

Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS)

2022 MIPS Group Participation Guide: Traditional MIPS



Contents

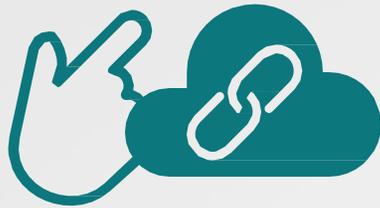
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Purpose: This resource focuses on Merit-based Incentive Payment System (MIPS) eligibility and participation, providing high-level information and actionable steps for interpreting your eligibility and participation requirements for the 2022 MIPS performance period.



How to Use This Guide



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

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Hyperlinks

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



Overview



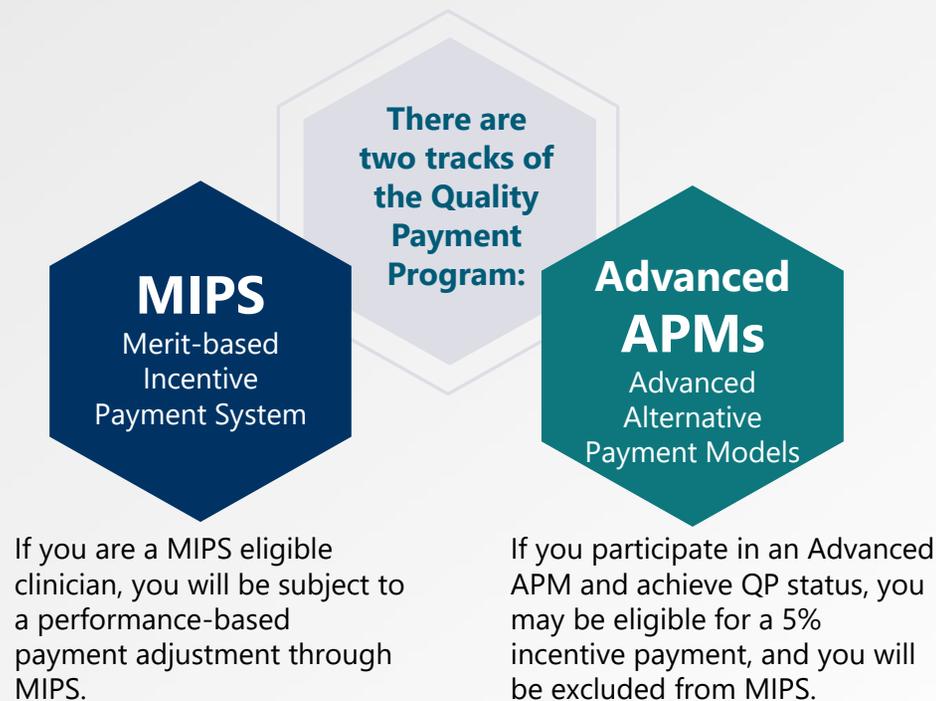
COVID-19 and 2022 Participation

The 2019 Coronavirus (COVID-19) public health emergency continues to impact 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 2022 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 application will be available in spring of 2022 along with additional resources.

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

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA advances a forward-looking, coordinated framework for clinicians to participate in the Quality Payment Program, which rewards value in 1 of 2 ways:



This guide will only cover the **MIPS participation in the Quality Payment Program**. For more information on participating in an Advanced APM, visit our [Advanced APM Overview webpage](#) and check out our APM related resources in the [Quality Payment Program Resource Library](#).

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program describes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

If you're eligible for MIPS in 2022:

- You generally have to submit data for the [quality](#), [improvement activities](#), and [Promoting Interoperability](#) performance categories. (We collect and calculate data for the [cost](#) performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

To learn more about MIPS eligibility and participation options:

- Visit the [How MIPS Eligibility is Determined](#) and [Participation Options](#) web pages on the [Quality Payment Program website](#).
- View the [2022 MIPS Quick Start Guide](#).
- Check your current participation status using the [QPP Participation Status Tool](#).

What is the Merit-based Incentive Payment System? (Continued)

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under the traditional MIPS, participants select from 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks, designed to reduce reporting burden, will be available to MIPS eligible clinicians.

- The **APM Performance Pathway (APP)**, is a streamlined reporting framework available beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs)** are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, MVPs incorporate a foundational layer that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities. **There are 7 MVPs that will be available for reporting in the 2023 performance year:**

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

We encourage clinicians interested in reporting an applicable MVP to become familiar with the MVP's requirements in advance of the 2023 performance year. For more information on the finalized MVPs, please refer to the CY 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to [MIPS Value Pathways section of the QPP website](#).

Quick Reference: Group Participation at a Glance for Traditional MIPS

The following table provides a high-level overview of the different aspects of group participation, which are explored in greater detail throughout this guide.

<p>Eligibility & Participation</p>	<ul style="list-style-type: none"> To participate in MIPS as a group, the practice (identified by Taxpayer Identification Number (TIN)) must: <ul style="list-style-type: none"> Exceed the established low-volume threshold OR be eligible to opt-in as a group; and Have at least 2 clinicians billing under the group's TIN; and Include at least 1 MIPS eligible clinician. You may also have a special status or other designation that qualifies you for reduced reporting requirements or bonus points. <ul style="list-style-type: none"> Find your eligibility information on qpp.cms.gov <p>Helpful hint: Sign in to qpp.cms.gov to review current eligibility information for your practice. Check your final eligibility status in December 2022.</p> <p>Don't have an account? Review the Quality Payment Program Access User Guide (ZIP)</p>
<p>Measure & Activity Selection/ Review</p>	<ul style="list-style-type: none"> Choose your 2022 quality measures. <ul style="list-style-type: none"> Groups that want to report CMS Web Interface measures and/or administer the Consumer Assessment for Healthcare Plans and Systems (CAHPS) for MIPS Survey need to register between April 1, 2022, and June 30, 2022. Choose your 2022 improvement activities. Review the required 2022 Promoting Interoperability measures. <p>Note: Groups with will be automatically evaluated and scored on 2 new measures calculated using administrative claims, if they meet the case minimum for the measures.</p>
<p>Data Collection</p>	<ul style="list-style-type: none"> Clinicians in the group perform the quality actions associated with the practice's selected measures (as appropriate to their scope of practice). Data is collected for the entire 12-month performance period. At least 50% of the clinicians in the group implement each selected improvement activity for a minimum of 90 continuous days, unless otherwise specified in the activity description. All clinicians perform the required Promoting Interoperability measures and collect the data in your practice's electronic health record (EHR) technology certified to the 2015 Edition and/or 2015 Edition Cures Update certification criteria for a minimum of 90 continuous days. <p>Note: In group participation, the practice aggregates data across the TIN, which could include covered professional services furnished by clinicians within the TIN who aren't required to participate in MIPS.</p>

Quick Reference: Group Participation at a Glance for Traditional MIPS (Continued)

Data Submission	<ul style="list-style-type: none">• Groups may submit their data themselves or use a third party intermediary to submit their measure and activity data.<ul style="list-style-type: none">○ The available submission type(s) – or method(s) by which data is submitted to CMS – vary by performance category.
Scoring	<ul style="list-style-type: none">• Clinicians will have their performance assessed and scored across all performance categories at the group level.<ul style="list-style-type: none">○ MIPS eligible clinicians participating as a group will get the group’s final score, unless they earn a higher score through individual or APM Entity participation.
Payment Adjustments	<ul style="list-style-type: none">• Each MIPS eligible clinician included in the group will receive a MIPS payment adjustment based on the group’s performance, unless they have another final score (from individual or APM Entity participation) that’s higher than the group’s final score.

Group Participation Frequently Asked Questions

What does it mean to participate in traditional MIPS as a group?

When you participate in traditional MIPS as a group, you're choosing to submit aggregated data on behalf of all clinicians billing under the group's TIN for each performance category requiring data submission: quality, improvement activities and Promoting Interoperability. (There are no data submission requirements for the cost performance category; we collect this data for you and calculate a score for the group.)

- The group will earn a final score based on the aggregated data submitted (or collected for you) across all performance categories.

Each MIPS eligible clinician in the group will receive the same final score and payment adjustment unless the clinician receives a higher final score from individual or APM Entity participation.

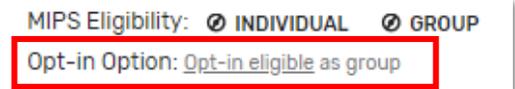


Group Participation Frequently Asked Questions (Continued)

How do we know if our practice can participate as a group?

There are 2 ways that you can find your practice’s current **group-level eligibility status** on qpp.cms.gov. Final eligibility will be available in December 2022.

1. Enter the National Provider Identifier (NPI) of any clinician in your practice into our [QPP Participation Status Tool](#).
 - a) Click on “PY 2022” if the display hasn’t begun to default to the “2022 Participation Status” tab.
 - b) Find your practice on the list of the clinician’s “Associated Practices” and look for the “Group” indicator of MIPS eligibility.
 - c) Your practice has the option to participate as a group and earn a MIPS payment adjustment if there is a green check mark next to “Group”, or if there is text indicating that the practice is opt-in eligible as a group.

You See	This Means
 <p>MIPS Eligibility: <input type="radio"/> INDIVIDUAL <input checked="" type="radio"/> GROUP</p>	<p>Your practice can choose to participate as a group, and the MIPS eligible clinicians in the group will receive a MIPS payment adjustment if you submit data as a group. (This includes clinicians who aren’t eligible as individuals.)</p>
 <p>MIPS Eligibility: <input type="radio"/> INDIVIDUAL <input checked="" type="radio"/> GROUP Opt-in Option: Opt-in eligible as group</p>	<p>Your practice can choose to participate as a group and can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group’s submission.</p> <p>Learn more about opt-in eligible groups on slide 24.</p>
 <p>MIPS Eligibility: <input type="radio"/> INDIVIDUAL <input checked="" type="radio"/> GROUP</p>	<p>Your practice can choose to voluntarily report, but your clinicians won’t receive a MIPS payment adjustment.</p>

Group Participation Frequently Asked Questions (Continued)

How do we know if our practice can participate as a group? (Continued)

2. Sign in to qpp.cms.gov and navigate to “Eligibility & Reporting” on the left-hand navigation.
 - a) Make sure to select “2022” as the Performance Year at the top of the page.
 - b) Look for the indicator under your practice’s name.
 - c) You have the option to participate as a group and earn a MIPS payment adjustment if you see text indicating that you are MIPS eligible or opt-in eligible as a group.

You See	This Means
	Your practice can choose to participate as a group, and all of the MIPS eligible clinicians who are eligible at the group level will receive a MIPS payment adjustment if you submit data as a group. (This includes individuals who aren’t eligible as individuals.)
	Your practice can choose to participate as a group and can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group’s submission. Learn more about opt-in eligible groups on slide 24 .
	Your practice can choose to voluntarily report, but your clinicians won’t receive a MIPS payment adjustment.

Group Participation Frequently Asked Questions (Continued)

If our practice is eligible as a group, are we required to participate as a group?

There is no requirement to participate as a group. If your practice is eligible at the group level, your practice has the option to participate as a group.

- If your practice chooses to participate as a group, the MIPS eligible clinicians who aren't eligible as individuals **will be included** in **MIPS** and receive a payment adjustment.

MIPS Eligibility: INDIVIDUAL GROUP

- If your practice chooses **not** to participate as a group, the MIPS eligible clinicians who are eligible as individuals will need to participate as individuals.

MIPS Eligibility: INDIVIDUAL GROUP

Group Participation Frequently Asked Questions (Continued)

Who are the MIPS Eligible Clinicians in our group?

For the 2022 performance year, the following are eligible clinician types:



*Including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry; osteopathic practitioners; and chiropractors¹⁾

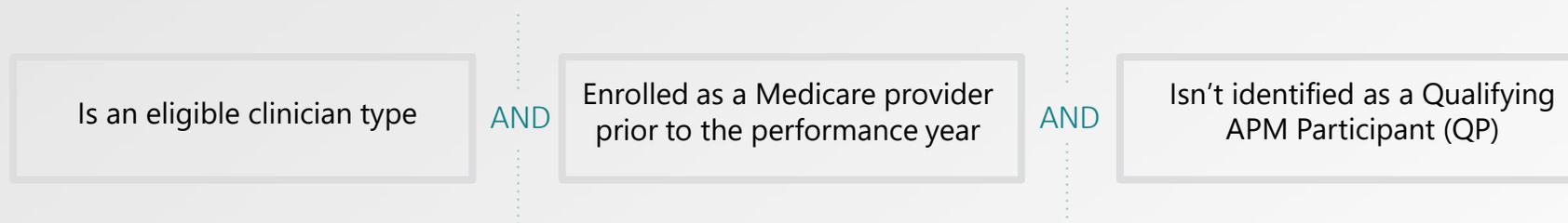
¹⁾With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which they perform this function.



Group Participation Frequently Asked Questions (Continued)

Who are the MIPS Eligible Clinicians in our group? (Continued)

For group participation, a MIPS eligible clinician:



When participating as a group, it is the group, and not each individual MIPS eligible clinician, that must exceed the low-volume threshold at the group level.

If we choose to report as a group, whose data do we need to include?

If you choose to participate in MIPS as a group, you'll need to collect and submit the available data from all of the clinicians within your group as appropriate to the quality measures you select. **This includes data for clinicians that aren't eligible for MIPS or a MIPS payment adjustment.**

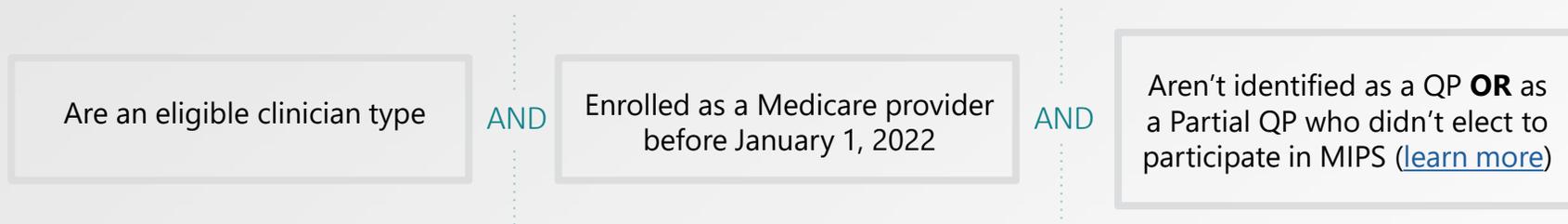
For improvement activities, each improvement activity for which groups attest must be performed by at least 50% of the clinicians billing under the group's TIN. Clinicians don't need to perform the activity concurrently, as long they each perform the activity for the required performance period (a continuous 90-day period during the calendar year, unless otherwise specified in the activity description).

For the quality, cost, and improvement activities performance categories, performance is measured across all clinicians in the group, including those that aren't MIPS eligible clinicians. For the Promoting Interoperability performance category, groups are required to submit the data collected in Certified Electronic Health Record Technology (CEHRT) on behalf of their MIPS eligible clinicians.

Group Participation Frequently Asked Questions (Continued)

Which clinicians in our practice are eligible for a payment adjustment based on our group submission?

Clinicians that have reassigned billing rights to your TIN are eligible for a 2024 MIPS payment adjustment based on the group submission if they:



MIPS eligible clinicians (meeting the criteria above) who didn't exceed the low-volume threshold at the individual level and those who start billing Medicare Part B claims under your TIN in the final 3 months of the MIPS performance year, between 10/1/2022 and 12/31/2022, are eligible for a MIPS payment adjustment based on the group's final score.

Your practice may choose to participate in MIPS as a group and the MIPS eligible clinicians within the practice may also choose to participate as individuals. If the MIPS eligible clinicians within your practice exceed the low-volume threshold at the individual level or elect to opt-in as individuals, they will be evaluated for 2 final scores: one from their individual participation and one from the group participation. They will receive the higher final score and associated MIPS payment adjustment when billing Medicare Part B claims under your practice's TIN in the 2024 payment year.

Group Participation Frequently Asked Questions (Continued)

How is a group different from a virtual group?

There are several distinctions between a group and a virtual group including the following: the number of TINs involved in the group or virtual group, the need to submit your participation choice to CMS in advance of the start of the 2022 performance year, and the way in which clinicians are assessed, scored, and receive a MIPS payment adjustment.

Group	Virtual Group
<ol style="list-style-type: none"> 1) A group is defined as a single TIN with 2 or more eligible clinicians (including at least 1 MIPS eligible clinician) as identified by their NPI who have reassigned their Medicare billing rights to the TIN. 2) There is no requirement for a practice to alert CMS of their intent to participate as a group in advance of data submission. 3) MIPS eligible clinicians in a group can also participate in MIPS as individuals or as part of an APM Entity; clinicians who participate in multiple ways will receive the highest final score attributed to them under their associated TIN/National Provider Identifier (NPI) combination. 	<ol style="list-style-type: none"> 1) A virtual group is defined as a combination of 2 or more TINs assigned to 1 or more solo practitioners (who are also MIPS eligible clinicians) or to 1 or more groups consisting of 10 or fewer eligible clinicians (including at least 1 MIPS eligible clinician), or both. 2) Clinicians that wish to form a virtual group must submit an election prior to the start of the 2022 performance year. The virtual group election period for the 2022 performance year closed on December 31, 2021. 3) MIPS eligible clinicians in a virtual group will receive the virtual group's final score and receive a MIPS payment adjustment based on the virtual group's final score, even if data are submitted at the group, individual or APM Entity level. <p>Want more information on virtual groups? Additional information on virtual group participation in MIPS is available in the Virtual Group Toolkit (ZIP).</p>

Group Participation Examples

Example 1: A practice has 4 physicians on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A enrolled in Medicare during the performance year.
- Clinician B enrolled in Medicare prior to the performance year but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D each enrolled in Medicare prior to the performance year and exceed the low-volume threshold as individuals at this practice.

For the 2022 performance year, the practice:

- Participates in MIPS at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 physicians as appropriate to the measures selected. For improvement activities, 2 physicians would be required to attest to completing the same activity during the performance year.

The group earns a final score that corresponds to a +1.2% MIPS payment adjustment based on their performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by **Clinicians B, C, and D** in the 2024 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- Clinician A isn't eligible to receive a MIPS payment adjustment because the clinician was newly enrolled in Medicare.

Group Participation Examples (Continued)

Example 2: A practice has a clinical pharmacist (Clinician A) and three physicians (Clinicians B, C, and D) on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A is a clinical pharmacist which isn't a MIPS eligible clinician type.
- Clinician B is a MIPS eligible clinician type but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D are MIPS eligible clinician types and exceed the low-volume threshold as individuals at this practice.

For the 2022 performance year, the practice:

- Participates at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 clinicians as appropriate to the measures selected. For improvement activities, 2 clinicians would be required to attest to completing the same activity during the performance year.

The group earns a final score that corresponds to a +0.5% MIPS payment adjustment based on their performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by **Clinicians B, C and D** in the 2024 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- The payment adjustment will not be applied to Clinician A because she is not a MIPS eligible clinician type.



Eligibility & Participation

Low-Volume Threshold

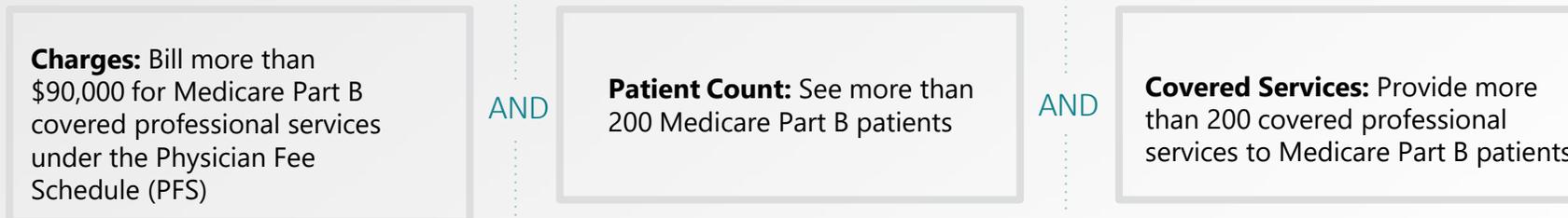
TIP: One professional claim line with positive allowed charges is considered one covered professional service.

How do you determine if our practice is eligible to participate in MIPS as a group?

We look at your Medicare Part B claims from two 12-month segments, called the MIPS Determination Period, to evaluate the total volume of care your practice provides to Medicare patients.



During each segment, we look to see if you and your practice exceed the low-volume threshold criteria:



To be eligible for MIPS, your practice must exceed all 3 of the low-volume threshold criteria during both 12-month segments of the MIPS Determination Period. Your practice may be eligible to opt-in to participate in MIPS as a group if you exceed some, but not all, of the low-volume threshold criteria.

Did you know? If your practice is newly formed or has otherwise established a new TIN between October 1, 2021, and September 30, 2022, we will only evaluate your eligibility during segment two).

Low-Volume Threshold (Continued)

What does it mean if our group is “opt-in eligible”?

If your group is otherwise eligible for MIPS and exceeds 1 or 2, but not all 3 low-volume threshold criteria, you are **opt-in eligible**.

If the group is opt-in eligible, you can:

Do nothing. Your group isn't required to participate in MIPS.

OR

Elect to opt-in. If your group decides to opt-in, the group will submit data at the group level, receive performance feedback, and the MIPS eligible clinicians within the group will receive a MIPS payment adjustment in 2024.

OR

Elect to voluntarily report. If your group wants to participate in MIPS but doesn't want its clinicians to receive a MIPS payment adjustment in 2024, the group can voluntarily report data and receive limited performance feedback.

The election to opt-in (or voluntarily report) to MIPS is irreversible. If you are considering this option, be sure to explore program requirements to ensure that you're prepared to collect and report on data needed to demonstrate successful performance.

How do we elect to opt-in or voluntarily report?

Opt-in eligible groups that want to submit data must submit an election before data can be submitted. Groups can submit this election themselves by signing in to qpp.cms.gov during the submission period and choosing to opt-in or voluntarily report. Alternately, if you're working with a Qualified Registry or QCDR, the vendor can submit this election on your behalf before submitting your data. (The [2021 MIPS Opt-In and Voluntary Reporting Election Guide \(ZIP\)](#) reviews what this process looked like for the 2021 performance year; at this time, we don't imagine significant changes to this process.)

Low-Volume Threshold (Continued)

Voluntary Reporting

If your group chooses to voluntarily report, your group will receive performance feedback based on the measures and activities for which the group submitted data. This can help to inform the group's potential future MIPS participation. If you submit data, you'll receive performance feedback, but the group's clinicians will not receive a MIPS payment adjustment. You can voluntarily report if you're identified as either MIPS exempt or as opt-in eligible for the 2022 MIPS performance year. Groups identified as opt-in eligible will need to submit their election before data can be submitted; groups identified as MIPS exempt can simply submit their data.



Eligible Groups vs. Opt-in Eligible Groups, and Group Voluntary Reporting

	Your group is eligible and chooses to submit data as a group	Your group is opt-in eligible and elects to opt-in	Your group voluntarily reports
Is the group required to make an active election indicating the chosen participation option?	NO	YES	YES, if you are opt-in eligible. NO, if your group isn't MIPS eligible.
Will the group receive performance feedback?	YES	YES	YES (no feedback on cost measures, Medicare Part B Claims quality measures, or administrative claims measures).
Will the MIPS eligible clinicians in the group receive a positive, neutral, or negative payment adjustment?	YES	YES	NO
Is the group's data eligible to be published in the Doctors & Clinicians section of Medicare Care Compare, formerly known as Physician Compare?	YES	YES	YES (but, able to opt-out of public reporting during preview period).
Will the group's quality measure submissions be used to establish historical MIPS measure benchmarks for future program years?	YES	YES	NO

Eligible Groups vs. Opt-in Eligible Groups, and Group Voluntary Reporting (Continued)

Can our group's eligibility change?

Yes, eligibility can change once we reconcile eligibility results from the 2 segments of the MIPS Determination Period. This information will be added to gpp.cms.gov in November/December 2022. If your group falls below all 3 elements of the low-volume threshold in either segment, your group will be ineligible to participate in MIPS as a group, except as voluntary reporters.

If you're currently eligible as a group, your group could:	If you're currently opt-in eligible as a group, your group could:	If you're currently ineligible as a group:
<ul style="list-style-type: none"> • Remain eligible; • Become opt-in eligible; or • Become ineligible (can still voluntarily report). 	<ul style="list-style-type: none"> • Remain opt-in eligible; or • Become ineligible (can still voluntarily report). 	<ul style="list-style-type: none"> • Your group will remain ineligible (can still voluntarily report).

Helpful hint: When you sign in to check your group's eligibility status, you can also view individual eligibility for the clinicians in your practice.

When you sign in before eligibility is updated in November/December of 2022:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2020, to Sept. 30, 2021, and received by CMS by October 30, 2021.

When you sign in after eligibility is updated in November/December of 2022:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2021, to Sept. 30, 2022, and received by CMS by October 30, 2022.
- If you have clinicians who participate in a MIPS APM, you may also see clinicians who didn't bill Medicare Part B claims but were identified as part of your practice on an APM participation list.

Did You Know?

It is possible for a practice to be opt-in eligible or ineligible as a group AND for a clinician in the practice to be individually eligible and required to participate in MIPS.

This can happen when a group falls below the low-volume threshold in the first segment and a new clinician joins in the second segment and exceeds the low-volume threshold.



Quick Reference: Special Status Designations

We determine if a group qualifies for most special statuses by reviewing Medicare Part B claims data from the two 12-month segments of the MIPS Determination Period.

The following table outlines special status designations and their impact on group reporting requirements for the 2022 performance year.

If a group has a “special status”, this will be indicated on qpp.cms.gov.

[Sign In](#) and navigate to the “Eligibility & Reporting” page

Or check the [QPP Participation Status NPI Lookup Tool](#)

(Click **Expand** next to the clinician’s name and scroll down to ‘Practice Level’ in the Other Factors section)

Special Status/ Reporting Factor	Description	Impact to MIPS Reporting and Scoring
Ambulatory Surgical Center (ASC)-based	All MIPS eligible clinicians associated with your practice are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Hospital-based	More than 75% of the MIPS eligible clinicians associated with your practice are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Non-patient Facing	More than 75% of the clinicians billing under your practice’s TIN meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points). Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no promoting interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.

Quick Reference: Special Status Designations (Continued)

Special Status/ Reporting Factor	Description	Impact to MIPS Reporting and Scoring
<p>Facility-based</p>	<p>More than 75% of the clinicians in the TIN are facility-based as individuals. Groups are assigned to the facility at which the plurality of clinicians in the TIN were assigned as individuals.</p> <p>Note: We don't evaluate clinicians and groups for the facility-based status in the 2nd segment of the MIPS Determination Period. The facility-based status and assigned facility currently displayed on qpp.cms.gov will only be updated if the assigned facility doesn't receive a Fiscal Year (FY) 2023 Hospital Value Based Purchasing (VBP) Program score.</p>	<p>Your group may qualify to receive scores for the quality and cost performance categories based on your assigned facility's FY 2023 Hospital VBP Program score.</p> <p>*To receive facility-based scoring as a group, your group must submit group level data for the improvement activities and/or Promoting Interoperability performance category(ies) to signal your intent to participate as a group.</p>
<p>Small Practice</p>	<p>There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.</p>	<p>NEW: Your group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%.</p> <p>Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points instead of 20 points).</p> <p>Groups who submit at least 1 quality measure will also receive 6 bonus points for the quality performance category.</p> <p>View Appendix D for additional information on the redistribution policies that apply to small practices.</p>



Quick Reference: Special Status Designations (Continued)

Special Status/ Reporting Factor	Description	Impact to MIPS Reporting and Scoring
Health Provider Shortage Area (HPSA)	More than 75% of the clinicians in the TIN are designated as practicing in a HPSA as individuals.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points).
Rural	More than 75% of the clinicians billing under the practice's TIN are in a ZIP code designated as rural using the most recent FORHP ZIP code file.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points instead of 20 points).





**Quality Performance
Category**

Overview

The quality performance category assesses health care processes, outcomes, and patient experiences of their care. This category accounts for 30% of your final score, unless you qualify for reweighting in another performance category.

Measure Selection

How many quality measures do we need to select?

The CMS Web Interface will sunset as a reporting option for traditional MIPS after the 2022 performance year.

You will need to:

Report on at least 6 MIPS quality measures, including at least 1 outcome measure. If no outcome measures are applicable, you may report another high priority measure.

OR

Report on a defined specialty measure set (if the specialty measures set has less than 6 measures, you'll meet quality reporting requirements if you report all the measures in the specialty set).

OR

Register for the CMS Web Interface and report on all 10 CMS Web Interface measures (You'll be automatically registered for the CMS Web Interface if you reported via the CMS Web Interface in 2021).

Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population and can choose from one or more collection types.

A collection type is a set of quality measures with the same data completeness criteria and specifications that follow a consistent format.

Where can I find information on the 2022 quality measures?

You can find measure descriptions, specifications and benchmarks on the [Explore Measures & Activities](#) tool on qpp.cms.gov.

Helpful Hints:

- Make sure you've selected the 2022 performance year.
- Search by key words or terms applicable to the care you provide.

You can also review the [2022 Quality Quick Start Guide \(PDF\)](#) for more tips on choosing quality measures.



Measure Selection (Continued)

Does our group have to report quality data if we're a facility-based practice?

If your group is identified by CMS as having a facility-based special status and if your group's assigned facility has a FY 2023 Hospital VBP Program score, your group can use that score for the quality performance category in lieu of submitting quality measures. (Please remember that the facility-based status is predictive until fall/late 2022 when the FY 2023 scores are available.)

However, **groups must submit data for the improvement activities and/or Promoting Interoperability performance categories** to qualify for facility-based scoring. This data submission alerts us of your group's intent to participate as a group.

Keep in mind:

- We won't know if your group's assigned facility has a FY 2023 Hospital VBP Program score until the end of the performance year – at this point, we will remove the facility-based status from any clinician or group assigned to a facility without a FY 2023 score.
- You can still submit quality measures. We'll calculate 2 final scores – 1 with facility-scoring and 1 without – and assign the higher final score to the group.
- Please review the [2022 Facility-Based Quick Start Guide \(PDF\)](#) for more information.

What do we need to know about collection types?

With the exception of the CMS Web Interface measures, groups can report measures from a combination of collection types for a single quality performance category score.

For example, a small practice could:

Report 2 Medicare Part B claims measures throughout the performance period.

+

Work with a Qualified Clinical Data Registry (QCDR) to collect and report 2 electronic Clinical Quality Measures (eCQMs) and 2 QCDR measures on their behalf during the 2022 submission period.

=

All 6 of these measures would contribute to a single quality performance category score for the group.

Measure Selection (Continued)

The table below walks through the different collection types, provides links to the 2022 measure specifications and provides helpful hints.

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2022	What You Need to Know
eQMs	2022 eCQM Specifications (ZIP)	<ul style="list-style-type: none"> • Groups can report eQMs if they use technology certified to the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both by December 31, 2022. • Groups can report their eQMs themselves or work with a third party intermediary to report these measures on their behalf. • eQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
Medicare Part B Claims Measures	2022 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP)	<ul style="list-style-type: none"> • Only small practices (15 or fewer clinicians) can report Medicare Part B claims measures. • When reporting as a group, claims measures must still be reported with the clinician’s individual (rendering) NPI. Don’t report claims measures with the group’s organizational NPI. • NEW: We’ll only calculate a quality score for groups based on individual claims data if group-level data is submitted for the improvement activities and/or Promoting Interoperability performance categories. • Claims measures can be reported in combination with eQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure. • Review the 2022 Part B Claims Reporting Quick Start Guide (PDF) for more information.
MIPS Clinical Quality Measures (MIPS CQMs)	2022 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	<ul style="list-style-type: none"> • Groups can report their MIPS CQMs themselves or work with a third party intermediary to collect and report these measures on their behalf. • MIPS CQMs can be reported in combination with Medicare Part B claims measures, eQMs, QCDR measures, and the CAHPS for MIPS Survey measure.



Measure Selection (Continued)

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2022	What You Need to Know
QCDR Measures	2022 QCDR Measure Specifications (Excel)	<ul style="list-style-type: none"> • Groups will need to work with a CMS-approved QCDR to report these measures on their behalf. • QCDR measures can be a great option for groups that provide specialized care or who have trouble finding MIPS measures that feel relevant to their practice. • QCDR measures can be reported in combination with eQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.
CMS Web Interface Measures	2022 CMS Web Interface Specifications and Supporting Documents (ZIP)	<ul style="list-style-type: none"> • Groups (with 25 or more eligible clinicians) must register in advance to report through the CMS Web Interface. • All 10 measures must be reported under this option, and each measure must be reported for the first 248 patients (or all patients if the sample has less than 248 patients) in the sample. • CMS Web Interface measures can be reported in addition to the CAHPS for MIPS Survey measure. • Review the 2021 CMS Web Interface Quick Start Guide (PDF) for more information. The 2022 version of the guide will be available in spring 2022. • 2022 is the final year that groups can report CMS Web Interface measures – this quality collection and submission type will sunset starting with the 2023 performance period.
CAHPS for MIPS Survey Measure	2022 CAHPS for MIPS Survey Overview Fact Sheet (PDF)	<ul style="list-style-type: none"> • Groups (with 2 or more eligible clinicians) that wish to administer the CAHPS for MIPS Survey must register in advance. • The CAHPS for MIPS Survey assesses patients’ experiences with primary care services. This measure is most appropriate for groups that provide primary care services. • The group assumes all costs associated with the CMS-approved survey vendor they contract with to administer the survey. • This measure can be reported in combination with eQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures. It can also be reported in addition to the CMS Web Interface measures.



Measure Selection (Continued)

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2022	What You Need to Know
Administrative Claims Measures	<p>2022 Risk of Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS (ZIP)</p> <p>2022 Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty for MIPS Measure (ZIP)</p> <p>2022 Hospital-Wide All-Cause Unplanned Readmission Rate for MIPS Groups Measure (ZIP)</p>	<ul style="list-style-type: none"> • NEW: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions. <ul style="list-style-type: none"> ○ This measure will have a case minimum of 18 cases and will only apply to groups or virtual groups with at least 16 clinicians. • The Hip Arthroplasty and Knee Arthroplasty Complication Measure has a 3-year measurement period. • These measures don't count as 1 of the 6 measures required to meet quality reporting requirements.

Data Collection & Submission

How much data do we need to collect?

There is a **12-month performance period** for the quality performance category, which means that your group must collect data for each quality measure from January 1 – December 31, 2022.

Data completeness refers to the volume of **performance** data reported for the measure's eligible population.

- When reporting a quality measure, your submission must identify the total eligible population (or denominator) as outlined in the measure's specification. (For small practices reporting Medicare Part B claims measures, we identify the eligible population for you.)
- To meet data completeness criteria, you must then report performance data (performance met or not met, or denominator exceptions) for at least 70% of the total eligible population (denominator).
- Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking"), would not be considered true, accurate, or complete and may subject you to audit.
- Note that data completeness is specific to Medicare patients for Medicare Part B claims measures only; QCDR measures, MIPS CQMs and eCQMs should include all-payer data. Measures that don't meet data completeness will earn 0 points, unless you're a part of a small practice in which case the measure will earn 3 points.

In group participation, quality measure data (numerators, denominators, etc.) are aggregated for all the clinicians in the group when submitting QCDR measures, MIPS CQMs, and/or eCQMs. Your quality measure data should represent performance for all clinicians in the group (as applicable to the measure), not just the MIPS eligible clinicians in the practice.

Groups registered for the CMS Web Interface, and small practices choosing to report Medicare Part B claims measures, will submit data for their quality measures at the Medicare patient level.



Data Collection & Submission (Continued)

EHR-based Quality Reporting

- If you transition from one electronic health record (EHR) system to another during the performance period, you'll need to aggregate the data from the previous EHR and the new EHR into one report for the full 12-month reporting period prior to submitting the data.
- If your practice uses multiple EHR systems for clinicians billing under the same TIN, you'll also need to aggregate data into a single report prior to submitting the data. For cases in which there are more than one EHR systems being used under a single TIN during the 2022 performance year and 12 months of data isn't available, you're required to submit as much data as possible. If you're submitting eQMs, all EHR systems must be certified to the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

International Classification of Diseases 10th Revision (ICD-10) Updates

- Each year, the Value Set Authority Center (VSAC) releases updates to ICD-10 coding that take effect October 1st.
- We'll identify the measures that are significantly impacted by these updates in the 2022 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released in late September. Measures that are significantly impacted by ICD-10 updates will have a 9-month performance period, ending September 30th, before the ICD-10 code changes take effect.
- Other measures may be impacted by these code changes, but not significantly enough to shorten the performance period. You should continue to report these measures according to the specification, reporting on encounters that use the codes identified in the measure's 2022 specification. You won't report on encounters that use updated codes not identified in the measure's 2022 specification.

Data Collection & Submission (Continued)

Measures Affected by Significant Changes during the Performance Period

We expanded the list of reasons that a quality measure may be impacted during the performance period to include errors in the finalized measure specifications. These errors include, but aren't limited to:

- Changes to active status of codes
- The inadvertent omission of codes
- The inclusion of inactive or inaccurate codes

Under our existing policies for measures affected by significant changes during the performance period:

- We'll truncate the performance period to 9 months if 9 consecutive months of data is available.
- We'll suppress the measure if 9 consecutive months of data isn't available or may result in patient harm or misleading results.



Data Collection & Submission (Continued)

How do we submit our data?

Data will generally be submitted during the 2022 submission period, January 3 – March 31, 2023. Some data can be submitted by the group while other data must be submitted by a third party intermediary. The table below outlines the different submission types available for the quality performance category.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Practice/Group representative)	Medicare Part B Claims Measures (Only for Small Practices)	Through your routine billing practices.	Throughout the performance period, with dates of service in calendar year 2022. Claims must be received by CMS by March 1, 2023. Please check with your Medicare Administrative Contractor (MAC) for the date claims must be submitted to them to meet this deadline.
	eCQMs	Sign in to qpp.cms.gov and upload a Quality Reporting Document Architecture (QRDA) III file.	January 3 – March 31, 2023
	MIPS CQMs	Sign in to qpp.cms.gov and upload a QPP JavaScript Object Notation (JSON) file.	January 3 – March 31, 2023
	CMS Web Interface Measures (Only for Registered Groups)	Manually enter your data or upload a file into the CMS Web Interface. OR Use our CMS Web Interface Application Programming Interface (API).	January 3 – March 31, 2023
Third Party Intermediaries (QCDRs, Qualified Registries, and Health IT Vendors)	eCQMs MIPS CQMs QCDR Measures	Sign in to qpp.cms.gov and upload a QRDA III or QPP JSON file. OR Use our QPP Submission API.	January 3 – March 31, 2023
CMS Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of qpp.cms.gov .	Early 2023, following data collection (standardized annual timeframe).





**Cost Performance
Category**

Overview

The cost performance category measures Medicare payments made for care provided to patients and accounts for 30% of your group's final score.

Measure Review

For the 2022 performance year, there are 25 cost measures:

- The Total per Capita Cost (TPCC) measure;
- The Medicare Spending per Beneficiary Clinician (MSPB Clinician) measure;
- 15 Procedural Episode-based measures;
- 6 Acute Inpatient Medical Condition Episode-based measures; and
- 2 Chronic Condition Episode-based measures.

Your group won't choose measures for the cost performance category. We look at your group's claims data to determine which of these measures apply to you.

Where can I find information on the 2022 cost measures?

You can find the measure descriptions, specifications ("Cost Measure Information Forms"), and code lists on the [Explore Measures & Activities](#) tool on qpp.cms.gov. We use performance period data to establish benchmarks and score cost measures, so there is no historical benchmark information for cost measures.

Helpful Hint: Make sure you've selected the 2022 performance year.

Data Collection & Submission

How do we submit our data?

There are no data submission requirements for the cost performance category. We use Medicare Parts A and B claims data to calculate your group's performance on cost measures.

We will calculate performance on the cost measures on behalf of all clinicians in your group – including those who aren't eligible to participate in MIPS.

You will only be scored for the cost performance category on measures for which a benchmark exists and your group meets the case minimum. If your group falls below the case minimum on all of the cost measures, the 30% weight for the performance category will be reallocated to other performance categories.

- [Appendix C](#) provides additional information on the redistribution of performance category weights view (**small practices** should review [Appendix D](#)).



**Improvement Activities
Performance Category**

Overview

The improvement activities performance category measures participation in activities that improve clinical practice and generally accounts for 15% of your group's final score.

Activity Selection

View [Appendix D](#) for more information on performance category weighting for small practices

How many improvement activities do we need to perform and submit?

Most groups will need to implement and attest to between 2 and 4 activities to receive the maximum 40 points in this performance category. Groups that are identified as non-patient facing, rural, HPSA, or a small practice earn twice the points for each activity and will need to implement and attest to 1 high-weighted or 2 medium-weighted activities to receive the maximum 40 points.

To receive full credit in this category if you're a certified or recognized patient-centered medical home or comparable specialty practice:

At least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice (by October 1, 2021)

AND

The group must attest to their status as a certified or recognized patient-centered medical home or comparable specialty practice during the submission period.

Where can I find information on the 2022 improvement activities?

You can find activity descriptions and weights on the [Explore Measures & Activities](#) tool on qpp.cms.gov.

Helpful Hints:

- Make sure you've selected the 2022 performance year.
- Search by key words or terms applicable to the care you provide.



Data Collection & Submission

What are the requirements for a group to attest to having completed an improvement activity?

A group can attest to an activity when at least 50% of the clinicians in the practice perform the activity. Each clinician must perform the activity for a continuous 90-day period during calendar year 2021 unless a different performance period is specified in the activity description. However, clinicians in the group don't have to perform the activity concurrently and don't have to be eligible for MIPS to be included in the 50% threshold.

Qualifying APM Participants (QPs) are excluded from MIPS and aren't required to report on any MIPS performance category. If your group includes some clinicians who participate in an Advanced APM and have QP status, they don't count toward the requirement that 50% of clinicians in the group perform the activity. However, you can include them in the 50% if they choose to perform the activity.

Example. Practice A has 4 clinicians and is reporting as a group. Clinician 1 and Clinician 2 are QPs, Clinician 3 and Clinician 4 aren't.

- If Clinicians 1 and 2 (the QPs) don't perform the activity, the group will meet the 50% threshold and can attest to the activity as long as **either** Clinician 3 or Clinician 4 perform the activity.
- If Clinicians 1 and 2 (the QPs) perform the activity, the group will meet the 50% threshold and can attest to the activity even if **neither** Clinician 3 or Clinician 4 perform the activity.

Data Collection & Submission (Continued)

How do we submit our data?

You can attest to your improvement activities yourself or use a third party intermediary to submit improvement activity data on your behalf during the 2022 submission period, January 3 – March 31, 2023. The table below outlines the different submission types available for the improvement activities performance category.

Qualified Registries and QCDRs generally must support all performance categories to be approved by CMS. However, if you're working with a QCDR or Qualified Registry, you should verify that they can support and submit your selected improvement activities.

Who	How
You (practice/group representative)	Sign in to qpp.cms.gov and attest to the activities you've implemented.
You (practice/group representative) or a third party intermediary	Sign in to qpp.cms.gov and upload a file with your activity attestations.
Third party intermediary	Perform a direct submission on your behalf, using our submissions API.



**Promoting Interoperability
Performance Category**

Overview

The Promoting Interoperability performance category promotes patient engagement and the electronic exchange of health information using CEHRT. This performance category accounts for 25% of your group's final score.

Measure Review

Which Promoting Interoperability measures do we have to report?

The 2022 Promoting Interoperability performance category focuses on 4 objectives:

- e-Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

View the following fact sheets for additional information on the new Promoting Interoperability measure and revised attestation statement:

- [2022 High Priority Practices SAFER Guides Fact Sheet \(PDF\)](#)
- [2022 Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Fact Sheet \(PDF\)](#)

Within these objectives, there are 5 to 6 required measures (dependent upon which measure(s) you choose to report for the HIE objective) in addition to the Security Risk Analysis measure, (new) High Priority Practices SAFER Guides measure, (revised) Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation (formerly called the information blocking attestation), and ONC direct review attestation. Some of these measures have exclusions; if you qualify, you can claim (submit) the exclusion instead of reporting the measure.

Your group may qualify for an exception or reweighting of this performance category.

Where can I find information about the 2022 Promoting Interoperability measures?

You can find measure specifications, exclusion information, and details about the attestations on the [Explore Measures & Activities](#) tool on qpp.cms.gov.

Helpful Hint: Make sure you've selected the 2022 performance period.



Data Collection & Submission

You must use CEHRT to collect your Promoting Interoperability performance category data. For the 2022 performance period, MIPS eligible clinicians may use certified technology meeting the existing 2015 Edition certification criteria, updated to the 2015 Edition Cures Update, or a combination of the two.

The CEHRT functionality must be in place by the first day of the Promoting Interoperability performance period.

The product must be certified to the 2015 Edition (and/or 2015 Edition Cures Update) criteria by the last day of the Promoting Interoperability performance period.

MIPS eligible clinicians must be using the 2015 Edition/2015 Edition Cures Update functionality for the **full** Promoting Interoperability performance period.

If your practice has several EHRs and not all are certified to the 2015 Edition, you will submit only the data collected in the 2015 Edition/2015 Edition Cures Update CEHRT.

Reminder:

A group is considered hospital-based and eligible for reweighting when **more than 75%** of the clinicians in the group meet the definition of a hospital-based individual MIPS eligible clinician.

The hospital-based status is different than the facility-based status which has implications for quality reporting. [Learn more.](#)

How much data do we need to collect?

Groups need to report the data collected in their 2015 Edition/2015 Edition Cures Update CEHRT for all required measures (or meet and claim an exclusion, if applicable) for a minimum of a continuous 90-day period during calendar year 2022.

In group participation, measure data from CEHRT (numerators and denominators) are aggregated for all of the MIPS eligible clinicians in the group.

You can submit a “yes” for the 2 required measures in the Public Health and Clinical Data Exchange objective as long as one MIPS eligible clinician is in active engagement with the registry.

Groups are only required to submit data from their MIPS eligible clinicians for this performance category.



Data Collection & Submission (Continued)

How does reweighting of the Promoting Interoperability performance category apply to groups?

A group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when:

- The group is identified on the [QPP Participation Status Lookup Tool](#) as hospital-based, ASC-based, non-patient facing, or (new for 2022) a small practice at the practice level; **OR**
- All of the group's MIPS eligible clinicians qualify individually for reweighting based on their clinician type, special status, or approved significant hardship exception. If any MIPS eligible clinician within the group doesn't qualify for reweighting, the group must submit Promoting Interoperability data.

If the group qualifies for reweighting but submits any data in this performance category, the group will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the final score.

What if clinicians in the group are facing a significant hardship?

There may be circumstances, out of your control, that make it difficult for you to meet the MIPS requirements. If each of the MIPS eligible clinicians in a group face a significant hardship and may qualify as individuals for reweighting the Promoting Interoperability performance category, the group may submit an application to have their Promoting Interoperability performance category score be reweighted to 0%.

If approved, the group will have their Promoting Interoperability performance category score reweighted to 0% and the category weight will be reallocated to the quality or improvement activities performance categories.

NOTE: Groups that have been approved for a hardship exception, but submit any data in this performance category, will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the group's final score.

Data Collection & Submission (Continued)

What if clinicians in the group are facing a significant hardship? (Continued)

If any MIPS eligible clinician within the group doesn't qualify for a significant hardship exception (or doesn't otherwise qualify for reweighting), the group can't apply to have their Promoting Interoperability performance category reweighted to 0% and will need to submit data for this performance category, submitting all available measure data in their CEHRT.

Groups can submit a hardship exception application when:

- The entire practice has decertified EHR technology (impacting all MIPS eligible clinicians).
- The entire practice has insufficient internet connectivity (impacting all MIPS eligible clinicians).
- The entire practice faces extreme and uncontrollable circumstances (impacting all MIPS eligible clinicians) such as disaster, practice closure, severe financial distress or vendor issues.
- The entire practice lacks control over the availability of CEHRT (impacting all MIPS eligible clinicians).

Simply lacking 2015 Edition CEHRT doesn't qualify the MIPS eligible clinician or group for re-weighting.

Reminder: Small practices qualify for automatic reweighting of the Promoting Interoperability performance category starting with the 2022 performance year.

Data Collection & Submission (Continued)

What data do we have to submit?

In order to receive a score greater than 0 for the Promoting Interoperability performance category, your group must:



Collect your data in EHR technology with 2015 Edition functionality (certified by the last day of the performance period) for a minimum of any continuous 90-day period in 2022;



Submit a "yes" to the Actions to limit or Restrict Interoperability of CEHRT Attestation (formerly named Prevention of Information Blocking);



Submit a "yes" to the new SAFER Guides attestation measure. Additional information is available on the [SAFER Guides](#) webpage on [HealthIT.gov](#);



Submit a "yes" to ONC Direct Review Attestation;



Submit a "yes" that you have completed the Security Risk Analysis measure in 2022;



Report the 5 to 6 required measures or claim their exclusion(s); and

- For measures that require a numerator and denominator (as defined in the measure specifications), you must submit at least a one in the numerator



Provide your EHR's CMS identification code from the [Certified Health IT product List \(CHPL\)](#), available on [HealthIT.gov](#).

Data Collection & Submission (Continued)

When reporting as a group, do we need to include data from MIPS eligible clinicians who individually qualify for reweighting?

Yes. When submitting data as a group for the Promoting Interoperability performance category, the group should combine all their MIPS eligible clinicians' data. This includes the data of MIPS eligible clinicians who may qualify for a reweighting of the Promoting Interoperability performance category when submitting data individually.

If these MIPS eligible clinicians are part of the group and have data in the group's CEHRT, their data should be included in the group's data submission, and they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians in the group.

The following types of MIPS eligible clinicians qualify for an automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when submitting data individually.



Data Collection & Submission (Continued)

How do we submit our data?

You can submit your group's Promoting Interoperability data yourself or use a third party intermediary to submit data on your behalf during the 2022 submission period, January 3 – March 31, 2023. The table below outlines the different submission types available for the Promoting Interoperability performance category.

QCDRs and Qualified Registries generally must support all performance categories to be approved by CMS, though some are exempted from supporting the Promoting Interoperability performance category based on the types of clinician they support. If you're working with a QCDR or Qualified Registry, verify whether they can support and submit your Promoting Interoperability measures.

Who	How
You (practice/group representative)	Sign in to qpp.cms.gov and attest to (manually enter) your Promoting Interoperability data.
You (practice/group representative) or a third party intermediary	Sign in to qpp.cms.gov and upload a file with your data.
Third party intermediary	Perform a direct submission on your behalf, using our submissions Application Programming Interface (API).



**Scoring & Payment
Adjustments**

How is our group's data scored?

For practices that choose to participate at the group level, group performance is assessed and scored at the practice (TIN) level across all 4 MIPS performance categories for the 2022 performance year.

Each category is scored based on the aggregated (group-level) data submitted or collected on your group's behalf.

How are payment adjustments applied?

Each MIPS eligible clinician participating in MIPS at the group level will receive a payment adjustment in the 2024 payment year based on the group's performance in 2022. MIPS payment adjustments will be applied to covered professional services furnished by MIPS eligible clinicians under the Physician Fee Schedule.

MIPS eligible clinicians who submit data as a part of a group AND individually will be evaluated as an individual and as a group for all performance categories. We will take the higher of the 2 final scores and apply the MIPS payment adjustment associated with it.

When the practice (TIN) participates as a group,

- Any individual (NPI) included in the TIN who is excluded from MIPS because they aren't a MIPS eligible clinician type or are identified as a new Medicare-enrolled clinician, a QP, or Partial QP **won't** receive a MIPS payment adjustment, regardless of their MIPS participation.
- Clinicians who are below the low-volume threshold as individuals, but otherwise eligible for MIPS, **will** receive a MIPS payment adjustment when reporting as a group provided no other exclusions apply to them.

What happens if a clinician joins our group after September 30 of the performance year?

We finalized in past rulemaking our policy for clinicians who start billing Medicare Part B claims at a practice (TIN) between October 1 and December 31, 2022.

- When the practice participates as a group, these clinicians will receive the group's final score and associated payment adjustment unless they are otherwise excluded (see the answer to the previous question).
- These clinicians will receive a neutral payment adjustment if the practice doesn't report as a group.

What happens if a clinician leaves our group during the performance year?

When submitting data as a group, your practice will report aggregated data from the clinicians billing under your TIN as appropriate to the measures and activities you select. This may include data from clinicians who left your practice prior to the end of the 2022 performance year.

Even if a MIPS eligible clinician left your practice, the clinician will still receive a final score and payment adjustment based on your practice's performance which may follow the clinician to any new practice (TIN) they join for the 2024 payment year.



Help, Resources, and Version History

Where Can I Get Help?

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.

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

Additional Resources

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

- [2022 MIPS Overview Quick Start Guide \(PDF\)](#)
- [2022 Cost User Guide \(PDF\)](#)
- [2022 Improvement Activities User Guide \(PDF\)](#)
- [2022 Promoting Interoperability User Guide \(PDF\)](#)
- [2022 Eligibility and Participation User Guide \(PDF\)](#)
- [2022 Facility-Based Quick Start Guide \(PDF\)](#)
- 2022 Quality User Guide (PDF)
- 2022 CMS Web Interface Quick Start Guide (PDF)
- 2022 Registration Guide for CMS Web Interface and CAHPS for MIPS (PDF)



Version History

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

Date	Description
4/1/2022	Original Posting.



Appendices

MIPS Group Participation Timeline

Participation and data submission deadlines for the 2022 performance year are included in the chart below. You can also visit the [performance year 2022 timeline](https://www.cms.gov/qpp/performance-year-2022-timeline) on [qpp.cms.gov](https://www.cms.gov/qpp).

Below are some key dates for MIPS group participation:

Dec. 2021	Jan. 1, 2022	Apr. 1, 2022	May 2022	June 30, 2022
<p>Initial 2022 performance year eligibility available.</p> <p>DO NOW: Check preliminary eligibility on the QPP Website.</p>	<p>2022 MIPS performance year begins.</p> <p>DO NOW: Review collection types and available quality measures so you can start collecting quality data.</p>	<p>Registration period begins for the CMS Web Interface and the CAHPS for MIPS Survey.</p> <p>DO NOW: Create a QPP account (ZIP) and request the Security Official role for your practice if you don't have QPP credentials and your group wants to register.</p> <p>This is the last year groups can register for the CMS Web Interface. This submission and collection type won't be available beginning with the 2023 performance period.</p>	<p>MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exception Applications Window Opens.</p> <p>DO NOW: Review information about exception applications on the QPP website.</p>	<p>Registration deadline for the CMS Web Interface and CAHPS for MIPS survey.</p> <p>DO NOW: Complete your registration before 8:00 p.m. ET.</p>

MIPS Group Participation Timeline (Continued)

Below are some key dates for MIPS group participation:

<p style="text-align: center;">Oct. 3, 2022</p> <p>The first day of the final continuous 90-day performance period in 2022 (applicable to most improvement activities and to the Promoting Interoperability performance category).</p> <p>DO NOW: Start performing your measures and implementing activities if you haven't already.</p>	<p style="text-align: center;">Nov/Dec, 2022</p> <p>Final 2022 performance year eligibility available.</p> <p>DO NOW: Check final eligibility on the QPP website.</p>	<p style="text-align: center;">Dec. 31, 2022</p> <p>2022 MIPS performance year ends.</p> <p>DO NOW: Prepare for data submission.</p> <hr/> <p>MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exceptions Applications Window Closes.</p> <p>DO NOW: Complete and submit your application by 8p.m. ET (if applicable).</p>	<p style="text-align: center;">Jan. 3, 2022 – March 31, 2023</p> <p>MIPS data submission period for the 2022 performance year.</p> <p>DO NOW: Create a QPP account and request a role for your practice so you can submit data or review data submitted on your behalf.</p>	<p style="text-align: center;">Summer 2023</p> <p>MIPS Performance feedback will be available.</p> <p>DO NOW: Sign in to qpp.cms.gov to review your performance feedback and associated payment adjustment for your clinicians.</p>	<p style="text-align: center;">Jan 1, 2024</p> <p>MIPS payment adjustments for the 2022 performance year go into effect.</p> <p>DO NOW: Review the MIPS payment adjustment applied to covered professional services furnished by your MIPS eligible clinicians on your remittance advance.</p>
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Data Submission Checklists

Once your practice has decided to participate as a group, you will need to make some decisions about the ways you will collect and submit your aggregated data for each of the performance categories requiring data submission.

- If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
- There is no checklist for the cost performance category because there are no data submission requirements. We collect and calculate your cost data for you.

Quality Performance Category Submission Checklist

Determine whether your practice may qualify for facility-based measurement:

- Sign in to qpp.cms.gov to find out if your practice is currently identified as facility-based at the group level.
- Review the [2022 Facility-Based Quick Start Guide \(PDF\)](#)
- Verify your facility-based status in fall/late 2022.

If your practice is not facility-based, or is facility-based but chooses to collect and submit additional quality measures, you will need to:

- Select your measures and collection type(s):
 - If you're a small practice reporting any Medicare Part B claims measures, begin adding quality data codes (QDCs) to your clinicians' claims.
 - If applicable, register for the CMS Web Interface by June 30, 2022.
 - If applicable, register to administer the CAHPS for MIPS Survey by June 30, 2022.
 - If you're administering the CAHPS for MIPS Survey, review the list of 2022 CMS-approved survey vendors. We anticipate this list will be available on the QPP Resource Library in summer 2022.
 - If reporting eQMs, talk to your CEHRT vendor to make sure:
 - Your data can be aggregated to and exported at the TIN-level.
 - Your EHR will be certified to the 2015 Edition (or 2015 Edition Cures Update) by the end of the performance period.
 - If reporting MIPS QMs, review the 2022 Qualified Postings to find a [Qualified Registry \(EXCEL\)](#) or [QCDR \(EXCEL\)](#) that supports the measures you've selected.
 - If reporting QCDR measures, review the 2022 Qualified Postings to find a [QCDR \(EXCEL\)](#) that has been approved for QCDR measures that are relevant for your practice.

Quality Performance Category Submission Checklist (Continued)

- Make your data available to a third party intermediary as appropriate.**
- Create a QPP account and connect to your organization (if you haven't already) so you can:**
 - **Sign In and Upload** your eCQM data in a CMS-approved file format.
 - Report your measures through the **CMS Web Interface**.
 - Review the data submitted on your behalf during the submission period.
 - Review your performance on claims measures submitted throughout the performance period.

Improvement Activities Category Submission Checklist

- Determine whether your group qualifies for double points for each activity**
- Review and select your activities**
- Identify the clinicians who will implement the activities:**
 - Each activity must be implemented by at least 50% of the clinicians in the group.
 - Activities don't need to be performed concurrently, but each clinician must perform the activity for a minimum of 90 continuous days during calendar year 2022, unless otherwise specified in the activity description.
- Decide whether you will work with a third party intermediary to submit data for you:**
 - If you decide to work with a QCDR, review the [2022 Qualified Postings \(EXCEL\)](#) and find one that supports the improvement activities performance category.
 - If you decide to work with a Qualified Registry, review the [2022 Qualified Postings \(EXCEL\)](#) and find one that supports the improvement activities performance category.
 - While you (or a third party intermediary) don't have to submit any supporting documentation when you attest to completing an improvement activity, you must keep documentation of the efforts your group undertook to meet the improvement activity for 6 years subsequent to submission. Review the [2022 MIPS Data Validation Criteria \(ZIP\)](#) for additional information.

Improvement Activities Category Submission Checklist (Continued)

- Make your data available to a third party intermediary, as appropriate**
- Create a QPP account and connect to your organization (if you haven't already) so you can:**
 - **Sign In and Upload** your activity data in a CMS-approved file format.
 - **Sign In and Attest** to your activities (providing 'Yes' values to the activities you've performed).
 - Review the data submitted on your behalf during the submission period.

Promoting Interoperability Performance Category Submission Checklist

- Determine whether your group qualifies for reweighting. If your group doesn't qualify for reweighting in this category, or does qualify but is able to collect and submit the Promoting Interoperability measures, you will need to:**
 - **Determine your performance period:**
 - A minimum of a continuous 90-day period in 2022.
 - Your EHR must have 2015 Edition (and/or 2015 Edition Cures Update) functionality in place by the first day of your performance period.
 - Your EHR must be certified to the 2015 Edition (and/or 2015 Edition Cures Update) by the last day of your performance period.
 - **Perform your annual [Security Risk Analysis \(ZIP\)](#)**
 - **Decide whether you will work with a third party intermediary to submit data for you:**
 - If you decide to work with a QCDR, review the [2022 Qualified Postings \(EXCEL\)](#) and find one that supports the Promoting Interoperability performance category.
 - If you decide to work with a Qualified Registry, review the [2022 Qualified Postings \(EXCEL\)](#) and find one that supports the Promoting Interoperability performance category.
 - If you decide to extract your measures directly from your CEHRT, talk to your CEHRT vendor to make sure your data can be aggregated to and exported at the TIN-level.
 - **Make your data available to a third party intermediary, as appropriate (including your EHR's ONC certification ID).**
 - **Create a QPP account and connect to your organization (if you haven't already) so you can:**
 - **Sign In and Attest** to your Promoting Interoperability data (reporting aggregated numerators and denominators, or 'Yes/No' values, as appropriate for measures and required attestation statements).
 - **Sign In and Upload** your Promoting Interoperability data in a CMS-approved file format.
 - Review the data submitted on your behalf during the submission period.

Performance Category Weight Redistribution Policies

Attention: If you are a small practice, please review [Appendix D](#) for the redistribution policies that apply to you.

Performance Category Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Reweighting Applies	30%	30%	15%	25%
Reweight 1 Performance Category				
No Cost	55%	0%	15%	30%
No Promoting Interoperability	55%	30%	15%	0%
No Quality	0%	30%	15%	55%
No Improvement Activities	45%	30%	0%	25%
Reweight 2 Performance Categories				
No Cost and No Promoting Interoperability	85%	0%	15%	0%
No Cost and No Quality	0%	0%	15%	85%
No Cost and No Improvement Activities	70%	0%	0%	30%
No Promoting Interoperability and No Quality	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities	70%	30%	0%	0%
No Quality and No Improvement Activities	0%	30%	0%	70%

Performance Category Weight Redistribution Policies for Small Practices

For the 2022 performance year, we've updated the performance category redistribution policies for small practices **to more heavily weight the improvement activities performance category** when other performance categories are reweighted.

Standard weighting for small practices (Promoting Interoperability automatically reweighted)

Quality



40% of MIPS Score

Cost



30% of MIPS Score

Improvement Activities



30% of MIPS Score

Promoting Interoperability



0% of MIPS Score

When both the **cost** and the **Promoting Interoperability** performance categories are reweighted:

Quality



50% of MIPS Score

Cost



0% of MIPS Score

Improvement Activities



50% of MIPS Score

Promoting Interoperability



0% of MIPS Score

NOTE: The following scenarios apply to all participating in MIPS, not just small practices.

When both the **quality** and the **Promoting Interoperability** performance categories are reweighted:

Quality



0% of MIPS Score

Cost



50% of MIPS Score

Improvement
Activities



50% of MIPS Score

Promoting
Interoperability



0% of MIPS Score

When **no** performance categories are reweighted (this means you submitted Promoting Interoperability data):

Quality



30% of MIPS Score

Cost



30% of MIPS Score

Improvement
Activities



15% of MIPS Score

Promoting
Interoperability



25% of MIPS Score