Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Participating in the Quality Performance Category in the 2021 Performance Year: Traditional MIPS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

Already know what MIPS is?
Skip ahead by clicking the links in the Table of Contents.

Purpose: This detailed resource focuses on the quality performance category requirements under the traditional Merit-based Incentive Payment System (MIPS) (original framework for collecting and reporting data since the inception of the Quality Payment Program), providing requirements and practical information about quality measure selection, data collection, and submission for the 2021 performance period for individual, group, virtual group, and Alternative Payment Model (APM) Entity reporting. This resource doesn't address quality requirements under the APM Performance Pathway (APP).

How to Use This Guide

How to Use This Guide

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

Table of Contents

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

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

Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct you to more information and resources.

Overview

COVID-19 and 2021 Participation

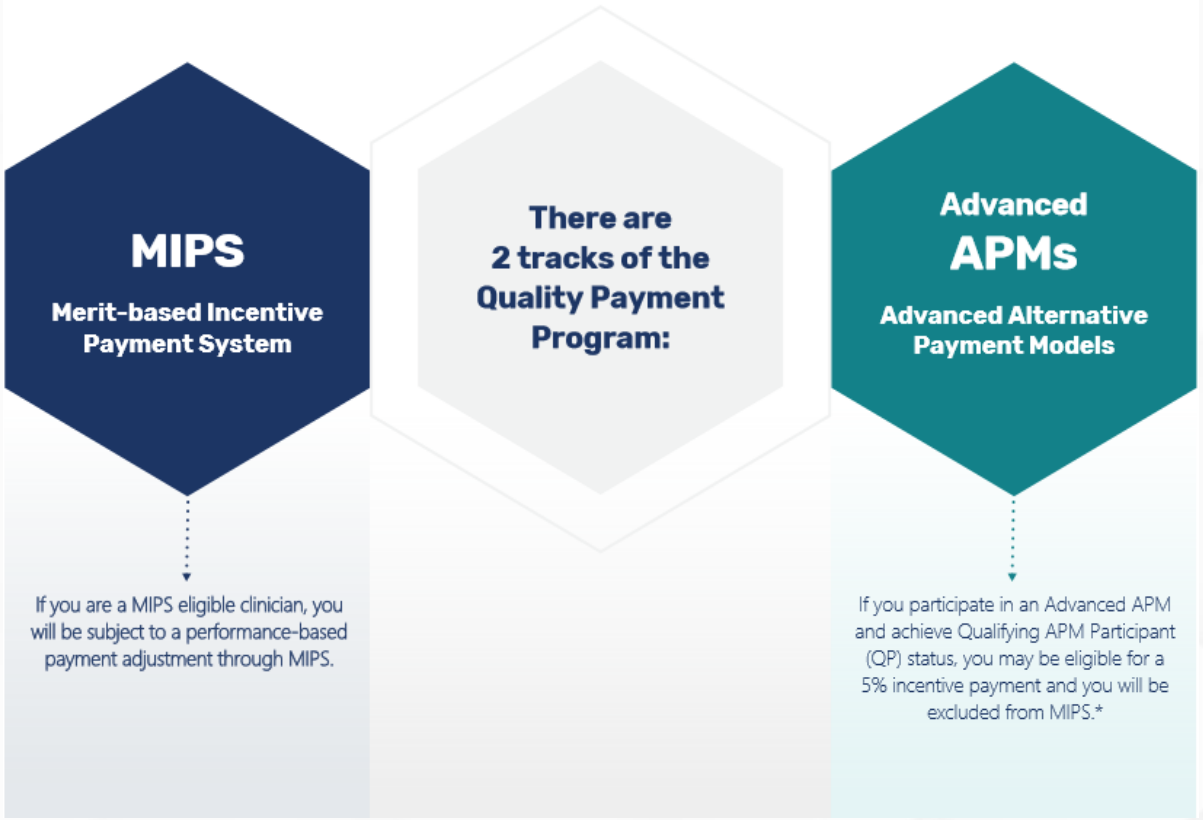
The 2019 Coronavirus (COVID-19) public health emergency continues to impact all clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2021 performance year, we will continue to use our Extreme and Uncontrollable 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 2021 along with additional resources.

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

For more information about the impact of COVID-19 on 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 Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which rewards value in one of 2 ways:



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

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in QPP, a program authorized by MACRA. The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and reward them for improving the quality of patient care and health outcomes.

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

If you're eligible for MIPS in 2021:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.
- 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 2021 performance year and applied to payments for covered professional services beginning on January 1, 2023.

To learn more about how to participate in MIPS:

- Visit the How MIPS Eligibility is Determined and Participation Overview webpages on the QPP website.
- View the 2021 MIPS Eligibility and Participation Quick Start Guide (PDF).
- Check your current MIPS 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 traditional MIPS, participants select from over 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks will be available to MIPS eligible clinicians:

The **APM Performance Pathway (APP)** is a streamlined reporting framework 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 a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority. We didn't propose any MVPs for implementation in 2021 but intend to do so through future rulemaking.

To learn more about the APP:

- Visit the APM Performance Pathway (APP) webpage on the QPP website.
- View the following:
  - 2021 APM Performance Pathway (APP) for MIPS APM Participants Fact Sheet (PDF)
  - 2021 APM Performance Pathway (APP) Infographic (PDF)
  - 2021 APM Performance Pathway Reporting Scenarios (PDF)
  - 2021 APM Performance Pathway Quick Start Guide (PDF)

To learn more about MVPs:

- Visit the MIPS Value Pathways (MVPs) webpage on the QPP website.

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

This guide examines the **quality performance category** under traditional MIPS for the 2021 performance year of QPP. For information about the quality performance category under the APP, please refer to the APP Quality Requirements webpage or the 2021 APM Performance Pathway Quick Start Guide (PDF).

Traditional MIPS Performance Category Weights in 2021: Individual, Group, and Virtual Group Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	20% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Traditional MIPS Performance Category Weights in 2021: APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
50%	0%	20%	30%

By law, the quality and cost performance categories must be equally weighed at 30% beginning with the 2022 performance period.

Quality Basics

Quality Basics

Quality Payment PROGRAM

Why Focus on Quality?

The quality performance category assesses the quality of care you deliver as evidenced by your performance on quality measures.

Quality measures are tools that help us to:

Measure health care processes, outcomes, and patient care experiences

AND

Link outcomes that relate to one or more of the following quality goals for health care that's:

- Effective
- Safe
- Patient-centered
- Equitable
- Timely

For the 2021 performance year, the quality performance category:

Is generally worth 40% of your MIPS Final Score for individual MIPS eligible clinicians, groups, and virtual groups participating in traditional MIPS (50% for MIPS eligible clinicians participating as an APM Entity)

AND

Has a 12-month reporting period

January 1, 2021 TO **December 31, 2021**

Quality Measures

For the 2021 performance period, you can choose measures most meaningful to your practice from more than **200 MIPS quality measures.**

To review the 2021 MIPS quality measures and Qualified Clinical Data Registry (QCDR) measures, visit the Explore Measures & Activities section of the QPP website and review the 2021 QCDR measure specifications.[1] Once you have found the MIPS quality measures that work for you, you'll need to look at the appropriate measure specifications for the collection type you choose to use.

MIPS scoring policies emphasize and focus on high priority measures that impact patients. High priority measures aren't an additional measure type, but fall within the following measure types:

- Outcome (includes intermediate outcome and patient-reported)
- Appropriate Use
- Patient Engagement/Experience
- Patient Safety
- Efficiency Measures
- Care Coordination
- Opioid-related

[1]Please check the Resource Library for updated QCDR measure specifications throughout the year as measure specifications may change.

Quality Measures (Continued)

Below is an overview of the 7 types of quality measures you may report for the quality performance category:

Quality Measures by Measure Type		
Measure Type	**Measure Type Definition**	**Example**
Process Measures	Process measures show what doctors or other clinicians do to maintain or improve the health of healthy patients or those diagnosed with a given condition or disease. These measures usually specify generally accepted recommendations for clinical practice.	The percentage of patients getting preventive services (such as mammograms or immunizations).
Outcome Measures	Outcome measures show how a health care service or intervention affects patients' health status.	The rate of surgical complications or hospital-acquired infections, such as surgical site infections.
Intermediate Outcome Measures	Intermediate outcome measures assess a factor or short-term result that contributes to an ultimate outcome. Under MIPS, intermediate outcome measures meet the outcome measure criteria.	Reducing a patient's blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.
Patient-Reported Outcome Measures	Patient-reported outcome measures are derived from outcomes reported by patients and can include any report of a patient's health condition, health behavior, or health care experience. These reports come directly from the patient without interpretation of the patient's response by a clinician. Under MIPS, patient-reported outcome measures meet the outcome measure criteria.	The percentage of patients who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.
Structure Measures	Structure measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care.	Using electronic support systems such as a continuity of care recall system or a reminder system for mammogram screenings.
Patient Engagement/Experience Measures	Patient Engagement/ Experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys.	Administering the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for MIPS Clinician/Group Survey measure.
Efficiency Measures	Efficiency measures can be used to assess the variability of the cost of health care and to direct efforts to make healthcare more affordable.	Ordering cardiac imaging when it does not meet the appropriate use criteria. Overusing neuroimaging in a target patient population (such as patients with headaches and a normal neurological exam).

Quality Measures (Continued)

As part of the Meaningful Measures initiative, we continue to incrementally remove process measures that require a limited quality action in order to move toward a streamlined inventory of meaningful and robust quality measures. For this approach, prior to removal, consideration will be given, but not limited to:

In addition, we assess the measure's adoption rate by assessing whether the measure meets case minimum and reporting volumes required for establishing a benchmark after being in the program for 2 consecutive performance periods. Removing measures by using this methodology ensures that the MIPS quality measures within the program are truly meaningful and measurable, where quality improvement is sought and measures with low reporting rates for 2 consecutive performance periods may be removed from MIPS.

- Appendix A identifies measures that were finalized for removal from the program, beginning with the 2021 performance period.
- Appendix B identifies measures that were finalized for removal for specific collection types, beginning with the 2021 performance period.

Reporting Requirements

To complete the reporting requirements for the quality performance category, you can:

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

OR

Report on all 10 required CMS Web Interface measures. This option is available to groups, virtual groups, and APM Entities with 25 or more clinicians that register in advance (April 1, 2021 - June 30, 2021) of the submission period. Registration isn't required for Shared Savings Program ACOs reporting on the CMS Web Interface measures as part of the reporting requirements under the APP.

The CMS Web Interface will **sunset** as a collection and submission type beginning with the 2022 performance period. If you have planned or are currently reporting MIPS quality measures through the CMS Web Interface, please start to prepare for a transition to a new collection type. For more information, please refer to quality resources on the QPP Resource Library.

For the quality performance category, all measures must be reported for the 12-month reporting period, January 1, 2021 - December 31, 2021.

NOTE: If you're a specialty group, you're not limited to reporting a defined specialty measure set. You may use the Explore Measures tool on the QPP website to search for measures relevant to your scope of practice.

Telehealth Guidance

As the COVID-19 public health emergency has affected the ability to perform patient-facing encounters, the use of telehealth capabilities has expanded.

Some quality measures include interactions occurring via telehealth. We encourage MIPS eligible clinicians, groups, virtual groups, and APM Entities to review other aspects of the quality action within the measure specification, including quality actions that cannot be completed by telehealth.

To determine whether the measure includes telehealth within the denominator, you should review the 2021 MIPS quality measures. If you have any questions on the ability to include encounters to report for measures that include telehealth capabilities, please contact the QPP Service Center.

For telehealth guidance related to electronic clinical quality measures (eCQMs), please review the Telehealth Guidance for eCQMs for Eligible Professional/Eligible Clinician 2021 Quality Reporting document posted on the Electronic Clinical Quality Improvement (eCQI) Resource Center for more information.

For CMS Web Interface users, please review the 2021 CMS Web Interface Measure Specifications and Supporting Documentation (ZIP) to determine if telehealth encounters are accepted for a specific measure.

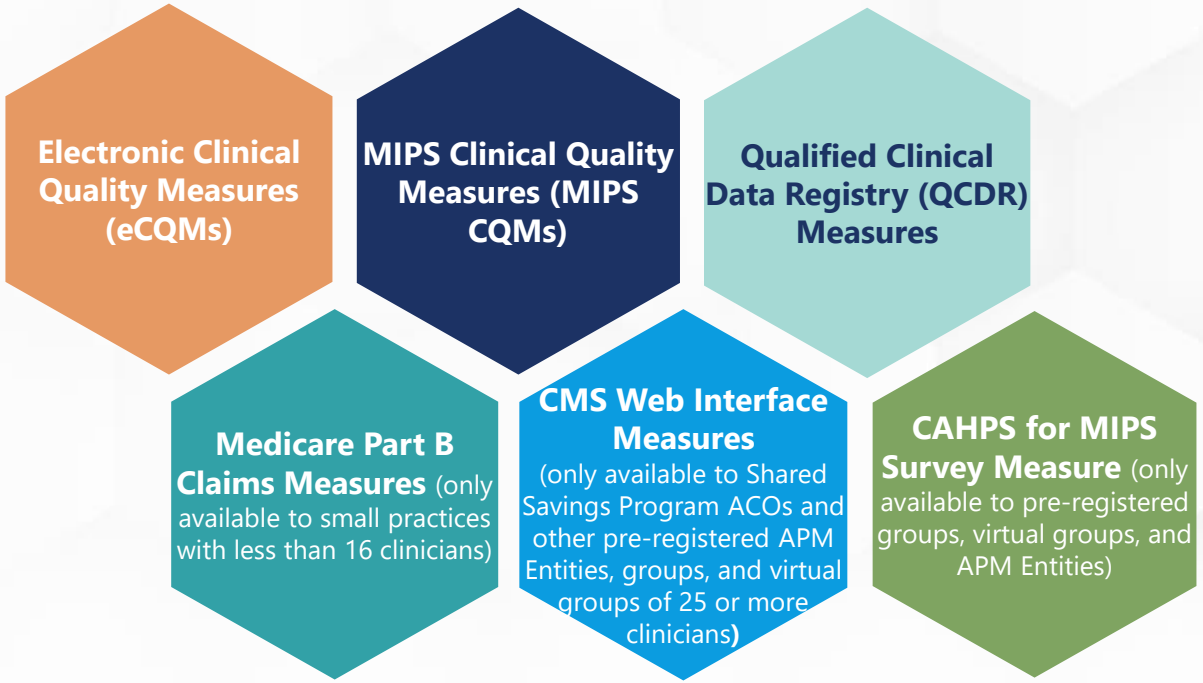
Collection Types

Collection Types

Collection Type refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.

For example: Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (< 9%), has different specifications depending on whether you're reporting the measure as an eCQM or as a Medicare Part B Claims measure. The data completeness criteria for Measure 001 are different as the eCQM includes all-payer data while the Medicare Part B Claims measure is limited to Medicare Part B patients.

There are 6 collection types, or ways you can collect and submit your quality measure data to CMS:



Collection Types (Continued)

There are 2 new MIPS quality measures that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment Program (MIPS) Eligible Clinician Groups (ZIP).
  - This measure will have a case minimum of 200 cases and will only apply to groups, virtual groups, and APM Entities.
- Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (ZIP).
  - This measure will have a case minimum of 25 cases and will apply to individuals, groups, virtual groups, and APM Entities.
  - This measure will also have a 3-year performance period (consecutive 36-month timeframe) that will start on October 1, 2018 (3 years prior to the performance period, and end on September 30, 2021 (current performance period), and proceed with a 3-month numerator assessment period.

The Hospital-Wide All-Cause Unplanned Readmission measure is replacing the All-Cause Readmission measure beginning with the 2021 performance period.

We'll aggregate quality measures collected through multiple collection types into a single quality performance category score. If you submit the same measure through multiple collection types, the one with the greatest number of achievement points will be selected for scoring. However, the CMS Web Interface measures can't be scored with collection types other than the CAHPS for MIPS Survey measure and/or administrative claims measures.

Collection Types

Quality Payment PROGRAM

Collection Types (Continued)

The table below provides additional details on each collection type, including the types available based on the way you plan to participate and submit data for traditional MIPS: as an individual, group, virtual group, or APM Entity.

Please note that ACOs participating in the Shared Savings Program are required to report the APP beginning with the 2021 performance period. If MIPS eligible clinicians or groups within an ACO choose to report through traditional MIPS in addition to the ACO's required reporting under the APP, they'll receive the higher MIPS Final Score and payment adjustment.

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?	Scoring Impact
Electronic Clinical Quality Measures (eCQMs)	2021 eCQM Specifications (ZIP) 2021 eCQM Flows (ZIP)	You can report eCQMs if you use technology that meets the 2015 Edition Certified Electronic Health Record Technology (CEHRT) criteria, the 2015 Edition Cures Update criteria, or a combination of both. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B Claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure that's collected in technology that meets the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both and submitted to CMS without manual manipulation (end-to-end electronic reporting). 1 bonus point will be given for each (additional) high priority measure reported. 2 bonus points will be given for each additional outcome measure reported.
MIPS Clinical Quality Measures (MIPS CQMs)	2021 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may choose to work with a Qualified Registry, QCDR, or Health IT vendor to support your data collection and submission. To see the lists of CMS-approved Qualified Registries and QCDRs, visit the QPP Resource Library. MIPS CQMs can be reported in combination with Medicare Part B Claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure (without an eCQM equivalent) that's collected in CEHRT and submitted to CMS without manual manipulation (end-to-end electronic reporting). 1 bonus point will be given for each (additional) high priority measure reported. 2 bonus points will be given for each additional outcome measure reported.

Collection Types

Quality Payment PROGRAM

Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?	Scoring Impact
Qualified Clinical Data Registry (QCDR) Measures	2021 QCDR Measure Specifications	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures which are approved during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that are relevant to their practice. You'll need to work with the QCDR to report these measures on your behalf. QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B Claims measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure collected in CEHRT and submitted to CMS without any manual manipulation (end to end electronic reporting). 1 bonus point will be given for each (additional) high priority measure reported. 2 bonus points will be given for each additional outcome measure reported.
Medicare Part B Claims Measures	2021 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP) 2021 Part B Claims Reporting Quick Start Guide (PDF)	Medicare Part B Claims measures are always reported with the clinician's individual (rendering) National Provider Identifier (NPI), even when participating as a group, virtual group, or APM Entity. Medicare Part B Claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals [Clinicians in small practices (fewer than 16 clinicians) only] • Groups [Small practices (fewer than 16 clinicians) only] • Virtual Groups (fewer than 16 clinicians in the virtual group) • APM Entities (fewer than 16 clinicians in the APM Entity)	1 bonus point will be given for each (additional) high priority measure reported. 2 bonus points will be given for each additional outcome measure reported.

Collection Types

Quality Payment PROGRAM

Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report using This Collection Type?	Scoring Impact
CMS Web Interface	2021 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)	If you want to report through the CMS Web Interface, groups, virtual groups, and APM Entities must register between April 1, 2021 and June 30, 2021. Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare patients for each measure within the application.	• Groups (registered groups with 25 or more clinicians) • Virtual Groups (registered virtual groups with 25 or more clinicians) • APM Entities (Shared Savings Program ACOs and registered APM Entities with 25 or more clinicians)	1 bonus point will be given for each eligible measure (capped at 10% of denominator) collected in your CEHRT and submitted directly to CMS via the CMS Web Interface Application Programming Interface (API) or Excel upload (end-to-end electronic reporting criteria).
CAHPS for MIPS Survey Measure	2021 CAHPS for MIPS Survey Overview Fact Sheet (PDF)	Groups, virtual groups and APM Entities can register between April 1, 2021 and June 30, 2021 to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience and care within a group, virtual group or APM Entity. This survey must be administered by a CMS-Approved Survey Vendor (PDF). This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B Claims measures, and QCDR measures.	• Groups (registered groups with 2 or more clinicians) • Virtual Groups (registered virtual groups with 2 or more clinicians) • APM Entities (registered APM Entities with 25 or more clinicians)	This is a patient engagement/experience survey measure that fulfills the requirement to report at least one high priority measure if no other outcome measure is available. 2 bonus points may be awarded if you report the required outcome measure through another collection type.

TIP: To review the 2021 MIPS quality measures, visit the Explore Measures & Activities section of the Quality Payment Program website and choose the 2021 performance year.

Collection Types (Continued)

What if I don't have 6 applicable measures, or an applicable outcome/high priority measure?

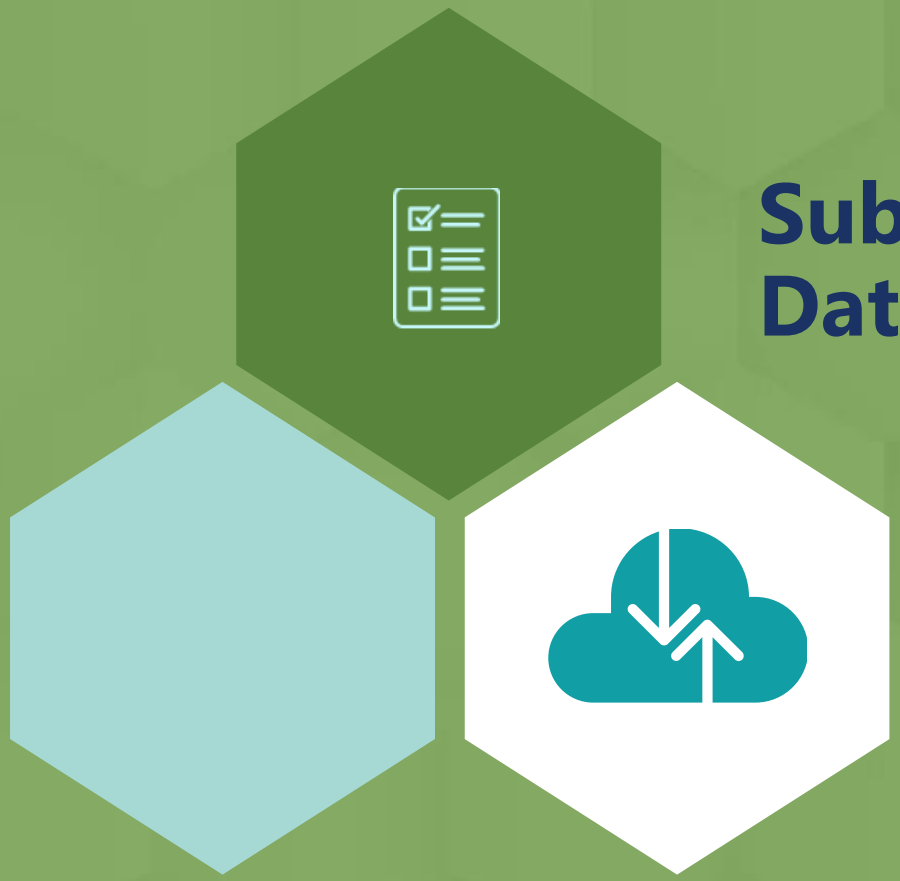
Start by reviewing the specialty measure sets. You can meet quality reporting requirements by reporting a complete specialty measure set, even if the measure set includes fewer than 6 measures.

If a specialty measures set doesn't apply to you, report all available measures that are clinically relevant to your practice. CMS will review the measure data submitted by you to determine if there were any other quality measures you may have been able to report. The MIPS Eligible Measure Applicability (EMA) process is applied to individuals, groups, virtual groups and APM Entities that have reported Medicare Part B Claims measures or MIPS CQMs and can result in scoring adjustments to reflect the number of required measures.

More information on the 2021 performance period EMA process and the measures we've identified as clinically related will be available on the QPP Resource Library by fall 2021.

Not sure where to begin?

Check out the 2021 Quality Quick Start Guide (PDF) for the 5 steps to help you get started with meeting the reporting requirements for the quality performance category.



Submitting Quality Data

Submitting Quality Data

Following the 2021 performance year, we'll assess your performance in the quality performance category based on the quality measure data you submit.

The 2021 performance period data submission period will open **January 3, 2022, and close March 31, 2022**.

Exception: For the Medicare Part B Claims submission type (only available to small practices), you don't need to submit quality data. We receive quality data when claims are submitted for payment. Please note that your Medicare Part B Claims measure data must be processed by your Medicare Administrative Contractor (MAC) and received by CMS no later than 60 days following the close of the 2021 performance period.

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 2021 performance year and 12 months of data is not available, you're required to submit as much data as possible. If you're submitting eCQMs, all EHR systems must meet the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

Preliminary scoring information will be available beginning **January 3, 2022**, once data has been submitted.

Your final performance feedback will be available in **Summer 2022**.

You can review your performance feedback by signing in to https://qpp.cms.gov/login.

Submitting Quality Data (Continued)

The following chart outlines your options for submitting quality measure data based on your submission (submitter) and collection types.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When (Submission Period)
You (Individual, Group, Virtual Group, or APM Entity Representative)	Medicare Part B Claims Measures (small practices only)	Through your routine Medicare Part B Claims billing practices.	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2022)
	eCQMs	Sign in to qpp.cms.gov and upload a QRDA3 file.	January 3 – March 31, 2022
	MIPS CQMs	Sign in to qpp.cms.gov and upload a QPP JSON file.	January 3 – March 31, 2022
	CMS Web Interface	Manually enter your data and/or upload a file into the CMS Web Interface or use the CMS Web Interface API.	January 3 – March 31, 2022
Third Party Intermediaries: QCDRs, Qualified Registries, and Health IT Vendors	eCQMs MIPS CQMs QCDR Measures	Sign in to qpp.cms.gov and upload a QRDA3 or QPP JSON file or use our QPP Submission API.	January 3 – March 31, 2022
CMS-Approved Survey Vendors	CAHPS for MIPS Survey measure	Secure method outside of qpp.cms.gov.	Following data collection (standardized annual timeframe)

Submitting Quality Data (Continued)

The level at which you participate in MIPS (individual, group, or virtual group) generally applies to all MIPS performance categories. We won't combine data submitted at the individual, group, and/or virtual group level into a single MIPS Final Score.

For example:

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

Exception: When participating as an APM Entity, the APM Entity will submit data for the quality and improvement activities performance categories at the APM Entity level. However, MIPS eligible clinicians in the APM Entity will submit data for the Promoting Interoperability performance category either at the individual or group level; we'll calculate an average score for the Promoting Interoperability performance category.

When small practices report Medicare Part B Claims measures, we automatically calculate a quality score at both the individual and group levels. Additionally, we'll calculate a score at the virtual group or APM Entity level if appropriate.

Scoring

Scoring

Quality measures submitted for the 2021 performance period will receive **between 0 and 10** measure achievement points.

You'll receive:

Between **3 and 10 achievement points** based on your performance in comparison to a benchmark if the quality measure meets the data completeness criteria (generally 70%), has a benchmark, and the volume of cases is sufficient (≥ 20 cases for most measures).

OR

3 achievement points if your quality measure meets the data completeness criteria, but either 1) doesn't have a benchmark, and/or 2) the volume of cases you've submitted is insufficient (≤20 cases for most measures).*

OR

0 achievement points if your quality measure doesn't meet data completeness requirements, which varies by collection type.

- If you're a small practice with 15 or fewer eligible clinicians, you would receive 3 measure achievement points.*

*These measure achievement points scoring policies don't apply to CMS Web Interface measures and administrative claims-based measures. For more information on the CMS Web Interface measures scoring policies, please refer to the 2021 CMS Web Interface Quick Start Guide (PDF).

Topped Out Quality Measures

A process measure is considered topped out if the median performance rate is 95% or higher (non-inverse measure) or is 5% or lower (inverse measure). A non-process measure is considered topped out if the level of variance is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. We identify topped out measures annually through our benchmarking process. Measures that are topped out for 4 consecutive years can be proposed for removal through rulemaking.

A measure is considered extremely topped out if the average performance rate is 98% or higher (non-inverse measure) or is 2% or lower (inverse measure). We would consider this measure for removal in the next rulemaking cycle, regardless of whether or not it's in the midst of the topped out measure lifecycle. However, we may consider retaining the measure if there are compelling reasons as to why this measure shouldn't be removed (for example, if the removal would impact the number of measure available to a specialist type).

Are all Topped Out Measures capped at 7 points?

No. A measure is capped at 7 points when it's topped out through the same collection type for 2 consecutive years. The 7-point cap is applied in the second year the measure is identified as topped out.

To identify if a measure is topped out or capped at 7 points, refer to the 2021 Quality Benchmarks (ZIP).

A measure may be topped out without being capped at 7 points. A "Y" (for "Yes") in the **Seven Point Cap** column (Column Q) of the benchmark file referenced above indicates the measure is capped at 7 points.

NOTE: QCDR measures are excluded from the topped out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped out during the annual self-nomination process, it may not be approved for the applicable performance period.

Benchmarks

Each MIPS quality measure is assessed against its benchmark to determine how many points the measure earns.

How are the Benchmarks Established?

We establish benchmarks specific to each collection type: QCDR measures, MIPS CQMs, eCQMs, CMS Web Interface measures, the CAHPS for MIPS Survey measure, Medicare Part B Claims measures, and the administrative claims measures.

Whenever possible, we use historical data to establish benchmarks. The 2021 historical benchmarks for eCQMs, MIPS CQMs, Medicare Part B Claims measures, and QCDR measures are based on actual performance data that was submitted to QPP for the 2019 performance period. If a quality measure doesn't have a historical benchmark for any of these collection types, we'll attempt to calculate a benchmark based on data submitted for the 2021 performance period.

Some measures may have certain substantive changes to their specifications from one year to the next that the historical data cannot be used to establish a benchmark.

For example, Quality ID 238: Use of High-Risk Medications in Older Adults required a substantive change in the 2021 performance period. This substantive change no longer allows direct comparison of performance data from previous submissions. In this case, we'll attempt to calculate a benchmark based on data submitted for the 2021 performance period.

NOTE: We'll use flat benchmarks to score Measure 236 Controlling High Blood Pressure for the MIPS CQM and Medicare Part B Claims collection types, and Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (< 9%) for only the Medicare Part B Claims collection type, as historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient. For Measure 001, we'll use a historical, performance-based benchmark to score the measure for the MIPS CQM and eCQM collection type, and only the eCQM collection type for Measure 236.

Benchmarks (Continued)

NEW: We'll attempt to calculate performance period benchmarks for the Hip Arthroplasty and Knee Arthroplasty Complication measure and the Hospital-Wide All-Cause Unplanned Readmission measure for the 2021 performance period.

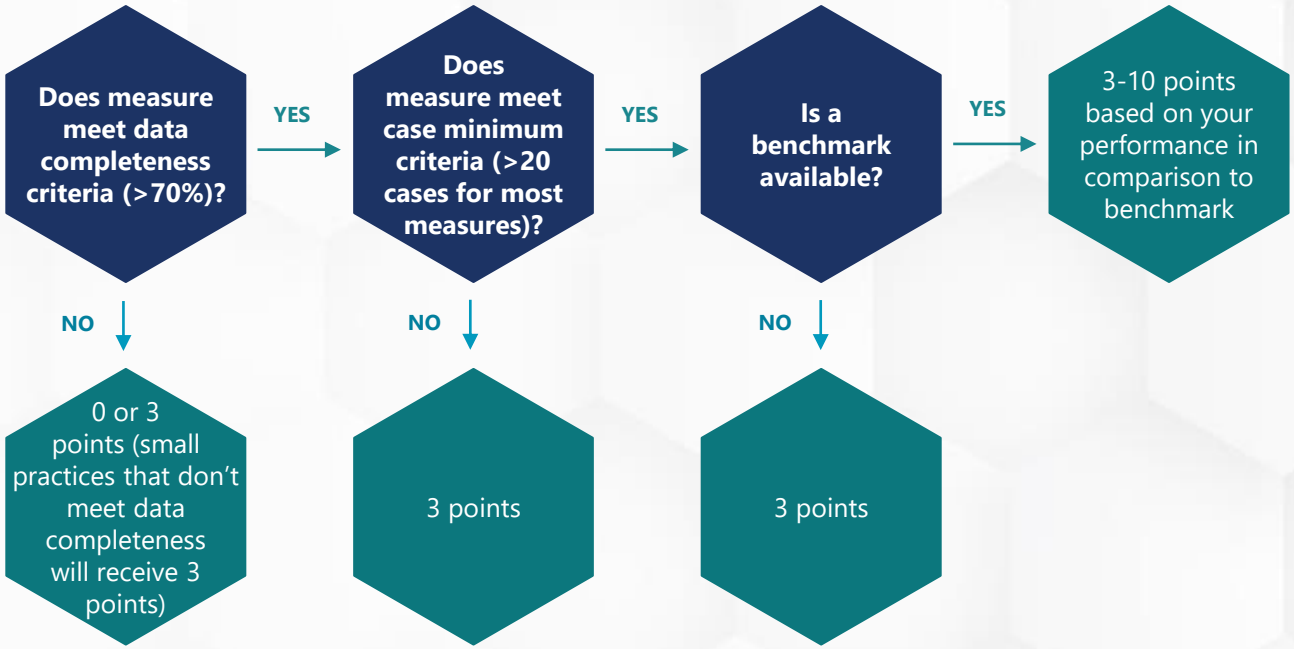
We use benchmarks from the Shared Savings Program to assess and score the CMS Web Interface measures. These benchmarks can be found in the Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs (PDF). (These benchmarks are also used for groups, virtual groups, and APM Entities that register to report CMS Web Interface measures for traditional MIPS).

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

Benchmarks (Continued)

How are Benchmarks Converted to Achievement Points?

- Each quality measure with a benchmark is scored using a 10-point scoring system, except for:
  - Measures capped at 7 points because they are in their second consecutive year of being topped out.
  - Measures that don't meet data completeness criteria.
  - Measures that are submitted with an insufficient case volume.
- Historical performance distribution for each measure is used to define deciles of performance that are used as the benchmark for the measure.



- The decile benchmarks are used to assign a measure score between 3 and 10 points.
- We compare your performance on a quality measure to the performance levels in the national deciles.
- The points you earn are based on the decile range that matches your performance rate.
- For measures with inverse performance rates, such as Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (< 9%) where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

Benchmarks (Continued)

NOTE: There is a 3-point floor for measures that can be reliably scored based on performance for the 2021 MIPS performance year. As a result, measures in the lowest deciles can't get less than 3 measure achievement points. (Reliably scored means a national benchmark exists, sufficient case volume has been met, and the data completeness requirement has been met.)

What if I chose a measure that doesn't have an historical benchmark?

- Quality measures that can't be reliably scored against a benchmark, or quality measures without an historical benchmark, will receive 3 measure achievement points (assuming the measure meets data completeness) unless a benchmark can be established with performance period data.
- If the measure doesn't also meet data completeness, it will receive 0 measure achievement points (except for small practices, which will receive 3 measure achievement points).
- The above applies to measures across all collection types except for the CMS Web Interface measures and administrative claims measures. The CMS Web Interface measures that don't have a benchmark aren't scored (included in the denominator) as long as the measure meets data completeness criteria.

Example 1

The below scoring example shows how to use the 2021 Quality Benchmarks (ZIP) to convert into measure achievement points, assuming that data completeness and case minimum have been met.

Measure 009: Anti-Depressant Medication Management, collected and reported as an eCQM.

Dr. Clark submits data for Measure 009 (eCQM) that results in a performance rate of 79.09% and 7.4 achievement points.

How?

This performance rate falls in Decile 7, which means a measure score of 7.0-7.9 points.

Scoring Example 1

$$\text{Achievement points} = X + \frac{(q - a)}{(b - a)}$$

$$\text{Achievement points} = 7 + \frac{(79.09 - 78.04)}{(80.94 - 78.04)}$$

$$\textbf{Achievement points} = \mathbf{7.4}$$

X = decile #
q = performance rate
a = bottom of decile range
b = top of decile range

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

$$\frac{(79.09 - 78.04)}{(80.94 - 78.04)} = 0.36206897\ldots$$

which is rounded to 0.4

Example 2

The below scoring example assumes case minimum and data completeness have been met.

Scoring Example 2

Measure XYZ[2] was collected and reported as a MIPS CQM but was significantly impacted by clinical guideline changes late in the performance year.

Lakeview Associates, a primary care clinic with 17 clinicians, submits 9 consecutive months of data as a group for Measure XYZ (MIPS CQM) that results in a performance rate of 85% and 8 achievement points.

How?

Starting with the 2021 performance year, new scoring flexibilities have been established to allow measures that are significantly impacted by clinical guideline or other coding changes to still be scored provided there are 9 consecutive months of reliable data.

If there aren't 9 consecutive months of reliable data, the measure will be suppressed. Suppressed measures won't be scored, and the total available measure achievement points will be reduced by 10 points for each suppressed measure that's submitted.

We'll identify measures that are significantly impacted by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) coding changes in the 2021 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released in late September 2021. Quality measures that are significantly impacted by clinical guideline or other coding changes will be publicly identified as soon as possible.

[2]Measures that are significantly impacted by clinical guideline or other coding changes for the 2021 performance year are yet to be determined.

Bonus Points

What is the end-to-end electronic reporting bonus?

You'll receive:

- **1 bonus point** per measure for reporting your quality data directly from your CEHRT without any manual manipulation. These are capped at **10%** of your quality performance category denominator.

What is the bonus for submitting additional outcome/high priority measures beyond the one required?

You'll receive:

- **1 bonus point** for each additional high priority measure.
- **2 bonus points** for each additional outcome measure.
- These bonus points aren't available to the additional high priority measures required by the CMS Web Interface. Bonus points are capped at **10%** of your quality performance category denominator.

How is the small practice bonus applied for the 2021 performance period?

Six bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least one MIPS quality measure. This bonus isn't added to individuals, groups, virtual groups, or APM Entities that are scored under facility-based scoring.

Note: If you submit eCQMs, you'll need to use CEHRT to collect the eCQM data. The CEHRT used to collect the eCQM data will need to meet the 2015 Edition CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.

.

Bonus Points (Continued)

How do these measure bonus points work?

Bonus points are added to the quality performance category achievement points (those earned based on performance) and each type of bonus is capped at 10% of the quality performance category denominator.

For example:

- Individuals, groups, virtual groups, and APM Entities that are scored on 6 quality measures (no administrative claims-based measures) can earn a maximum of 60 points. This means they can earn **up to 6** end-to-end bonus points (10% of 60 points) and **up to 6** additional outcome/high priority bonus points (10% of 60 points).
- Groups, virtual groups, and APM Entities that are scored on 6 quality measures, and the Hip Arthroplasty and Knee Arthroplasty Complication measure **OR** the Hospital-Wide All-Cause Unplanned Readmission measure can earn a maximum of 70 points. This means they can earn **up to 7** end-to-end bonus points (10% of 70 points) and **up to 7** additional outcome/high priority bonus points (10% of 70 points).
- Groups, virtual groups, and APM Entities that are scored on 6 quality measures, the Hip Arthroplasty and Knee Arthroplasty Complication measure, and the Hospital-Wide All-Cause Unplanned Readmission measure can earn a maximum of 80 points. This means they can earn **up to 8** end-to-end bonus points (10% of 80 points) and **up to 8** additional outcome/high priority bonus points (10% of 80 points).
- Groups, virtual groups, and APM Entities reporting through the CMS Web Interface that are scored on all CMS Web Interface measures and the CAHPS for MIPS Survey and the Hospital-Wide All-Cause Unplanned Readmission measure (or the Hip Arthroplasty and Knee Arthroplasty Complication measure) can earn a maximum of 90 points. This means they can earn **up to 9** end-to-end bonus points (10% of 90 points).

However, your quality performance category score can never exceed 100%.

Example

Dr. Johnson is a MIPS eligible clinician at a primary care practice. He is participating as a group that reports 7 eCQM measures and 2 MIPS CQMs.

His group is also scored on the Hip Arthroplasty and Knee Arthroplasty Complication measure and the Hospital-Wide All-Cause Unplanned Readmission measure.

Measure Type	Collection Type	Achievement Points	Bonus Points	Total Points
Outcome Measure #1	MIPS CQM	8.2	N/A (Required)	8.2
Process Measure	eCQM	9.0	1 (End-to-End)	10.0
Process Measure	eCQM	9.1	1 (End-to-End)	10.1
Outcome Measure #2	eCQM	7.4	1 (End-to-End) 2 (Additional Outcome)	10.4
High Priority Measure	eCQM	8.1	1 (End-to-End) 1 (Additional High Priority)	10.1
Process Measure	MIPS CQM	~~5.1~~ 0	N/A	~~5.1~~ 0
Outcome Measure #3	eCQM	~~3.5~~ 0	1 (End-to-End) 2 (Additional Outcome)	~~6.5~~ 3
Outcome Measure #4	eCQM	~~6.7~~ 0	1 (End-to-End) 2 (Additional Outcome)	~~9.7~~ 3
Process Measure	eCQM	8.4	1 (End-to-End)	9.4
Hospital-Wide All-Cause Unplanned Readmission Measure	Administrative Claims	9.5	N/A	9.5
Hip Arthroplasty and Knee Arthroplasty Complication Measure	Administrative Claims	8	N/A	8
Totals		**67.7**	**14**	**80**

Note: Points for quality measures that didn't fall within the top 6 measures used for scoring have been crossed out. When determining which measures are included in the top 6, we select the highest scoring outcome measure (if no outcome measure was submitted, we'll select the highest scoring high priority measure) and then select the next 5 highest scoring measures. However, we'll include any bonus points from the remaining measures, as long as the 10% cap hasn't been reached for the applicable bonus.

Even though the group was eligible to earn up to 14 bonus points resulting in a total score of 81.7, the overall quality performance category score can't exceed 100% (80 points for this group), so the group will receive the maximum of 80 points for the quality performance category.

Improvement Scoring

For the 2021 performance year, you can earn **up to 10 percentage points** based on the rate of your improvement in the quality performance category from the previous performance year.

You'll be evaluated for improvement scoring for the 2021 performance year when you:

- Meet the quality performance category requirements for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure OR submit as many measures as were available and applicable OR report all 10 measures in the CMS Web Interface; all measures must meet data completeness requirements).
- Have a quality performance category achievement percent score based on reported measures for the previous performance period (2020 performance year).
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

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

How is improvement scoring calculated?

Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2020) performance year to the quality performance category achievement percentage score for the current (2021) performance year. Measure bonus points aren't included in improvement scoring.

Scoring Example

Improvement Scoring Example

An example of how to calculate the improvement percent score:

For the 2020 performance period, Dr. Johnson earned 38 measure achievement points and 6 measure bonus points for reporting an additional outcome measure and 4 measures with end-to-end electronic reporting.

For the 2021 performance period, Dr. Johnson earned 50 measure achievement points and 4 measure bonus points with end-to-end electronic reporting.

- 2020 quality performance category achievement percent score = 63%
  - (38/60)
  - Excludes the 6 bonus points
- 2021 quality performance category achievement percent score = 83%
  - (50/60)
  - Excludes the 4 bonus points
- The increase in the quality performance category achievement percent score from the previous (2020) performance period to the current (2021) performance period = 20%
  - (83% - 63%)
- The improvement percent score is 3.2% which will be added to the percent score earned for reported measures.
  - (20%/63%)*10% = 3.2%

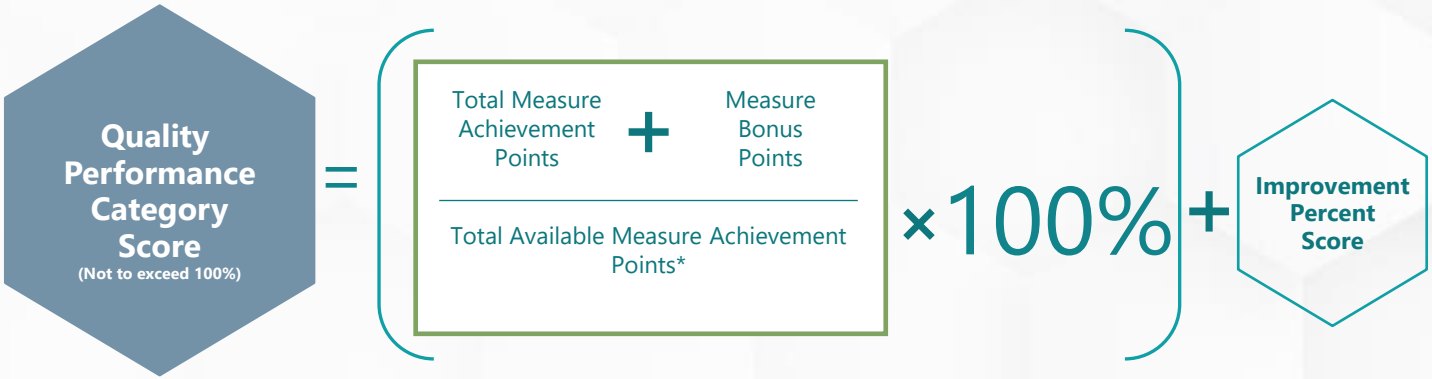
Please note that the improvement percent score can't be negative and is capped at 10%.

Improvement Percent Score = (2021 Achievement Percent Score (83%) – 2020 Achievement Percent Score (63%) = 20%) / **Prior Performance Period Quality Performance Category Achievement Percent Score** (63%) × 10%

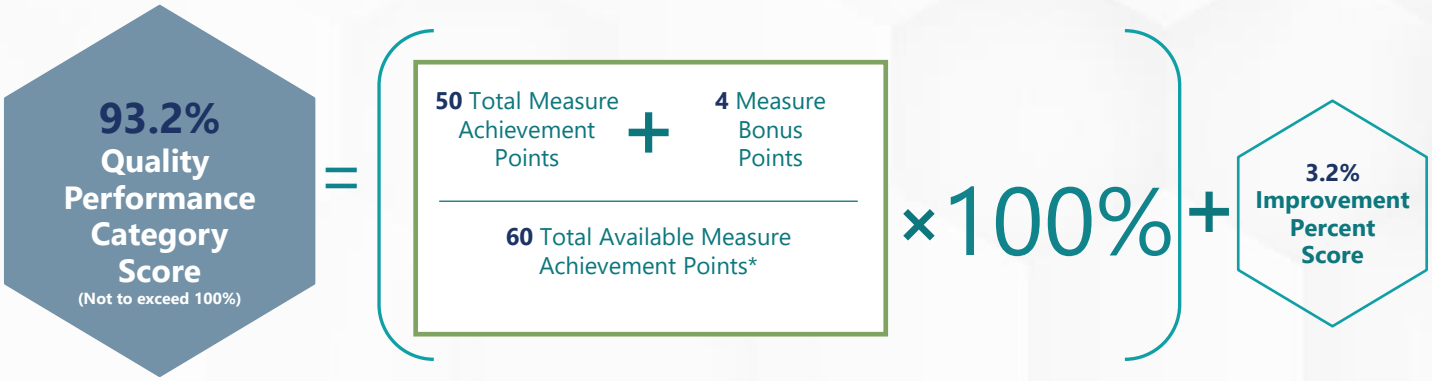
Improvement Percent Score = 3.2%

Calculating the Quality Performance Category Score

The quality performance category score is a product of the following equation:



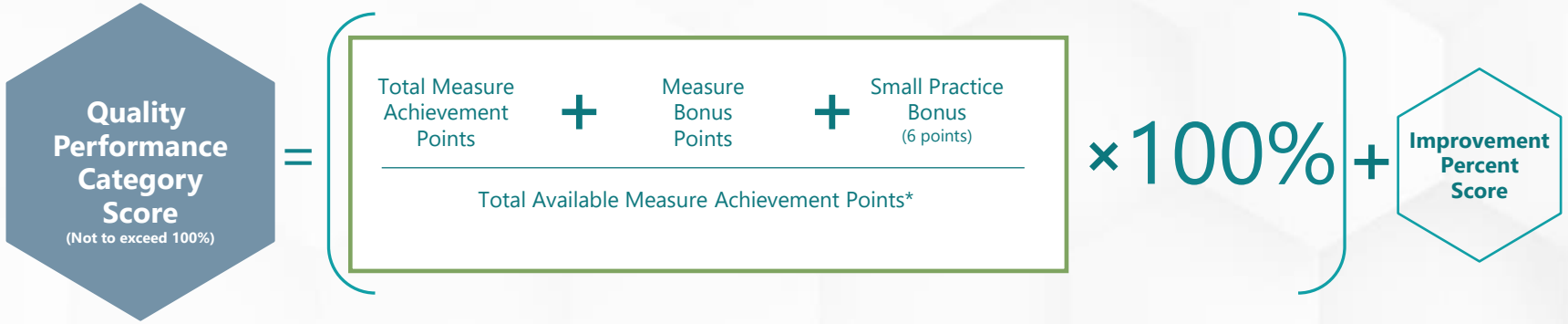
Example:



*Total available measure achievement points = # of required measures x 10

Calculating the Quality Performance Category Score (Continued)

The quality performance category score **for small practices** is a product of the following equation:



Your quality performance category score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your final score.

*Total available measure achievement points = # of required measures x 10

Calculating the Quality Performance Category Score (Continued)

Your quality performance category score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your final score.

Example 1:

The clinician, group or virtual group is scored on all 4 MIPS performance categories:

93.2% x 40% x 100 = 37.28 points under the quality performance category contributing to the final score

Example 2:

The clinician, group, or virtual group can't be scored on the cost performance category:

93.2% x 55% x 100 = 51.26 points under the quality performance category contributing to the final score

Example 3:

The clinician, group, or virtual group isn't scored on the Promoting Interoperability performance category, but is scored for the cost performance category:

93.2% x 65% x 100 = 60.58 points under the quality performance category contributing to the final score

Maximum Points Available in the Quality Performance Category

Your quality performance category score is determined by dividing the achievement points that you receive for the measures you submitted (and any bonus points) by the maximum number of achievement points that you could receive, which will depend on your collection type. The maximum number of points available can vary.

Measure Type	Maximum Points Available
eCQMs, Medicare Part B Claims Measures, MIPS CQMs, and QCDR Measures	• Individual – 60 points
	• Individual – 70 points if scored on the Hip Arthroplasty and Knee Arthroplasty Complication measure.
	• Groups/virtual groups/APM Entities – 60 points if the Hip Arthroplasty and Knee Arthroplasty Complication measure **OR** the Hospital-Wide All-Cause Unplanned Readmission measure doesn't apply.
	• Groups/virtual groups/APM Entities – 70 points if scored on the Hip Arthroplasty and Knee Arthroplasty Complication measure **OR** the Hospital-Wide All-Cause Unplanned Readmission measure.
	• Groups/virtual groups/APM Entities – 80 points if scored on both the Hip Arthroplasty and Knee Arthroplasty Complication measure **AND** the Hospital-Wide All-Cause Unplanned Readmission measure.
CMS Web Interface Measures	• Groups/virtual groups/APM Entities – 70 points for CMS Web Interface measures.
	• Groups/virtual groups/APM Entities – 80 points for CMS Web Interface measures, and 1 administrative claims measure OR CAHPS for MIPS Survey measure.
	• Groups/virtual groups/APM Entities – 90 points for CMS Web Interface measures and 2 administrative claims measures.
	• Groups/virtual groups/APM Entities – 90 points for CMS Web Interface measures, and 1 administrative claims measure and the CAHPS for MIPS Survey measure.
	• Groups/virtual groups/APM Entities – 100 points for CMS Web Interface measures, and 2 administrative claims and the CAHPS for MIPS Survey measure.

Facility-Based Measurement Scoring

Facility-based clinicians, groups, and virtual groups may have the option to use facility-based measurement scores for their quality and cost performance category scores.

Facility-based measurement scoring will be used for your quality and cost performance category scores when:

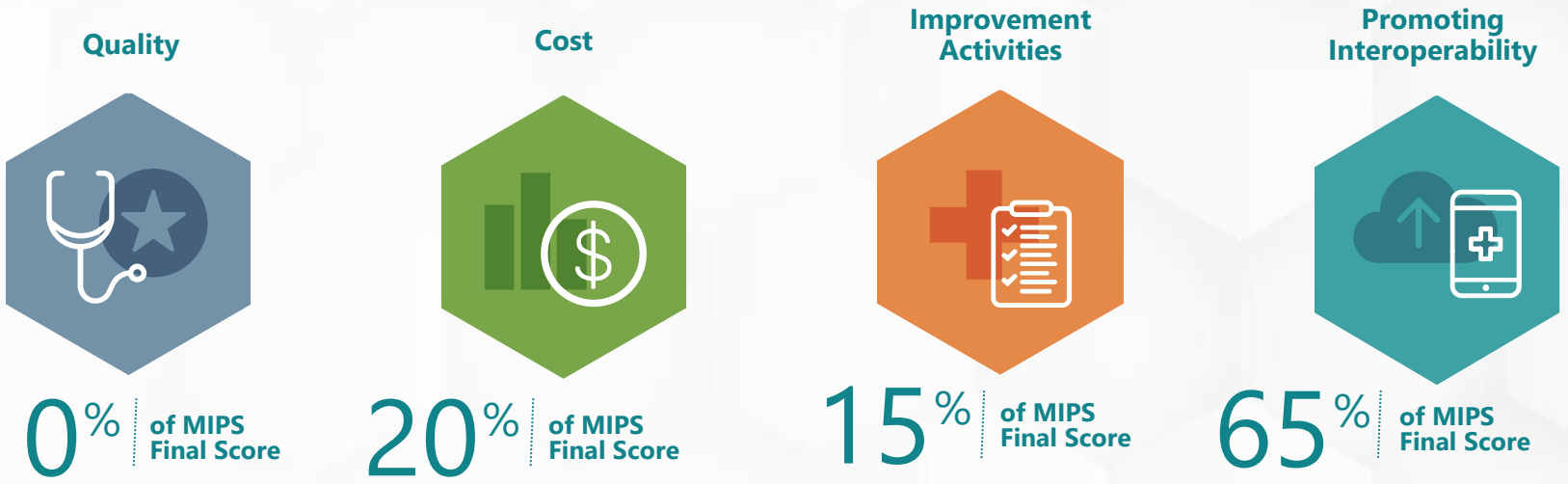
- You're identified as facility-based.
- You're assigned to a facility with a FY 2022 Hospital Value-Based Purchasing (VBP) Program score (information is not available until the Fall 2021).
- Facility-based score results in a higher Hospital VBP Program combined quality and cost score than the MIPS quality and cost measure data we calculate for you.

The 2021 Facility-Based Measurement Quick Start Guide (PDF) and facility-based indicators are available on the QPP Participation Status Tool.

Reweighting the Quality Performance Category

If you don't submit data for the quality performance category because there are no quality measures available to you or your 2021 Extreme and Uncontrollable Circumstances application is approved, you won't earn any points for the quality performance category, and its performance category weight will be redistributed to other performance categories.

The following example outlines the weight distributions for each performance category when the quality performance category is weighed to 0% for individuals, groups, or virtual groups:



*The example assumes that you/your group/your virtual group can be scored for the cost performance category.

Reweighting the Quality Performance Category (Continued)

The previous example also applies to APM Entities:

Quality

0% of MIPS Final Score

Cost

0% of MIPS Final Score

Improvement Activities

25% of MIPS Final Score

Promoting Interoperability

75% of MIPS Final Score

NOTE: We anticipate that reweighting of the quality performance category for lack of available measures would be a rare occurrence because there are quality measures applicable and available for most clinicians. Please contact QPP at 1-866-288-8292 or by email at QPP@cms.hhs.gov if you believe there are no MIPS quality measures available to you.

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

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

The following resources are available on the QPP Resource Library and other QPP and CMS webpages:

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

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

Connect with your local Technical Assistance organization. We provide no-cost technical assistance to **small, underserved, and rural practices** to help you successfully participate in the Quality Payment Program.

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

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Additional Resources

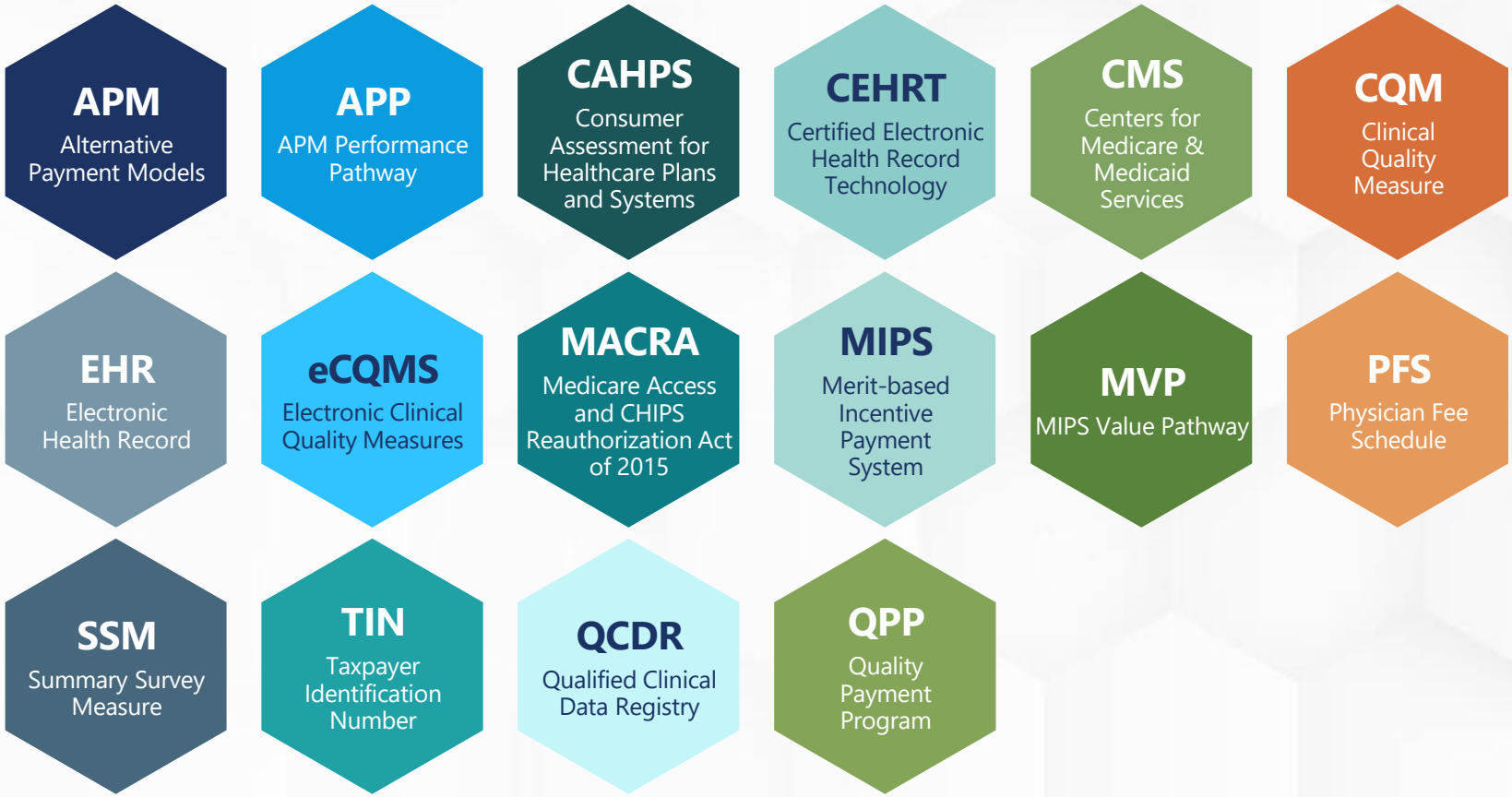
The following resources are available on the QPP Resource Library and other QPP and CMS webpages:

- 2021 MIPS Overview Quick Start Guide (PDF)
- 2021 Quality Quick Start Guide (PDF)
- 2021 Eligibility and Participation Quick Start Guide (PDF)
- 2021 Part B Claims Reporting Quick Start Guide (PDF)
- 2021 Quality Benchmarks (ZIP)
- 2021 MIPS Quality Measures List
- 2021 Cross-Cutting Quality Measures (PDF)
- 2021 Qualified Clinical Data Registries (QCDRs) Qualified Posting
- 2021 Qualified Registries Qualified Posting
- 2021 QPP Final Rule Resources (ZIP)
- 2021 Self-Nomination Toolkit for QCDRs & Registries (ZIP)
- 2021 QCDR Measure Specifications
- 2021 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)
- 2021 Clinical Quality Measure Specifications and Supporting Documents (ZIP)
- 2021 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP)

Help, Resources, Glossary, and Version History

Quality Payment PROGRAM

Glossary



Version History

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

Date	Description
4/28/2021	Original Version

Appendix

Appendix A: Measures Finalized for Removal in the CY 2021 Physician Fee Schedule (PFS) Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
069	Process	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	MIPS CQM
146	Process	Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	Medicare Part B Claims MIPS CQM
333	Efficiency	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)	MIPS CQM
348	Outcome	Implantable Cardioverter-Defibrillator (ICD) Complications Rate	MIPS CQM
390	Process	Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options	MIPS CQM
408	Process	Opioid Therapy Follow-up Evaluation	MIPS CQM
412	Process	Documentation of Signed Opioid Treatment Agreement	MIPS CQM
414	Process	Evaluation or Interview for Risk of Opioid Misuse	MIPS CQM
435	Patient Reported Outcome	Quality of Life Assessment for Patients with Primary Headache Disorders	Medicare Part B Claims MIPS CQM
437	Outcome	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure	Medicare Part B Claims MIPS CQM
458	Outcome	All-Cause Hospital Readmission	Administrative Claims

Appendix B: Measures Finalized for Removal of Specific Collection Types in the CY 2021 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
012	Process	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Removed: Medicare Part B Claims, MIPS CQM Retained: eCQM
048	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years or Older	Removed: Medicare Part B Claims Retained: MIPS CQM
052	Process	Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy	Removed: Medicare Part B Claims Retained: MIPS CQM
268	Process	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	Removed: Medicare Part B Claims Retained: MIPS CQM
419	Process	Overuse of Imaging for the Evaluation of Primary Headache	Removed: Medicare Part B Claims Retained: MIPS CQM

Appendix C: Measures Finalized for Addition in the CY 2021 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type
479	Outcome	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups	Administrative Claims
480	Outcome	Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)	Administrative Claims