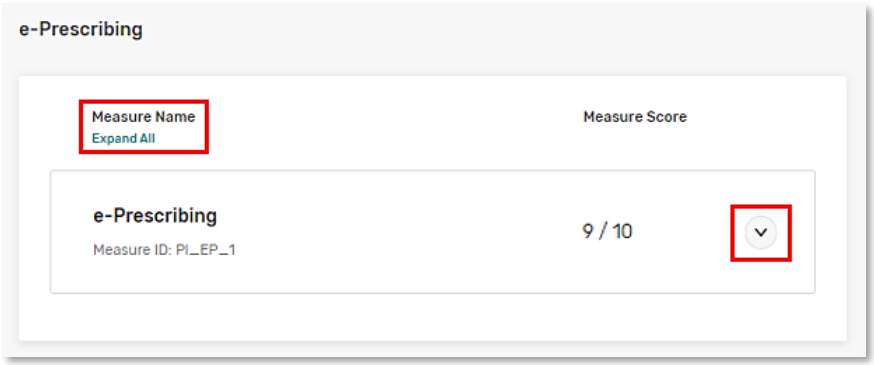
Promoting Interoperability

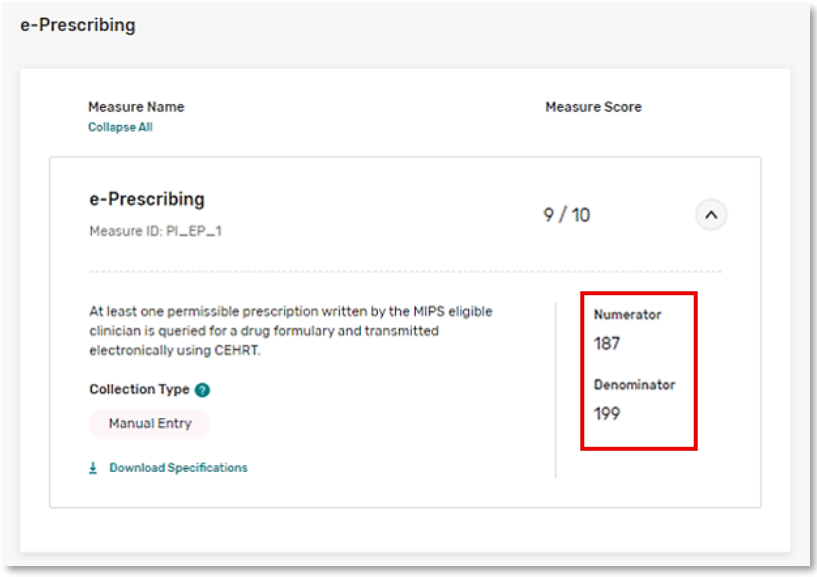
The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed.

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

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

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





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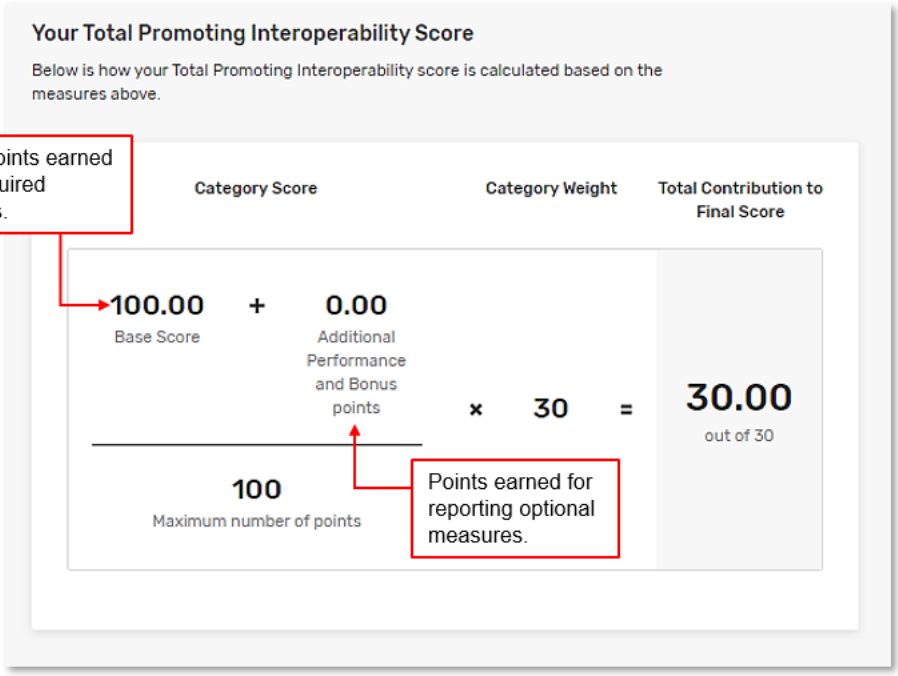
At the bottom of the Promoting Interoperability page, you can see how we arrived at the points contributing to your final score. We divided the points earned by 100 (the maximum number of points available), then we multiplied that number by the category weight.



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

If a MIPS eligible clinician or group submitted any data for the Promoting Interoperability performance category, CMS scored them according to the data submitted and the category **WASN'T** reweighted to 0%. This includes clinicians and groups who started data entry (such as 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 but should've qualified for reweighting based on your clinician type, special status, and/or exception status, you may need to request a targeted review. (Refer to the 2020 Targeted Review User Guide (PDF)).

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 for the performance category.

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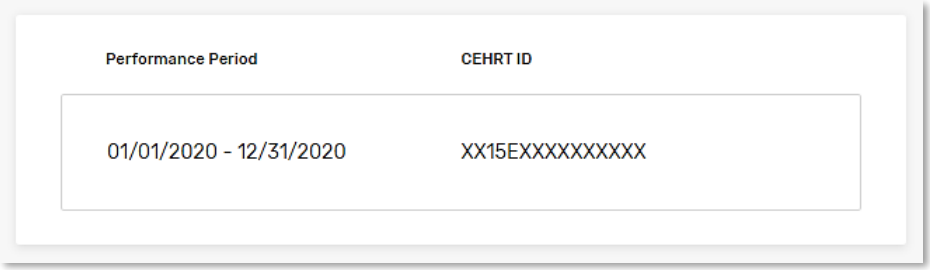
What Is a CEHRT ID?

2015 edition Certified EHR Technology (CEHRT) is required for reporting your MIPS Promoting Interoperability measures.

The CEHRT identification number (ID) is the CMS Certification ID for your EHR product(s) proving that it's certified by The Office of the National Coordinator for Health Information Technology (ONC) to the 2015 Edition. Submissions without a valid CEHRT ID result in a performance category score of 0.



We Participate in a MIPS APM and Submitted Our Promoting Interoperability Measures as Individuals. Why Is Our Score Lower Than What We Saw During 2019 Submissions?

The score you saw during submission was based on the individual or group data you submitted and isn't your final Promoting Interoperability performance category score. Under the APM scoring standard, each MIPS eligible clinician in the APM Entity receives the same score, which is a weighted average of all the scores for the MIPS eligible clinicians in the APM Entity.

Cost

Why Don't I See Any Cost Measure Information?

CMS is reweighting the cost performance category from 15% to 0% for the 2020 performance period for all MIPS eligible clinicians, regardless of participation as an individual, group, virtual group or APM Entity. The 15% cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(D).

As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they'll receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year. This reweighting of the cost performance category applies in addition to the EUC policy under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), §414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3).

Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC will still have their cost performance category weighted to 0%.

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Facility-Based Scoring

Facility-based scoring allows certain clinicians and groups to receive scores in the quality performance category for the 2020 MIPS performance period based on their attributed facility's Fiscal Year (FY) 2020 performance in the Hospital Value-Based Purchasing (VBP) Program.

If you qualified for facility-based scoring, you'll see a message on the quality page of feedback showing **Your QPP Equivalent Quality Score Based on the HVBP Percentile.**

We map this performance to performance by MIPS eligible clinicians and groups on MIPS quality measures to arrive at a score for the performance category.

Step 1. We looked at your facility's FY 2021 Hospital VBP Program score.

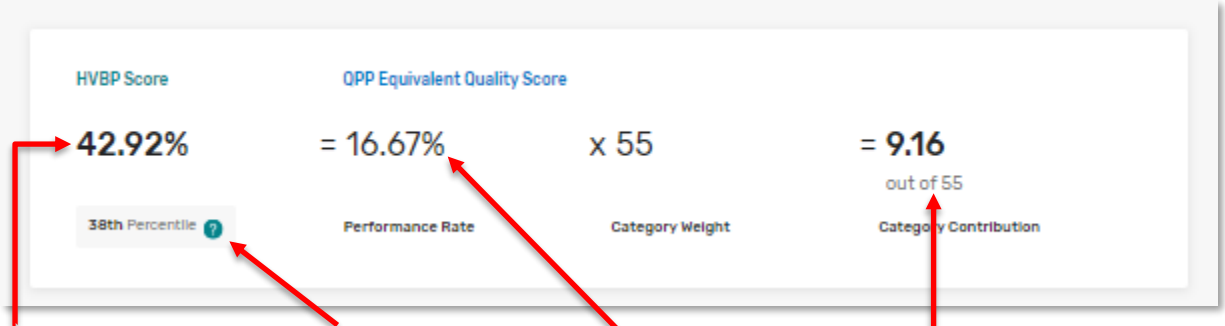
Step 2. We determined how your facility's FY 2021 Hospital VBP Program score compared to all other facilities with a FY 2021 Hospital VBP Program score and arrive at a percentile.

Step 3. We looked at the range and distribution of unweighted PY 2020 MIPS Quality performance category percentile scores for MIPS participants, and identified which 2020 MIPS quality (percentile) score mapped to the percentile associated with your FY 2021 Hospital VBP Program score. Note that we won't assign a quality percentile score below 30%.

Step 4. We multiplied the mapped 2020 MIPS quality percentile score by the 2020 quality performance category weight to determine the quality performance category points contributing to your final score. (Note, this would be 70% for those who qualify for reweighting in the Promoting Interoperability performance category.)

Let's apply these steps to the example below:

Quality



Step 1: Your facility had a total performance score of 42.92%.	**Step 2:** This score put you in the 38th percentile of all facilities participating in the Hospital VBP program.	**Step 3:** Clinicians in the 38th percentile for the MIPS quality performance category earned a 16.67% score.	**Step 4:** The rate from Step 3 is multipled by the category weight of 55% to arrive at 9.16 points out of 55 points.

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Why Did We Only Receive a Quality Score from Facility-Based Measurement?

We weren't able to calculate facility-based scores for the cost performance category for PY 2020. To determine your facility-based score for cost, we map your facility's Total Performance Score (from the Hospital VBP program) to MIPS cost performance category scores received by MIPS eligible clinicians.

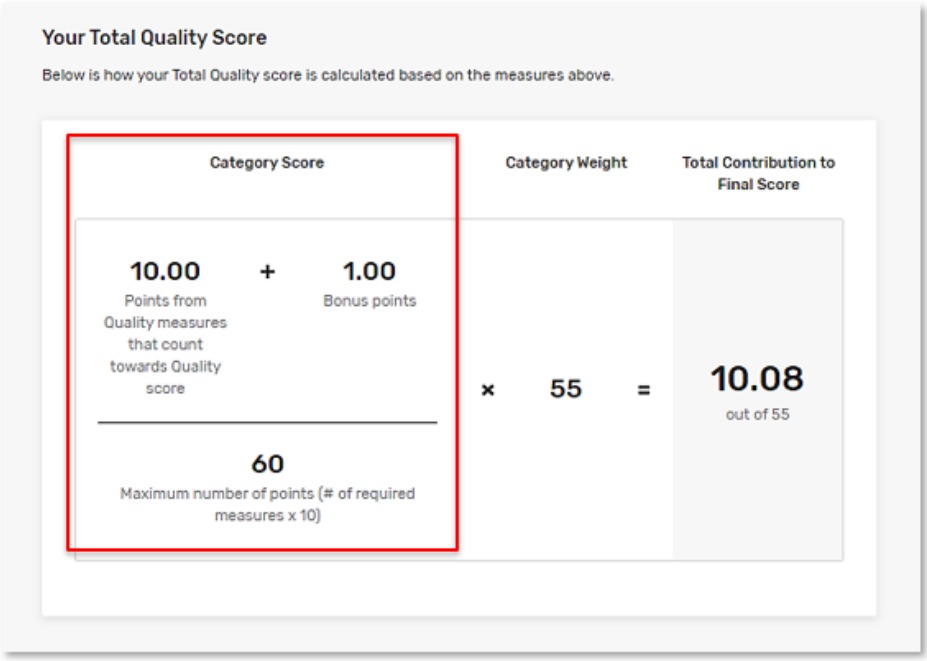
- Example: Your facility's Total Performance Score was in the 87th percentile for all facilities that participated in the Hospital VBP program. We'd assign you a facility-based cost score equal to the MIPS cost score representing the 87th percentile for all MIPS eligible clinicians that were scored on MIPS cost measures.

Because we're not calculating MIPS cost measures or scoring this performance category for PY 2020, we can't do the mapping required to establish a facility-based cost score. Cost reweighting doesn't affect our ability to calculate a facility-based score in the quality performance category for clinicians and groups that were eligible to receive one.

What is the "Performance Rate" in the QPP Equivalent Score?

The Performance Rate value is the unweighted percentile score (for the quality performance category) that maps to your Hospital VBP score percentile.

For context, the unweighted percentile score for an individual clinician, group or virtual group would correlate to the product of the highlighted portion of their Total Quality Score calculation below.



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Items and Services

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

The Items and Services section of your performance feedback includes information about your patients' healthcare and emergency department use. The purpose of this breakdown is to provide clinicians and groups with additional information on the types of Medicare covered items used by their patients throughout a calendar year (CY). Please note that the Items and Services data is 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 used by patients using Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS codes represent a standard coding system for procedures, supplies, products, and services billed by health care providers. The data in the Items and Services section of performance feedback is aggregated by ranges of HCPCS codes for ease of review.

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

The Healthcare Common Procedure Coding System is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare beneficiaries 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:** These codes are alpha-numeric 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 doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency. All CPT codes are 5 digits and can be either numeric or alphanumeric, depending on the category. As noted above, Level I of the HCPCS is comprised of CPT-4 codes, a numeric coding system maintained by the AMA.

[1] https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf

How Are HCPCS Codes Divided into Sections in The Items and Services Section of Performance Feedback?

In the Items and Services feedback, the HCPCS codes are categorized based on the following ranges of codes for ease of review:[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
HCPCS H	Alcohol and drug abuse treatment services or rehabilitative services
HCPCS J	Drugs administered other than oral method, chemotherapy drugs
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS V	Vision, hearing and speech-language pathology services

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

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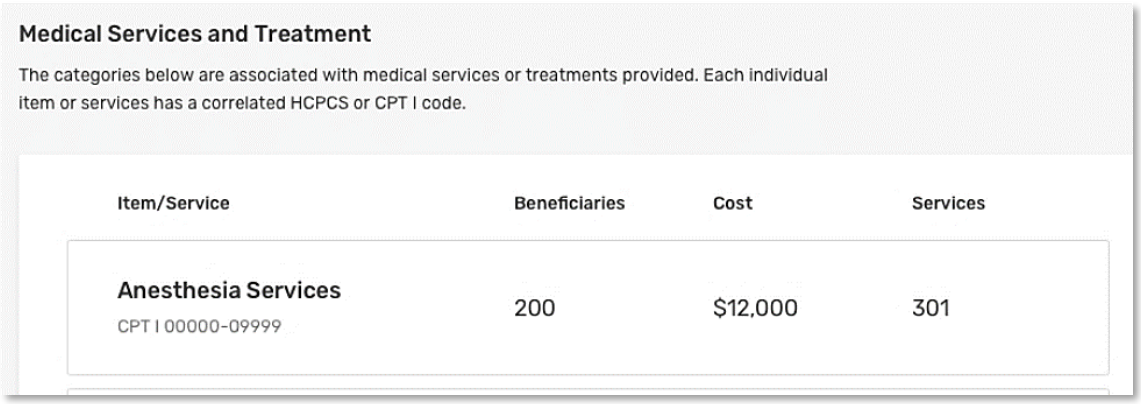
What Data is Being Used in The Items and Services Section of Performance Feedback?

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Type 71 and 72) billed with dates of services between January 1, 2020, and December 31, 2020 and received by CMS within 60 days of 12/31/2020 (a "60-day runout").



How is the Number of "Beneficiaries," in the Items and Service Section of Performance Feedback, Derived?

The number of patients reflected is the number of all patients for the related HCPCS/CPT codes on Part B professional claim lines with positive allowed charges.

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 CY2020 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY 2020.

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 CY2020 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2020.

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How is the "Cost," in the Items and Service Section of Performance Feedback, Derived? Is the Cost Adjusted and/or Price Standardized in Any Way? If So, How?

The cost reflected in Items and Services is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines. These numbers are raw allowed charge amounts and aren't payment standardized, risk adjusted, nor specialty adjusted.

For individual clinicians, the number of services reflected 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 CY2020 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2020.

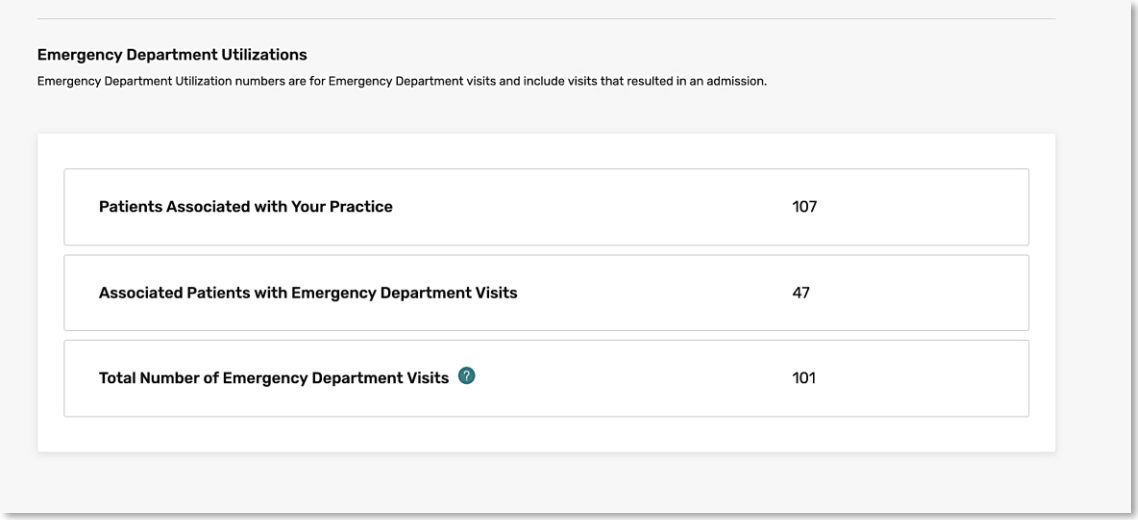
For groups, this number is the sum of all Part B-enrolled patients' allowed charge amounts on professional claim lines with allowed charges for patients who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2020 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2020.

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 CY2020 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2020.

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 CY2020 AND at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2020.

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 or RHC's CCN, then that patient and their services aren't included in the provision of Items & 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 either 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 either 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 other provider’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 E. See Appendix F for a list of Medical Specialists, Surgeons, and Other Physicians Included in the Second Step of Attribution. For a list HCPCS codes that identify primary care services, please refer to Appendix G.

A patient is excluded from the population measured for purposes of providing Items & 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 resides 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 he/she newly enrolled in Medicare or he/she died during the performance period.

The case minimum for provision of Items & 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 & 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 & 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 emergency department (ED) visit in CY 2020. An ED visit is defined as any 2020 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 CY2020.

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Performance Feedback for APM Entities and Clinicians Scored Under the APM Scoring Standard

We Participate in a MIPS APM. What Kind of Feedback Will Be Available to Us?

MIPS performance feedback for clinicians scored under the APM scoring standard will be available to the APM Entity and the individual clinicians directly. The clinicians and entities participating in the following models will be able to access their performance feedback based on the APM scoring standard directly on qpp.cms.gov:

- Medicare Shared Savings Program Accountable Care Organizations (ACO)
- Next Generation ACO Model
- Other MIPS APM Entities:
    - Oncology Care Model (OCM)
    - Comprehensive ESRD Care (CEC) Model
    - Comprehensive Primary Care Plus (CPC+)
    - Bundled Payments for Care Improvement (BPCI) Advanced
    - Independence at Home Demonstration (IAH)
    - Maryland Total Cost of Care (TCOC)
    - Vermont All Payer ACO (VT ACO)

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Shared Savings Program ACO participants

Access Type	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity (Staff User or Security Official role for the APM Entity)	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data (including the CAHPS for ACO Survey) submitted to QPP by or on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM Entity roll up") Can download: • Promoting Interoperability scores attributed to each clinician in the Entity based on their individual or group submission	Can view: • A message that they've earned full credit for this performance category	N/A
Practice (ACO Participant TIN) (Staff User or Security Official role for the Practice)	• Can view a message that they have clinicians participating in an Alternate Payment Model. • **Can't** view any scoring information related to the APM scoring standard. • Can view performance category scores and a final score based solely on the data submitted or calculated at the individual or group level.Can view a payment adjustment based on the group's final score if there are clinicians in the group who will be scored based on the group's data.				
Individual Clinicians (Clinician Role) **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data submitted to QPP by or on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM Entity roll up") • Their individual score based on data submitted by their ACO Participant TIN	Can view: • A message that they've earned full credit for this performance category	If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record

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Next Generation ACO Participants

Access Type	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity (Staff User or Security Official role for the APM Entity)	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data (including the CAHPS for ACO survey) submitted to QPP by or on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM Entity roll up" – click here for more information) Can download: Promoting Interoperability scores attributed to each clinician in the Entity	Can view: • A message that they've earned full credit for this performance category	N/A
Individual Clinicians (Clinician Role) **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score • Quality measure data (including the CAHPS for ACO Survey) submitted to QPP by or on behalf of the Entity	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) • Their individual score based on data submitted at the individual or group level	Can view: • A message that they've earned full credit for this performance category	If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record

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Other MIPS APM Entities

Access Type	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity	Can view: • Final Score • Payment Adjustment	Can view: • 50% auto-credit if applicable • Performance category score and measure details if quality was submitted by the APM Entity. Can download: • Quality scores attributed to each clinician in the Entity if quality was submitted by individuals in the Entity.	Can view: • Aggregated, weighted performance category score ("APM entity roll up" – click here for more information) Can download: • Promoting Interoperability scores attributed to each clinician in the Entity	Can view: • A message that they've earned full credit for this performance category	N/A
Individual Clinicians **"Final Score"** tab – click here for more information	Can view: • Final Score • Payment Adjustment	Can view: • Performance category score and quality measure details.	Can view: • Aggregated, weighted performance category score ("APM Entity roll up" – click here for more information) • Their individual score based on data submitted at the individual or group level	Can view: • A message that they've earned full credit for this performance category	If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record

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General

Why Does My Final Performance Feedback Differ from My Preliminary Performance Feedback?

When the 2020 submission period closed, CMS continued to make preliminary performance feedback available, providing information about scores in progress. Final MIPS Performance Feedback includes the following:

- Performance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure.
- Improvement Activity credit based on successful participation in the CMS Study on Factors Associated with Reporting Quality Measures.
- Scoring updates based on the creation of performance period benchmarks for quality measures without a historical benchmark.
- 2021 payment adjustment information for MIPS eligible clinicians.
- Access to request a targeted review.

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.)

What If There Is An Error With My Payment Adjustment/Performance Feedback/Final Score?

If you believe an error has been made in your 2022 MIPS payment adjustment calculation, you have until 8 p.m. ET on October 1, 2021, to request a targeted review.

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

What's a Targeted Review?

A Targeted Review is a process where 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 2022 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. For more information on Targeted Review, please review the 2020 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.

Where Can I Learn More?

- Quality Payment Program
- Payment Year 2022 MIPS Payment Adjustment User Guide (PDF)
- 2020 Targeted Review User Guide (PDF)
- 2020 Performance Period Benchmarks (ZIP)
- 2020 MIPS Scoring Guide (PDF)
- 2020 APM Scoring Standard Guide (PDF)

Contact the Quality Payment Program Service Center at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m.- 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Comment
8/3/2021	Original version

Appendix A: Automatic Extreme and Uncontrollable Circumstances Policy

Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2020 performance category reweighting policies that CMS will apply to individual clinicians under the MIPS automatic EUC policy, including those that submit MIPS data as individuals. (This doesn't reflect reweighting for clinicians scored under the APM scoring standard.)

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

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Appendix B: Extreme and Uncontrollable Circumstances Application

Performance Category Reweighting Scenarios

The table below identifies the performance category reweighting scenarios applicable to group and virtual group participation for the 2020 performance year.

Please note that we have updated the table to reflect the 0% reweighting of the cost performance category for everyone in the 2020 performance year.

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

Reweighting Scenario	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No additional reweighting from an approved EUC application, approved Promoting Interoperability hardship exception, clinician type or special status					
No Cost	55%	30%	15%	0%	Positive, Negative, or Neutral
Reweight 2 Performance Categories					
No Cost and No Promoting Interoperability	85%	0%	15%	0%	Positive, Negative, or Neutral
No Cost and No Quality	0%	85%	15%	0%	Positive, Negative, or Neutral
No Cost and No Improvement Activities	70%	30%	0%	0%	Positive, Negative, or Neutral
Reweight 3 Performance Categories					
No Quality, No Cost, No Improvement Activities	0%	100%	0%	0%	Neutral
No Quality, No Cost, No Promoting Interoperability	0%	0%	100%	0%	Neutral
No Cost, No Improvement Activities, No Promoting Interoperability	100%	0%	0%	0%	Neutral
Reweight 4 Performance Categories					
All performance categories reweighted to 0%	0%	0%	0%	0%	Neutral

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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 group-level ("practice") performance feedback ✓ View and download clinician-level performance feedback (excluding APM participants) ✓ View and download payment adjustment information for all clinicians in the practice (excluding APM participants)	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 (clinicians scored under the APM scoring standard). You'll only be able to view feedback on the data submitted at the individual or group level. X View performance feedback for your virtual group
Staff User or Security Official for an **APM Entity**	✓ View and download MIPS performance feedback for the entire Entity under the APM scoring standard ✓ View and download payment adjustment information for all clinicians in the Entity	X View the Promoting Interoperability data submitted by individual clinicians and groups in your APM entity
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ View preliminary scoring for your clients based on the data you submitted for them (same information that was available during the submission period)	X View final performance feedback or payment adjustment information for your clients, which may include: ○ Data submitted by your clients directly ○ Data submitted by another third party on behalf of your clients ○ Data collected and calculated by CMS on behalf of your clients ▪
Clinician Role	✓ View your performance feedback and payment adjustment information for all associated APM Entities, practices, and virtual groups	X View performance feedback or payment adjustment information for other clinicians
Staff User or Security Official for a **Virtual Group**	✓ View virtual group-level performance feedback	X View performance feedback about data submitted by individuals or practices in your virtual group

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Appendix D: Quality Measures with Scoring Changes

The following measures have MIPS scoring changes due to clinical guideline changes during the 2020 performance period, or because specifications were determined during or after the performance period to have substantive changes. CMS hasn't identified any MIPS quality measures requiring performance data to be truncated to a 9-month performance period for 2020 due to the annual ICD-10 code update.

Quality Measure ID/ Name	Collection Type	Reason for Measure Change	Impact to Scoring, Submission and Feedback Expectations
Measure 069 Hematology: Multiple Myeloma: Treatment with Bisphosphonates	MIPS Clinical Quality Measures (CQM)	Updated National Comprehensive Cancer Network® (NCCN) Guidelines for Multiple Myeloma	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 134/PREV-12 Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS Web Interface	Substantive change: removal of Systematized Nomenclature of Medicine (SNOMED) codes	Excluded from scoring (Denominator reduced by 10 points) if data completeness is met. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 419 Overuse of Imaging for the Evaluation of Primary Headache	Medicare Part B Claims	Necessary quality data code was inadvertently inactivated during the Healthcare Common Procedure Coding System (HCPCS) update process	Excluded from scoring (Denominator reduced by 10 points) if data is submitted on the suppressed measure. We are currently updating our systems to reflect suppression; once updated your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 370/MH-1 Depression Remission at 12 Months	CMS Web Interface	Measure doesn't have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Your feedback will show "- -" if measure was reported, but excluded from scoring

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Measure 438/PREV-13 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	Measure doesn't have a benchmark	Excluded from scoring (Denominator reduced by 10 points) if data completeness met Your feedback will show "- -" if measure was reported, but excluded from scoring
Measure 458 All-cause Hospital Readmission	Administrative Claims	Specific to MIPS, the measure steward has indicated that the measures' risk adjustment models need to be updated to account for factors outside of the clinician's control	Excluded from scoring, will not be attributed to quality performance category. There will be no feedback for this measure.

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Appendix E: 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 F: 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)	

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Appendix F (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)	

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Appendix G: 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.

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