Quality Payment
PROGRAM

Alternative Payment Models (APMs)

Alternative Payment Model (APM) Performance Pathway (APP) Scoring Guide for the 2024 Performance Period

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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.

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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

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) advances a forward-looking and coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks.

In MIPS, you may earn performance-based payment adjustments for the services you provide to Medicare patients.

An Alternative Payment Model (APM) is a payment approach that rewards health care providers for delivering high-quality and cost-efficient care. APMs can focus on specific health conditions, care episodes, provider types, or communities. An Advanced APM is an APM that meets certain additional criteria

- Note: If you are a MIPS eligible clinician and participate in an Advanced APM but don't achieve Qualifying APM Participant (QP) status because you did not meet the required payment amount or patient count threshold, you are required to report to MIPS.
- A 5% incentive payment applies to payment years 2019-2024, a 3.5% incentive payment applies to payment year 2025, and a 1.88% incentive payment applies to payment year 2026. The conversion factor also begins in payment year 2026.

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

The APP is an optional MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs, with the exception of Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). To view the list of MIPS APMs, please go to the 2023 and 2024 Comprehensive List of APMs. Please note that all Shared Savings Program ACOs are required to report their quality data via the APP.

The APP is optional for MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the 4 snapshot dates (March 31, June 30, August 31, and December 31) during a performance period.

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

- All MIPS APM participants who report the APP in 2024 will automatically receive full credit for the improvement activities performance category score.
- In addition, under the APP, the cost performance category is weighted to 0% of the MIPS final score, because all MIPS APM participants are already responsible for costs through their APMs.

Please note: The Shared Savings Program uses “performance year” instead “performance period.” Since the APP Toolkit is used by both Shared Savings Program ACOs and non-Shared Savings Program entities, the term “performance period” is used throughout.

Who Can Report the APP?

The APP can be reported by individual MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM. Virtual groups aren't eligible to report the APP.

ACOs participating in the Shared Savings Program are required to report the APP for the purpose of assessing their quality performance for that program.

- When an ACO reports the APP, ACO participants who are MIPS eligible clinicians don't have to report quality measures separately. However, MIPS eligible clinicians in the ACO still need to report Promoting Interoperability data and receive full credit for the improvement activities performance category and do not get evaluated on the cost performance category .
- An ACO that fails to report the APP at the APM Entity level wouldn't meet the Shared Savings Program quality performance standard or the alternative quality performance standard. If an ACO fails to report the APP at the APM Entity level, or if a MIPS eligible clinician or group finds it is in their best interest to report separately, MIPS eligible clinicians in the ACO could report quality measures outside the ACO via the APP or a different MIPS reporting option, at the group or individual eligible clinician level.

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

Getting Started: Reviewing MIPS Terms

Collection type[3]

- Collection Type refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data. The following collection types apply to APP reporting:
  - Electronic clinical quality measures (eCQMs).
  - MIPS clinical quality measures (MIPS CQMs).
  - Medicare Part B Claims measures (available only to individuals, groups, and APM Entities with the small practice designation (15 or fewer clinicians) Not available to Shared Savings Program ACOs).
  - CMS Web Interface measures (available only to Shared Savings Program ACOs; PY 2024 will be the final year).
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (required for groups and APM Entities with 2 or more MIPS eligible clinicians reporting the APP).
  - Medicare CQMs for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) (available only to Shared Savings Program ACOs).
- Appendix C explains each of these collection types in further detail.

Did you know? If you submit eCQMs, you need to use CEHRT to collect the eCQM data. The CEHRT must be certified under the ONC Health IT Certification Program and that meets the Base EHR definition at 45 CFR 170.102.

[3] The term "Collection Type" is unique to the quality performance category and doesn't apply to the other performance categories.

Getting Started: Reviewing MIPS Terms (Continued)

Submitter Type[4]

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

Submission Type

- Submission type is the mechanism by which the submitter type submits data to CMS:
  - Direct (transmitting data through a computer-to-computer interaction, such as an Application Programming Interface, or API).
  - Sign in and upload (attaching a file).
  - Sign in and attest (manually entering data).
  - Medicare Part B claims (available to individuals, groups, and APM entities with the small practice designation only).
  - CMS Web Interface (Shared Savings Program ACOs only).

[4] While Virtual Groups meet the definition of Submitter type per 42 CFR 414.1305, Virtual Groups are not eligible to report the APP.

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APP: Quality Performance Category

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

OPTION 1: APP Quality Measures Set

(Individual, Group, APM Entity – All Models/Programs, Excluding Shared Savings Program ACOs)

Quality ID: 001

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician
- Group (Representative of a Practice)
- APM Entity
- Third Party Intermediary

Quality ID: 134*

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician
- Group (Representative of a Practice)
- APM Entity
- Third Party Intermediary

Quality ID: 236*

Controlling High Blood Pressure

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician
- Group (Representative of a Practice)
- APM Entity
- Third Party Intermediary

Quality ID: 321

CAHPS for MIPS

COLLECTION TYPE
- CAHPS for MIPS Survey

SUBMITTER TYPE
- Third Party Intermediary

Quality ID: 479

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

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE
- N/A

Quality ID: 484

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE
- N/A

Medicare Part B Claims measures can only be reported by individuals, groups, and APM Entities with the small practice designation and are limited to Medicare patients. No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2024

* Please see slide 14 for additional information

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

Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures. Shared Savings Program ACOs that choose to report the CMS Web Interface measures must also administer the CAHPS for MIPS Survey and will be evaluated on 2 administrative claims measures. This alternative measure set is available only to Shared Savings Program ACOs.

Note: The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface.

OPTION 2: APP Quality Measures Set – CMS Web Interface Measure Set
(Shared Savings Program ACOs only)

Quality ID: 001/DM-2

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 134/ PREV-12

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 236/HTN-2

Controlling High Blood Pressure

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 318/CARE-2

Falls: Screening for Future Fall Risk

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 110/PREV-7

Preventive Care and Screening: Influenza Immunization

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 226/ PREV-10

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

COLLECTION TYPE
- CMS Web Interface

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

*The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface.

Quality Payment PROGRAM

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

OPTION 2: APP Quality Measures Set – CMS Web Interface Measure Set (Continued)
(Shared Savings Program ACOs only)

Quality ID: 113/PREV-6	Quality ID: 112/PREV-5	Quality ID: 438/PREV-13	Quality ID: 370/MH-1	Quality ID: 321	Quality ID: 479	Quality ID: 484
Colorectal Cancer Screening	**Breast Cancer Screening**	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	**Depression Remission at Twelve Months**	**CAHPS for MIPS**	**Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups**	**Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CAHPS for MIPS Survey SUBMITTER TYPE • Third Party Intermediary	COLLECTION TYPE • Administrative Claims SUBMITTER TYPE • N/A	COLLECTION TYPE • Administrative Claims SUBMITTER TYPE • N/A

What Quality Data Submission Options are Available? (Continued)

Beginning with the 2024 performance period, Medicare CQMs are a new collection type for Shared Savings Program ACOs that can only be reported through the APP. With the Medicare CQM collection type, an ACO that participates in the Shared Savings Program may collect and report data on the ACO's Medicare fee-for-service (FFS) beneficiaries that meet the definition of a beneficiary eligible for Medicare CQMs at 42 CFR 425.20, instead of their all payer/all patient population.

OPTION 3: APP Quality Measures Set – eCQM/MIPS CQM/Medicare CQM Measure Set
(Shared Savings Program ACOs Only)

Quality ID: 001/ 001SSP *	Quality ID: 134/ 134SSP *	Quality ID: 236/ 236SSP *	Quality ID: 321	Quality ID: 479	Quality ID: 484
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	**Preventive Care and Screening: Screening for Depression and Follow-up Plan**	**Controlling High Blood Pressure**	**CAHPS for MIPS**	**Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups**	**Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
COLLECTION TYPE • eCQM • MIPS CQM • Medicare CQM SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • eCQM • MIPS CQM • Medicare CQM SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • eCQM • MIPS CQM • Medicare CQM SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CAHPS for MIPS Survey SUBMITTER TYPE • Third Party Intermediary	COLLECTION TYPE • Administrative Claims SUBMITTER TYPE • N/A	COLLECTION TYPE • Administrative Claims SUBMITTER TYPE • N/A

* Indicates Medicare CQM Measure Submission File Identifier.

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

Are you submitting quality measures through the CMS Web Interface?

- Skip ahead.

Quality Measure Performance Period

- Quality measures have a 12-month performance period (January 1, 2024 – December 31, 2024).

What Does "Data Completeness" Mean?

- "Data completeness" refers to the volume of performance data reported for the measure's eligible population.
- When reporting a quality measure, you must identify the entire eligible population as outlined in the measure's specification.
- **To meet data completeness criteria, you must identify the entire eligible population in your submission and report performance data for at least 75% of the eligible population.**

To illustrate:

$$\text{Data Completeness} = \frac{\text{Number of patients for which performance data is submitted } \textit{(met, not met, or denominator exception)}^{2}}{\text{Total number of patients in eligible population}}$$

Did you know?

- You can use multiple collection types when reporting Quality IDs 001 /001SSP, 134/134SSP, and 236/236SSP. For example, you could report Quality ID 001 as an eCQM and Quality IDs 134 and 236 as MIPS CQMs.

For more information, view the 2024 MIPS Data Completeness Quick Start Guide.

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

Data Completeness and Eligible Population

- For Medicare Part B Claims measures, we identify the eligible population (denominator) for you based on the claims you submit.
- When reporting eCQMs and MIPS CQMs, your denominator eligible **encounters include your entire patient population**, not just your Medicare patient population.
- **NEW for Performance Period 2024:** For Shared Savings Program ACOs reporting a Medicare CQM, we provide a list of beneficiaries eligible for Medicare CQM reporting through quarterly reports based on your Medicare FFS patients. You must use this list along with other data sources to identify the eligible population (denominator) for each measure and validate your quality measure data.
- For eCQMs and MIPS CQMs, you (or your vendor) identify the eligible population in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications. For Medicare CQMs, use the QPP JSON specifications. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician, group, or APM Entity's performance (submitting only favorable performance data, commonly referred to as "cherry-picking"), wouldn't be considered true, accurate, or complete and may subject you to audit.

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

How is "Data Completeness" Determined for Shared Savings Program ACOs?

To meet **data completeness** requirements, ACOs must also identify their entire eligible population across all participants, and report performance data for at least 75% of their eligible population.

- For eCQMs and MIPS CQMs, the denominator eligible population will reflect 100% of the eligible and matched, deduplicated population across all participant Tax Identification Numbers (TINs) and CMS Certification Numbers (CCNs) in the ACO.
- When reporting Medicare CQMs, your denominator eligible population includes the ACO's Medicare FFS beneficiaries that meet the definition at 42 CFR 425.~~5~~20 instead of the all payer/all patient population.
- Data completeness is calculated based on the data you submit.
- Since eCQMs are specified to be calculated using all-payer data and submitted electronically without any manual manipulation, ACOs that submit an eCQM via Certified Electronic Health Record Technology (CEHRT) would generally achieve 100 percent data completeness.
- Each eCQM contains data regarding 100 percent of the MIPS eligible clinicians' matched patient population and its end-to-end electronic reporting ensures no cases are excluded from the submission. In the case of an ACO using multiple CEHRT, eCQM reporting requires the aggregation of data across all CEHRT used across the ACO into a single submission to ensure the ACO meets the measure specification by accounting for its complete eligible and matched patient population.

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

How is "Data Completeness" Determined for Shared Savings Program ACOs? (Continued)

- MIPS CQM and Medicare CQM measure specifications allow for the use of multiple sources of data (e.g., EHRs, paper records, registries, claims data) to compile a measure's numerator and denominator, so an ACO must undertake additional effort to ensure it meets the data completeness standard.
- An ACO submitting via the MIPS CQM or Medicare CQM collection types must report performance data ("Performance Met," or "Performance Not Met," or denominator exceptions) for at least 75% of their eligible and matched population denominator.
- For additional information regarding the reporting of eCQMs and MIPS CQMs, the below resources are available:
  - **Guidance Document:** Reporting MIPS CQMs and eCQMs in the APP (PDF, 865KB)
  - **Webinar:** Reporting MIPS CQMs and eCQMs in the APP and FAQs from December 15, 2022.
- Overview of the Quarterly List of Beneficiaries Eligible for Medicare CQMs Data Dictionary and Template: https://acoms.cms.gov/knowledge-management/view/8282.
  - Note: to access the above resource, you need ACO-MS access.

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

Quality Benchmarks

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

- Benchmarks differ by collection type. The 3 APP measures (Quality IDs 001/001SSP, 134/134SSP, and 236/236SSP) can be reported through multiple collection types.
- Different benchmarks will be used for scoring based on whether you report these measures as eCQMs, MIPS CQMs, Medicare CQMs (available to Shared Savings Program ACOs only), or Medicare Part B Claims measures (available to individuals, groups, and APM Entities with the small practice designation only).

Whenever possible, we use historical data to establish benchmarks.

- Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years before the applicable performance period.
- The historical benchmarks for the 2024 MIPS performance period were established from quality data submitted for the 2022 MIPS performance period.

Note: For more information about the 2024 quality benchmarks, please review the 2024 Quality Benchmarks on the Benchmarks page of the QPP website.

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

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

If a quality measure's collection type doesn't have a historical benchmark, we'll attempt to calculate a benchmark based on data submitted for the 2024 performance period. These performance period benchmarks will be available in the 2025 calendar year.

We can establish performance period benchmarks when at least 20 instances of the measure are reported through the same collection type and meet data completeness and case minimum[5] requirements and have a performance rate greater than 0% (or less than 100% for inverse measures).

- We'll attempt to calculate a performance period benchmark for the new Medicare CQM collection type, which isn't eligible for historical benchmarking for the 2024 or 2025 performance periods. For performance period 2026 and beyond, CMS will score Medicare CQMs using historical benchmarks when baseline period data are available.
- We'll also attempt to calculate a performance period benchmark for Measures 134 and 236 (eCQM collection type); these measures were suppressed as eCQMs in the 2022 performance period.

Under the APP, measures without a historical or performance period benchmark are excluded from scoring as long as data completeness is met.

[5] Most measures have a case minimum requirement of ≥20 cases. However, some measures have a different case minimum requirement. The case minimum requirements for each measure can be found in their respective measure specifications in the QPP Resource Library.

Note: For more information about the 2024 quality benchmarks, please review the 2024 Quality Benchmarks on the Benchmarks page of the QPP website.

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

How are Measures Scored?

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

- A benchmark is available.
- The volume of cases that you've submitted is sufficient (≥20 cases for most measures).
- You've met data completeness requirements (identified all denominator eligible encounters and submitted performance data for at least 75% of the denominator eligible encounters).

We'll use flat benchmarks to score the MIPS CQM and Medicare Part B claims collection types for Quality IDs 001 and 236.[6]

The 2024 Quality Benchmarks reflect these flat benchmarks.

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

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

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

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

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

Measure Achievement Points When Reporting the APP

1-10 points	3 points (small practices only)	0 (0 out of 10 points)	0 (0 out of 10 points)	N/A (0 out of 0 points)
You'll receive between 1 and 10 achievement points for quality measures that meet case minimum and data completeness requirements and that can be scored against a benchmark.	Small practices receive 3 points for measures that don't meet data completeness requirements.	You'll receive 0 points for measures that don't meet data completeness requirements. This doesn't apply to small practices.	You'll receive 0 points for measures that are required but unreported. (You must report performance data for the measure to be considered reported.)	Measures that don't have a benchmark or meet the case minimum requirement are excluded from the total measure achievement points and total available measure achievement points as long as you meet data completeness requirements Suppressed measures will also be excluded from scoring when submitted if data completeness is met.

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

Example: Assigning Measure Achievement Points

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

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

- Achievement points are determined by mapping the performance rate to the benchmark for the measure, specific to collection type.
- Remember that Quality ID 236 is scored according to the flat benchmark methodology for Medicare Part B Claims and MIPS CQM, which is reflected in the 2024 Quality Benchmarks.
- Quality ID 236 was suppressed as an eCQM in 2022, so the measure will be scored against a performance period benchmark if one can be calculated.
- Quality ID 236SSP is new in the 2024 performance period, so the measure will be scored against a performance period benchmark if one can be calculated.

The following extract from the 2024 Quality Benchmarks shows the range of performance rates associated with each decile for each collection type for Quality ID 236.

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

Example: Assigning Measure Achievement Points (Continued)

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 2. Identify which decile performance rate falls in.

- Determine the decile that the performance rate falls in
- In this case, the measure performance rate is 66.74, which corresponds to Decile 7 (eligible for 7.0 – 7.9 points)

Measure Name	Controlling High Blood Pressure
Quality ID#	236
Collection Type	MIPS CQM
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 1	1.00 – 9.99
Decile 2	10.00 – 19.99
Decile 3	20.00 – 29.99
Decile 4	30.00 – 39.99
Decile 5	40.00 – 49.99
Decile 6	50.00 – 59.99
Decile 7	60.00 – 69.99
Decile 8	70.00 – 79.99
Decile 9	80.00 – 89.99
Decile 10	≥90.00

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

Example: Assigning Measure Achievement Points (Continued)

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 3. Use this formula and the decile to calculate achievement points.

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

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

$$\text{decile \# } 7 + \left[\frac{66.74 - 60.00}{70.00 - 60.00}\right] = 0.674\ldots = 7.7$$

…which is rounded to 0.7

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

Data Aggregation and Multiple Submissions

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

Let's look at an example:

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

For more information, view the 2024 Data Aggregation Guide.

If you submit the same measure through **multiple collection types,** we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points for 2 collection types for the same measure. It is important to note, that when reporting the same measures through multiple collection types, the measure should be completely reported through each collection type; CMS will not aggregate data from multiple collection types to calculate a single measure score.

Let's look at an example:

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

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

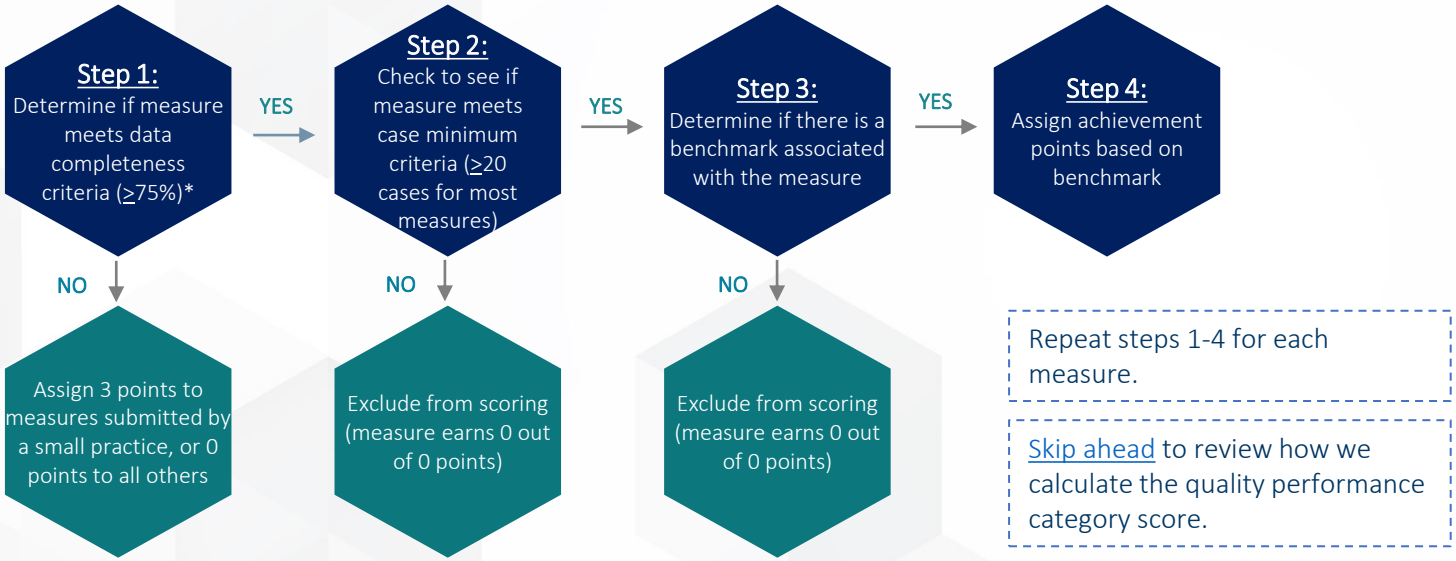
Factors Impacting Numerator Points and Available Denominator Points

Under certain circumstances, your numerator points for a measure may be set to 0, and your denominator (10 x the number of measures you're required to report) may be lower than the maximum points available.

Maximum Points by Reporting Label	
There's no historical benchmark for one of the required APP quality measures and we can't calculate one based on data submitted for the performance period…	…the measure will receive 0 out of 0 points.
You don't meet the case minimum for one or more quality measures…	…the measure will receive 0 out of 0 points.
Your group or APM Entity doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey…	…we'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS survey measure.
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available. **NOTE:** To the extent feasible, we will identify suppressed measures by the beginning of the submission period.	…we'll lower the denominator by 10 points for each impacted measure. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.

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

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



*For Shared Savings Program ACOs, the denominator eligible population will reflect 100% of the eligible and matched, deduplicated population across all participant TINs and CCNs in the ACO. The numerator reflects 75% met/not met.

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

How are the CMS Web Interface Measures Assessed in the Quality Performance Category When Reporting the APP for the 2024 Performance Period?

- For the 2024 performance period, only Shared Savings Program ACOs may report CMS Web Interface measures. When you submit data for the 10 required measures through the CMS Web Interface, your performance on each scored measure is assessed against a benchmark to see how many points you earn for the measure. ACOs submitting their quality measures through the CMS Web Interface will be assessed against benchmarks established under the Shared Savings Program. The benchmarks used for the CMS Web Interface are identified in the Performance Year 2024 APM Performance Pathway: CMS Web Interface Benchmarks for ACOs.

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

- CMS Web Interface measures without an existing benchmark don't count toward your quality performance category score, as long as you meet reporting requirements for such measures.
- The following CMS Web Interface measures don't have a benchmark for the 2024 performance period:
  - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (PREV-13/MIPS Quality ID# 438)
  - Depression Remission at Twelve Months (MH-1/MIPS Quality ID# 370)

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

REMINDER: The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface. ACOs may use the CMS Web Interface Transition Guide to begin preparation for the transition.

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored?

CMS Web Interface measures are scored according to the performance rates calculated from the numerator, denominator, and exception data reported for the measure.

Measure-Level Scoring for CARE-2, HTN-2, PREV-5, PREV-6, PREV-7, PREV-10 and PREV-12.		
Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
0.00 - 9.99 %	1 – 1.9 points	Decile 1
10.00 - 19.99%	2 – 2.9 points	Decile 2
20.00 - 29.99%	3 - 3.9 points	Decile 3
30.00 - 39.99%	4 - 4.9 points	Decile 4
40.00 - 49.99%	5 - 5.9 points	Decile 5
50.00 - 59.99%	6 - 6.9 points	Decile 6
60.00 - 69.99%	7 - 7.9 points	Decile 7
70.00 - 79.99%	8 - 8.9 points	Decile 8
80.00 - 89.99%	9 - 9.9 points	Decile 9
>= 90.00%	10 points	Decile 10
Note: MH-1 and PREV-13 don't have a benchmark and will be excluded from scoring provided data completeness is met.		

Measure-Level Scoring for DM-2 (Inverse Measure, Lower Performance Rate indicates Better Performance)		
Performance Rate Range	Available Achievement Points	Mapping to MIPS Benchmark Deciles
100.00 - 90.01%	1 – 1.9 points	Decile 1
90.00 – 80.01%	2 – 2.9 points	Decile 2
80.00 - 70.01%	3 - 3.9 points	Decile 3
70.00 - 60.01%	4 - 4.9 points	Decile 4
60.00 - 50.01%	5 - 5.9 points	Decile 5
50.00 - 40.01%	6 - 6.9 points	Decile 6
40.00 - 30.01%	7 - 7.9 points	Decile 7
30.00 - 20.01%	8 - 8.9 points	Decile 8
20.00 - 10.01%	9 - 9.9 points	Decile 9
<= 10.00%	10 points	Decile 10

Submitting CMS Web Interface Measures (Continued)

How are CMS Web Interface Measures Scored? (Continued)

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

Measure Achievement Points			
1-10 points	0 (0 out of 10 points)	N/A (0 out of 0 points)	N/A (0 out of 0 points)
You'll continue to receive between 1 and 10 achievement points for quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.	You'll continue to receive 0 points (0 out of 10) for measures that don't meet data completeness requirements. If you don't report a measure without a benchmark, you'll receive a score of zero points and the denominator used to calculate your quality performance category score will increase by 10 points.	You won't be scored on measures for which your sample is fewer than 20 Medicare patients, as long as you report on all the patients in the sample.	You won't be scored on measures without a benchmark as long as you meet data completeness requirements.

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

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

Submitting CMS Web Interface Measures (Continued)

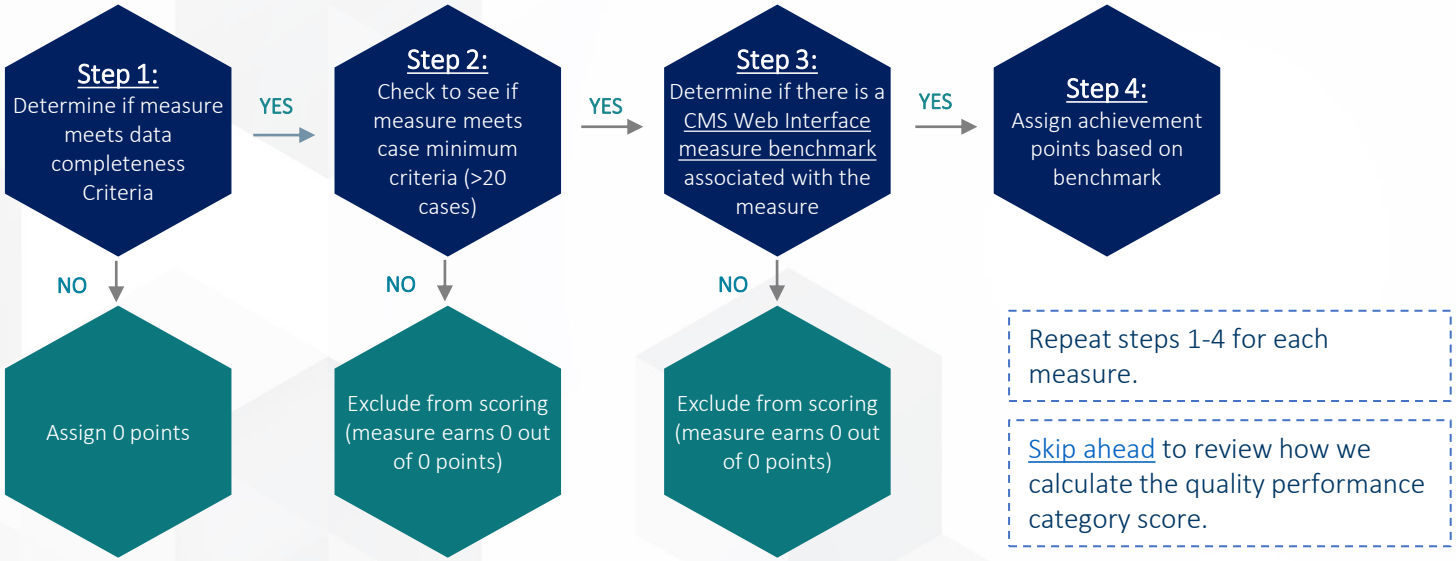
Can the Denominator (Maximum Number of Achievement Points) Be Lower or Higher Than 110 Points?

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

IF …	THEN …
The ACO doesn't report a measure without a benchmark…	…we'll increase the denominator by 10 points for each measure without a benchmark that the ACO didn't report.
The ACO doesn't meet the case minimum for one or more measures…	…we'll lower the denominator by 10 points for each measure for which the ACO doesn't meet the case minimum but does meet data completeness criteria.
The ACO doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey…	…we'll lower the denominator by 10 points to account for the ACO's inability to administer the CAHPS for MIPS Survey.
A CMS Web Interface measure is determined to be significantly affected by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results, and 9 months of consecutive, reliable data isn't available… **Note:** To the extent feasible, we will identify suppressed measures by the beginning of the submission period.	…we'll lower the denominator by 10 points for each affected measure. Why? So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control.

Submitting CMS Web Interface Measures (Continued)

What Are the Steps for Scoring CMS Web Interface Measures?



Submitting CMS Web Interface Measures

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

- 80 Points for the 8 scored CMS Web Interface measures + 10 Points for Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure + 10 Points for CAHPS for MIPS measure + 10 Points for HWR Rate for MIPS Eligible Clinician Groups measure for a total of 110 measure points.[5]
    - If the ACO doesn't report on a measure without a benchmark (PREV-13/MIPS Quality ID #438 or MH-1/MIPS Quality ID #370), the ACO will receive a score of zero points and will result in a denominator increase of 10 points per each unreported measure toward the MIPS quality performance category score.
        - Example: The ACO reports the 8 CMS Web Interface measures with a benchmark, earning 10 out of 10 points on each of those measures. The ACO doesn't report the 2 measures without a benchmark, so those measures earn 0 out of 10 points. The ACO also receives 10 out of 10 points for the 2 administrative claims measures and the CAHPS for MIPS measure. The ACO will earn 110 out of 130 measure points.

Did you know?

- The maximum number of measure points available is different from the quality performance category weight.
- The category weight is the number of points that the quality performance category can contribute to your MIPS final score.
- The total number of points for the quality performance category will be calculated as a percentage (for example, 99 out of 110 points would be 90%) and then multiplied by the category weight of 50% to determine how many quality points contribute to the final score. Continuing the example, 90% x the 50% performance category weight would result in 45 out of 50 points towards the ACO's final score.

[5] The total available measure achievement points may be less than the maximum points described in this slide if the individual, group, or APM Entity does not meet case minimum or minimum beneficiary sampling requirement on a measure(s).

CAHPS for MIPS Survey Measure

What Are the Steps for Scoring the CAHPS for MIPS Survey Measure?

Groups and APM Entities reporting the APP must register to administer the CAHPS for MIPS Survey. After registering, an approved CAHPS for MIPS survey vendor must be selected to administer the survey. Shared Savings Program ACOs are required to report the APP, they are automatically registered but must still select a vendor to administer the survey.

NOTE: Beginning in the 2024 performance period, registered groups and APM Entities (including Shared Savings Program ACOs) are required to contract with a CAHPS for MIPS Survey vendor to administer the Spanish translation of the survey to Spanish-preferring patients.

CAHPS for MIPS Measure Scoring and Benchmarks

We established a benchmark for individual summary survey measures (SSMs) in the CAHPS for MIPS measure. These benchmarks were calculated using historical data from the 2022 performance period. Each SSM is awarded 1 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS measure score is calculated by the average number of points across all scored SSMs. Please review the 2023 historical CAHPS for MIPS benchmarks in the 2024 Quality Benchmarks webpage.

NOTE: If your group or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements, we'll exclude the measure from scoring.

Administrative Claims Measures

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

- Hospital-wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure.
  - This measure has a case minimum of 200 cases and will apply to groups and APM Entities with at least 16 clinicians.
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
  - This measure has a case minimum of 18 cases and will apply to groups and APM Entities with at least 16 clinicians. Please note APM participants that achieve QP status are not included in the calculation of the MCC measure, under the APP.

Administrative Claims Scoring and Benchmarks

For the HWR Rate for MIPS Eligible Clinician Groups measure and Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure, we intend to calculate performance period benchmarks for the 2024 performance period.

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, and APM Entities

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

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points / Total Available Measure Achievement Points*) + Improvement Score

A total of 6 bonus points will be added to the numerator of the quality performance category score for MIPS eligible clinicians in small practices who submit data on at least one quality measure. (These bonus points are only available to individuals, groups and APM Entities with the small practice designation.)

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

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

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points + Small Practice Bonus (6 points)[6]) / Total Available Measure Achievement Points* + Improvement Score

What Happens If a Shared Savings Program ACO Reports CMS Web Interface Measures and eCQMs/MIPS CQMs/Medicare CQMs?

We would calculate scores for each measure or measure set — score(s) for eCQMs/MIPS CQMs/Medicare CQMs and a separate score for the CMS Web Interface measures — and use whichever measure set results in the higher MIPS quality performance category score.

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

[6] No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2024.

Calculating the Quality Performance Category Score (Continued)

What is Improvement Scoring?

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

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

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

1. Full participation in the quality category for the current performance period:
    - Submits a complete set of APP quality measures.
    - All submitted quality measures must meet data completeness requirements.
2. Data sufficiency standard is met — that is, data is available and can be compared:
    - There is a quality performance category achievement score (the score earned by measures based on performance, excluding bonus points) for the previous performance period (2023 performance period) and the current performance period (2024 performance period).
    - Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did you know?

Improvement scoring 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 before the current MIPS performance period.

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

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

Maximum Points by Reporting Label	
Individuals	• 30 POINTS – For the 3 required quality measures: o The CAHPS for MIPS Survey can't be administered for individual clinicians. o The Hospital-wide, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure doesn't apply to individual clinicians. o Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure doesn't apply to individual clinicians.
Groups and APM Entities	• 60 POINTS – For the 3 required quality measures + CAHPS for MIPS measure + HWR measure + MCC measure
ACOs Reporting eCQMs/MIPS CQMs/Medicare CQMs	• 60 POINTS – For the 3 required quality measures + CAHPS for MIPS measure + HWR measure + MCC measure

Did you know?

- The maximum number of measure points available is different from the quality performance category weight.
- The category weight identifies the number of points that the quality performance category can contribute to your MIPS final score.
- The total number of points for the quality performance category will be calculated as a percentage (for example, 55 out of 60 points would be 91.6%) and then multiplied by the category weight of 50% to determine the category's contribution to the final score.
- If you don't submit at least one required APP quality measure, you will receive zero points in this performance category unless you qualify for the performance category to be reweighted.
- The total measure available achievement points may be less than the maximum points described on this slide when the individual, group, or APM Entity does not meet case minimum requirement or minimum beneficiary sampling requirement.

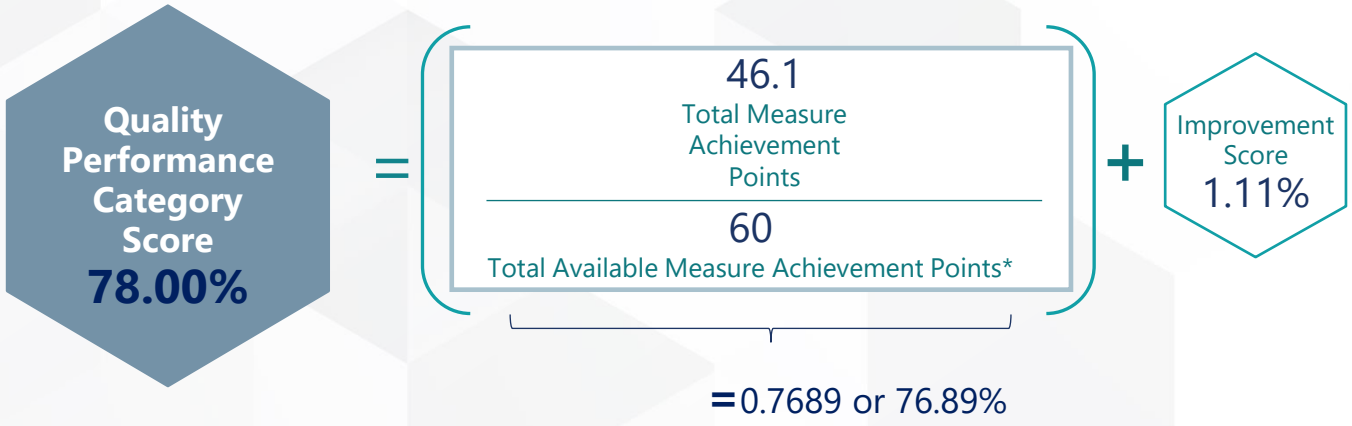
Calculating the Quality Performance Category Score (Continued)

Scoring Example #1

An APM Entity participating in ACO Realizing Equity Access and Community Health (ACO REACH) earns 46.1 achievement points out of 60 possible points for the 2024 performance period.

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

- Their 2024 achievement score = 46.1/60 = 76.89%.
- Their 2023 achievement score = 69.02%.
- The increase in their achievement score = 76.89% - 69.2% = 7.69%.
- Their improvement score = (7.69% ÷ 69.2%) ÷ 10 = 1.11%.



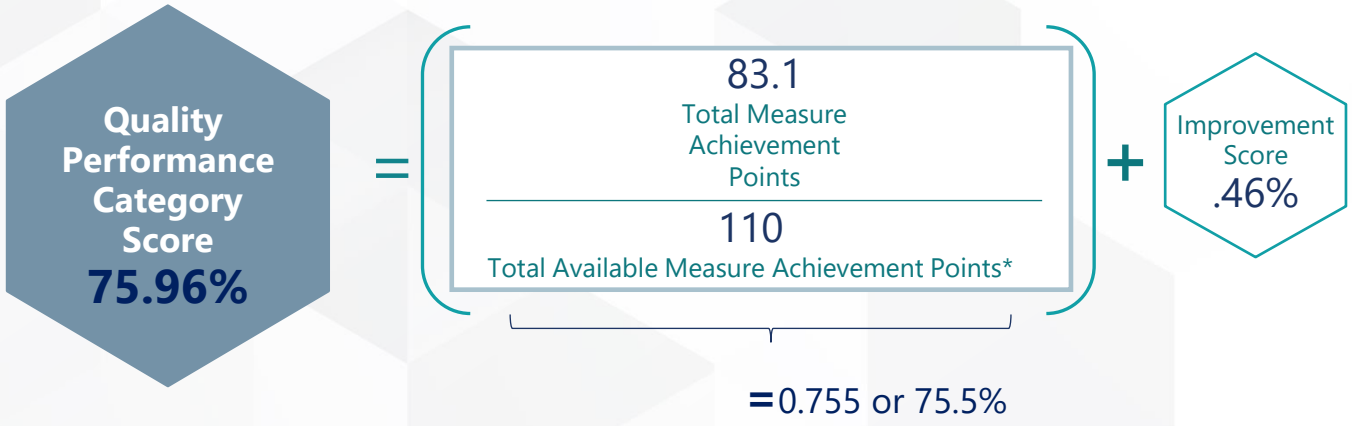
Calculating the Quality Performance Category Score (Continued)

Scoring Example #2

A Shared Saving Program ACO reported a full set of quality measures through the CMS Web Interface for 2023 and 2024. They earn 83.1 achievement points out of 110 possible points for the 2024 performance period.

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

- Their 2024 achievement score = 83.1/110 = 75.5%.
- Their 2023 achievement score = 72.2%.
- The increase in their achievement score = 75.5% - 72.2% = 3.3%.
- Their improvement score = (3.3% ÷ 72.2%) ÷ 10 = .46%.



How is My Quality Performance Category Score Calculated?

To determine how many points the quality performance category contributes to your final score, we multiply your quality performance category score by the quality performance category weight. When reporting the APP, we multiply your quality performance category score by 50% (the quality performance category weight under the APP).[7]

For more information, visit the Quality: APP Requirements webpage.

Can the Quality Performance Category Be Reweighted?

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

- If you qualify for our extreme and uncontrollable circumstances (EUC) policy, you may request performance category reweighting through the EUC application. Please check the Exceptions Application webpage for more information.
- In the rare instance that you can't meet the case minimum for any quality measures, you won't be scored on this performance category, and it will be reweighted to 0% of your final score. We anticipate that reweighting of the quality performance category will be rare.

Please see Appendix A for more information on the reweighting of the quality performance category, including the EUC policy.

[7] For Shared Savings Program ACOs, note that only the quality performance score is used by the Shared Savings Program to calculate shared savings and losses, including any relevant adjustments by the Shared Savings Program. The MIPS final score is not utilized by the Shared Savings Program.

APP: Improvement Activities Performance Category

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

MIPS APM participants reporting the APP don't need to submit any data for the improvement activities performance category for the 2024 performance period. Each year, we'll assign a score for the improvement activities performance category for each MIPS APM. All MIPS APM participants who report the APP in 2024 will automatically receive full credit for the improvement activities performance category score (20 out of 20 points towards your MIPS final score).

Improvement Activities

20% **of MIPS Score**

APP: Promoting Interoperability Performance Category

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

Objectives	Measures		Requirements
e-Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Query of Prescription Drug Monitoring Program (PDMP)		Required unless an exclusion is claimed
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 is reported
		Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 is reported
	Option 2	HIE Bi-Directional Exchange	Required (no exclusion available), unless option 1 or option 3 is reported
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (no exclusion available), unless option 1 or option 2 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required unless an exclusion(s) is claimed
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting		Optional measures (no exclusions available)

Promoting Interoperability

30% | **of MIPS Score**

Did You Know?

If you claim an exclusion for the e-Prescribing measure, you can't report the Query of PDMP measure; an exclusion will be automatically applied.

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

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

- Use CEHRT functionality that meets ONC's certification criteria in 45 CFR 170.315 to collect your data (certified by the last day of the performance period) and report the measures on the previous slide
- Submit a "yes" to the Actions to Limit or Restrict the Interoperability of CEHRT attestation (previously named the Prevention of Information Blocking attestation)
- Submit a "yes" or "no" to the ONC Direct Review attestation
- Submit your level of active engagement for the required Public Health and Clinical Data Exchange measures you're reporting
- Submit a "yes" that you have completed the Security Risk Analysis measure during 2024
- Submit the CMS EHR Certification identification code for your EHR product(s) (You can find this information here)
- Submit a "yes" to completing the High Priority Practices Guide of the SAFER Guides measure during 2024

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

Data Submission

A single submission (file upload, API, or attestation; by you or a third party) is recommended to report Promoting Interoperability data.

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

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2024?

For the 2024 performance period, each required measure will be scored based on the performance data you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Query of PDMP measure, Public Health and Clinical Data Exchange objective measures (required and optional/bonus), the optional HIE Bi-Directional Exchange and TEFCA measures, and the Security Risk Analysis and High Priority Practices Guide of the SAFER Guides attestation measure which require a “yes” or “no” submission. Each measure will contribute to your total Promoting Interoperability performance category score.

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

NOTE: Beginning with the 2024 performance period, APM Entities, including Shared Savings Program ACOs, can choose to submit their Promoting Interoperability data at the APM Entity level. If no APM Entity level data is reported, we’ll calculate a Promoting Interoperability score for the APM Entity based on the individual and group data submitted.

It is important to note that MIPS eligible clinicians that participate in an ACO are required to report this performance category because the are MIPS eligible clinicians, but data submitted does not affect the calculation of shared savings and shared loses in the Shared Savings Program.

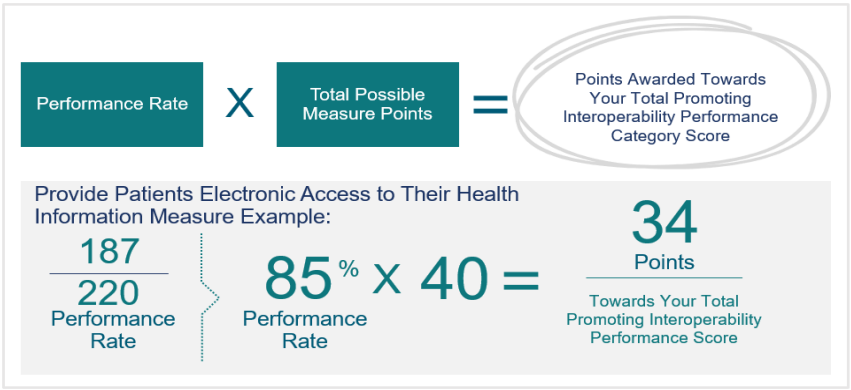
How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2024? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES/NO
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required (unless option 2 or 3 is reported)	1 – 15 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 15 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange	Required (unless option 1 or 3 is reported)	30 points	YES/NO
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (unless option 1 or 2 is reported)	30 points	YES/NO
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required	1 – 25 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required	25 points for the entire objective	YES/NO
	Bonus (Optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		Optional	5 bonus points	YES/NO

How Are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2024? (Continued)

For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure.

Below is an example featuring the Patients Electronic Access to their Health Information measure, which is worth up to 10 points.



Important to Note:

You can earn a maximum of 5 bonus points for submitting 1 (or more) of the optional measures in the Public Health and Clinical Data Exchange objective (you'll earn a maximum of 5 bonus points even if you submit more than 1 measure).

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

- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 if the numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category.)

Scoring Promoting Interoperability Measures Submitted with a Yes/No

For the Query of PDMP measure, you'll receive 10 points for this measure when:

- You submit a "yes" for the required measure.

* Note: If you submit an exclusion, the points will be redistributed to another measure or objective.

For the Public Health and Clinical Data Exchange objective, you'll receive 25 points for this objective when:

- You submit a "yes" for the Immunization Registry Reporting measure AND you submit a "yes" for the Electronic Case Reporting measure*.

  OR

- You submit a "yes" for one required measure AND you submit an exclusion for the other required measure.

* Note: If you submit an exclusion for both required measures, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

For Option 2 or 3 in the HIE objective, you'll receive 25 points for this objective when:

- You submit a "yes" to participating in bi-directional exchange OR you submit a "yes" to enabling exchange under participating in a TEFCA.

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

While there are 105 total points available, individuals, groups, and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

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

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

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

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

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

How Is the Promoting Interoperability Performance Category Scored?

APM Entity Participation

When reporting the APP as an APM Entity, Promoting Interoperability data can be reported at the individual, group, or APM Entity level.

Promoting Interoperability Reported at the APM Entity Level

Since the 2023 performance period, APM Entities have been able to submit aggregated Promoting Interoperability data at the APM Entity level on behalf of all MIPS eligible clinicians in the APM Entity. The score is calculated the same way as for individuals and groups.

Promoting Interoperability Reported at the Individual or Group Level

The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.

The APM Entity can also earn the bonus points if at least one individual or group in the APM Entity reports any of the optional measures in the Public Health and Clinical Data Exchange objective (5 bonus points), but the Promoting Interoperability performance category score can't exceed 100%.

Promoting Interoperability Performance Category Score = Total Points Earned for Completed Measures / Total Possible Measure Points

REMINDER: APM Entities that fail to do the following during reporting will contribute 0 points toward their Promoting Interoperability performance category score: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).

APM Entity's Promoting Interoperability Score = (Sum of Points Earned by All MIPS Eligible Clinicians for Required Measures / (Total MIPS Eligible Clinicians in APM Entity − MIPS Eligible Clinicians Who Receive Performance Category Reweighting)) + 5 Bonus Points (if at least one clinician reported an optional measure)

Promoting Interoperability Performance Category Scoring for APM Entities – PI Roll Up Example

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

	Points for Required Measures (Excluding Bonus Points)	Optional Measures from Public Health and Clinical Data Exchange Objective Reported?
MIPS Eligible Clinician 1	**87**	**Yes**
MIPS Eligible Clinician 2	**87**	No
MIPS Eligible Clinician 3	**77**	No
MIPS Eligible Clinician 4	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 5	**92**	No
MIPS Eligible Clinician 6	**85**	No
MIPS Eligible Clinician 7	**0** – didn't meet reporting requirements	No
MIPS Eligible Clinician 8	N/A – qualified for reweighting	N/A – qualified for reweighting
MIPS Eligible Clinician 9	**49**	**Yes**
MIPS Eligible Clinician 10	**82**	No

Did you know?

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

Promoting Interoperability Performance Category Score

$$= \frac{87 + 87 + 77 + 92 + 85 + 0 + 49 + 82}{10 - 2} + 5 = 74.9\%$$

Points from Required Measures

Total MIPS Eligible Clinicians in APM Entity

MIPS Eligible Clinicians Who Receive Reweighting

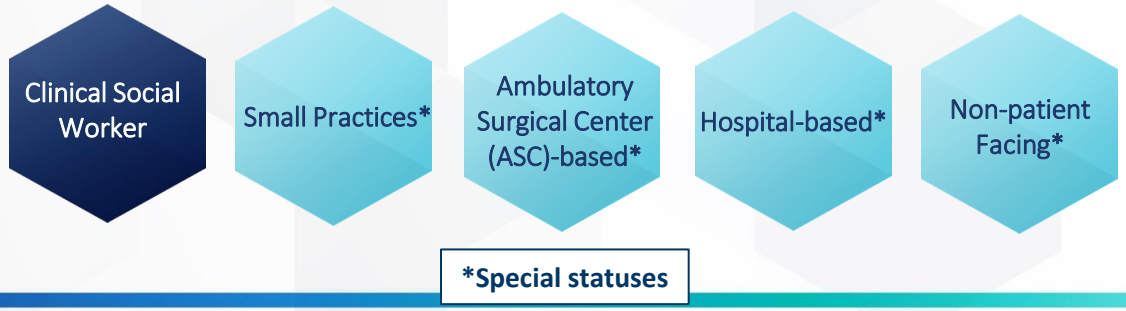
Bonus Points from Optional Public Health and Clinical Data Exchange measures

Can the Promoting Interoperability Performance Category be Reweighted?

Yes. There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score. Note that submitting Promoting Interoperability data will override any automatic or approved reweighting.

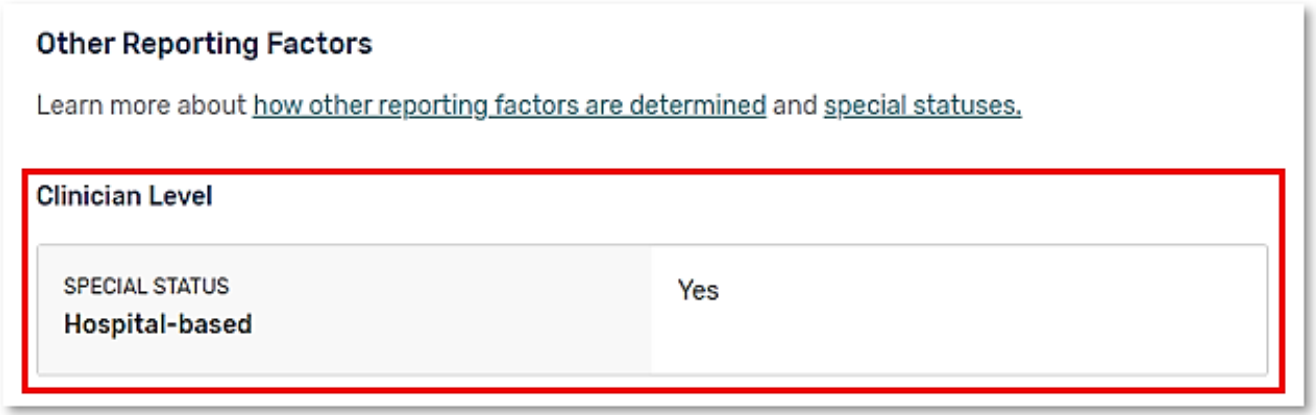
1. The MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application is available for submitting requests to reweight performance categories. Please check the Exception Applications webpage for more information.
2. An individual or group can submit a Promoting Interoperability Hardship Exception application citing one of the following specified reasons for review and approval:
   - Insufficient internet connectivity
   - Extreme and uncontrollable circumstances
   - Lack of control over the availability of CEHRT
   - Decertified EHR technology (decertified under the ONC Health IT Certification Program)

   If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you later submit data for this performance category. Learn more about hardship exceptions.
3. Some MIPS eligible clinicians qualify for automatic reweighting based on provider type or special status (see the QPP Participation Status Tool):



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

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.



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

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

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

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

Just as with individual participation, groups that qualify for reweighting but submit data for this performance category will be scored just like any other MIPS eligible clinician, and their Promoting Interoperability performance category will be weighted at 30% of the final score.

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.

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

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

Individual MIPS eligible clinicians and groups participating as an APM Entity that qualify for automatic reweighting or have an approved Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category. They'll be excluded from the calculation when we determine the APM Entity's score but will still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire APM Entity for the 2024 performance period. This could occur when all of the MIPS eligible clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

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

APP: MIPS Final Score

Quality Payment PROGRAM

How My MIPS Final Score is Calculated

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

APP Performance Category Weights in 2024:

Quality

Up to **50** points toward your MIPS final score

+

Cost

Up to **0** points toward your MIPS final score

+

Improvement Activities

Up to **20** points toward your MIPS final score

+

Promoting Interoperability

Up to **30** points toward your MIPS final score

+

Up to **10** points toward your MIPS final score

=

Up to **100** points toward your MIPS final score

EXAMPLE: APP Performance Category Weights in 2024:

Quality

91.6% X 50% X 100 =

toward your MIPS final score

+

Cost

N/A

toward your MIPS final score

+

Improvement Activities

100% X 20% X 100 =

toward your MIPS final score

+

Promoting Interoperability

94% X 30% X 100 =

toward your MIPS final score

+

Complex Patient Bonus

toward your MIPS final score

=

97.20 points

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

The MIPS final score can't exceed 100 points

What is the Complex Patient Bonus?

The complex patient bonus awards **up to 10 bonus points** based on the medical complexity and social risk of your patients. These bonus points are added to the MIPS final score for qualifying MIPS eligible clinicians, groups, and APM Entities.

The complex patient bonus is composed of 2 distinct calculations which are added together:

- The first calculation looks at medical complexity as determined by the average Hierarchical Condition Categories (HCC) risk score of your Medicare patient population.
- The second calculation looks at social risk as determined by the proportion of your Medicare patient population that's dually eligible for both Medicare and Medicaid.

We'll calculate the HCC risk scores and dual eligibility ratio for the unique Medicare patients treated during the second 12-month segment of the MIPS determination period.

The **complex patient bonus** is limited to MIPS eligible clinicians, groups, and APM Entities with at least one risk indicator (either average HCC risk score or dual eligibility ratio) at or above the median risk indicator calculated for all MIPS eligible clinicians, groups, virtual groups and APM Entities from performance period 2023.

We'll evaluate each MIPS eligible clinician, group, or APM Entity for their eligibility to receive the complex patient bonus.

Eligibility for the Complex Patient Bonus

Step 1

- We'll identify the **median HCC risk score** and **median dual eligibility ratio** based on the complex patient bonus included in the final score attributed to MIPS eligible clinicians (whether participating as an individual, group, or APM Entity) in performance period 2023.

Step 2

- We'll calculate the average HCC risk score and dual eligibility ratio for each MIPS eligible clinician, group, and APM Entity for performance period 2024.
  - **Average HCC risk score** = sum of HCC risk scores for the unique Medicare patients treated*/number of unique Medicare patients treated*
  - **Dual eligibility ratio** = unique Medicare patients treated* who were dually eligible for Medicare and full- or partial-Medicaid benefits/unique Medicare patients treated*

*Medicare patients must have been treated between October 1, 2023 and September 30, 2024 to be included in these calculations.

Step 3

- We'll compare your average HCC risk score and dual eligibility ratio (calculated in Step 2) to the median values identified in Step 1.
  - **If either (or both) of your risk indicators is at or above the median identified in step 1, you're eligible to receive the complex patient bonus.**

Did you know?

A patient's HCC risk score is based on:

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

Calculating the Complex Patient Bonus

Step 1

- We'll identify the **mean HCC risk score and mean dual eligibility ratio** based on the complex patient bonus included in the final score attributed to MIPS eligible clinicians (whether participating as an individual, group, or APM Entity) in the 2023 performance period. (This is different than the median calculated to determine eligibility.)

Step 2

- We'll calculate **a standardized** score for the medical complexity component.
  - **Medical component standardized score =** (your 2024 average HCC risk score MINUS the 2023 mean HCC risk score from step 1)/ standard deviation for the 2023 mean HCC risk score from step 1.

Step 3

- We'll calculate **a standardized** score for the social risk component.
  - **Social component standardized score =** (your 2024 dual eligibility ratio MINUS the 2023 mean dual eligibility ratio from step 1)/ standard deviation for the 2023 mean dual eligibility ratio from step 1

Step 4

- We'll calculate the medical complexity component contribution to your complex patient bonus.
  - **Medical complexity complex patient bonus points =** 1.5 + 4*(standardized score from step 2)

Step 5

- We'll calculate the social risk component contribution to your complex patient bonus.
  - **Social risk complex patient bonus points =** 1.5 + 4*(standardized score from step 3)

Step 6

- We'll calculate your total complex patient bonus
  - **Complex patient bonus =** Medical complexity points (step 4) + Social risk points (step 5)

If only 1 of the 2 risk indicators – medical complexity or social risk – was at or above the median when we determined your eligibility for the complex patient bonus, then the other will contribute 0 points toward your complex patient bonus.

APP: MIPS Payment Adjustment

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

MIPS Payment Adjustment

- Clinicians with a final score above the performance threshold of 75 points will earn a positive payment adjustment (subject to a scaling factor).
- Clinicians with a final score at the performance threshold of 75 points will earn a neutral payment adjustment.
- Clinicians with a final score below the performance threshold of 75 points will receive a negative payment adjustment. The maximum negative adjustment is -9%.

MIPS payment adjustments are calculated to ensure budget neutrality. The final MIPS payment adjustments for a year will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold.

- More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease (lower positive payment adjustments) because more MIPS eligible clinicians receive a positive MIPS payment adjustment.
- More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase (higher positive payment adjustments) because more MIPS eligible clinicians would have negative MIPS payment adjustments, and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

REMINDER: The 2022 performance period/2024 payment year was the last year for the exceptional performance adjustment.

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be.

Why? MIPS is required by law to be a budget-neutral program. Generally speaking, this means that the amount of the payment adjustment will depend on the overall participation and performance of clinicians in the program for a certain year. The table below illustrates how 2024 MIPS final scores will correlate to 2026 MIPS payment adjustments for MIPS eligible clinicians.

Final Score	Payment Adjustment
75.01 – 100.00 points	Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)
75.00 points (Performance threshold=75.00 points)	Neutral MIPS payment adjustment (0%)
18.76 – 74.99 points	Negative MIPS payment adjustment (between -9% and 0%)
0.00 – 18.75 points	Negative MIPS payment adjustment of -9%

REMINDER: The 2022 performance period/2024 payment year was the last year for the exceptional performance adjustment.

FAQs

What Might a Clinician or Group Choose to Report Separately From Their APM Entity?

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

Why Might an Individual or Group Choose to Report the APP Separate from their APM Entity?

An individual or group of MIPS eligible clinicians might choose to report the APP separately if:
They believe they'll receive a higher score by reporting at the individual or group level than at the APM Entity level;

1. They want to streamline their data collection and reporting; or
2. Their APM Entity has indicated that it won't report to MIPS on their behalf.

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

Do We Need to Tell CMS That We're Reporting the APP, Traditional MIPS, or an MVP in Advance of the Submission Period?

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

What Happens if Your ACO Doesn't Report Quality Measures?

If you're a MIPS eligible clinician participating in a Shared Savings Program ACO (or any MIPS APM) and your APM Entity doesn't report quality measures to MIPS on your behalf, you would receive a MIPS quality performance category score of 0 points and a final score below the performance threshold of 75 points, resulting in a negative payment adjustment, unless you report as an individual or group via the APP or traditional MIPS. We encourage individuals and groups that participate in the Shared Savings Program to reach out to their ACO during the performance period to determine whether the ACO will report data on their behalf. But regardless of the APM Entity's decision to report on behalf of its participants, individuals or groups of MIPS eligible clinicians who participate in MIPS APMs may choose to report the APP or traditional MIPS.

As a reminder, Shared Savings Program ACOs must report quality data via the APP at the APM Entity level to be eligible for shared losses and shared savings through the Shared Savings Program.

Will the Health Equity Adjustment under the Shared Savings Program Impact My MIPS Payment Adjustment?

No. For ACOs that report the 3 eCQMs/MIPS CQMs/Medicare CQMs and meet all other eligibility criteria for the health equity adjustment, CMS uses the health equity adjusted quality performance score in several Shared Savings Program determinations. For more information on the Health Equity Adjustment, please see the Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology v11 Specifications (PDF,1.9MB).

Can ACOs use Medicare CQMs to Meet the Shared Savings Program's eCQM/MIPS CQM Reporting Incentive?

No, Medicare CQM measures are not eligible for the Shared Savings Program's eCQM/MIPS CQM reporting incentive. To be eligible for the eCQM/MIPS CQM reporting incentive, an ACO must report all 3 measures (Quality ID#s 001, 134, and 236) as eCQMs or MIPS CQMs and meet the MIPS data completeness and case minimum requirements for all 3 of those measures; achieve a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set; and achieve a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set.

Where Can Clinicians Go for Additional Support?

Additional resources are available on the QPP website and the QPP Resource Library.
We will continue to provide support to clinicians who need assistance. While our support offerings reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance to help them successfully participate.

We encourage clinicians to contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time or by email at QPP@cms.hhs.gov. To help ACOs navigate the Shared Savings Program, please reach out to your ACO Coordinator as your first line of contact. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History

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

Date	Description
9/12/2024	Original Posting.

Appendices

Appendix A: Reweighting the Performance Categories

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

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

Performance Category Redistribution for the 2023 Performance Period/2025 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
Standard Weighting				
General weighting for all performance categories	50%	0%	20%	30%
Reweighting 1 Performance Category				
No Promoting Interoperability: *PI → Quality and IA*	75%	0%	25%	0%
No Quality: *Quality → IA and PI*	0%	0%	25%	75%

NOTE: If multiple performance categories have been reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a MIPS final score equal to the performance threshold regardless of whether any data is submitted.

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

When an Exclusion is Claimed

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

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed…
e-Prescribing	e-Prescribing		Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure OR …the 10 points are redistributed to the HIE Bi-Directional Exchange measure OR …the 10 points are redistributed to the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	Query of Prescription Drug Monitoring Program (PDMP)		Yes	…the 10 points are redistributed to the e-Prescribing measure
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	…the 15 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	…the 15 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	No	N/A
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	No	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		No	N/A
Public Health and Clinical Data Exchange	**Report on the 2 required measures:** • Immunization Registry Reporting • Electronic Case Reporting		Yes	…the 25 points are still available in this objective if you claim an exclusion for one of the required measures and submit a "yes" attestation for the other required measure in the objective. … the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim two exclusions.
	Bonus: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		N/A	N/A

NOTE: Even if you claim 1 or 2 exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures, you can still earn a total of 5 bonus points by reporting 1, 2 or 3 of the optional Public Health and Clinical Data Exchange measures (Public Health Registry Reporting, Clinical Data Registry Reporting, or Syndromic Surveillance Reporting).

Appendix C: Quality Measure Collection Types

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
eCQMs	PY 2024 APP Quality Requirements (All Participants, Excluding SSP ACOs) (ZIP, 3MB) PY 2024 APP Quality Requirements (SSP ACOs Only) (ZIP, 6MB) Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)	You can submit eCQMs if you use technology that is certified to align with ONC's regulations at 45 CFR 170.315. 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. For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.	• Individuals • Groups • APM Entities
MIPS CQMs	PY 2024 APP Quality Requirements (All Participants, Excluding SSP ACOs) (ZIP, 3MB) PY 2024 APP Quality Requirements (SSP ACOs Only) (ZIP, 6MB) Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)	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. For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.	• Individuals • Groups • APM Entities

Appendix C: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
Medicare Part B Claims	2024 Medicare Part B Claims Measure Specifications and Supporting Documents 2024 Part B Claims Reporting Quick Start Guide	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.	• Individuals [Clinicians in small practices (15 or fewer clinicians) only] • Groups [small practices (15 or fewer clinicians) only] • APM Entities (15 or fewer clinicians in the APM Entity) • No Shared Savings Program ACOs met the criteria for small practice designation at the APM Entity level in PY 2023.
CMS Web Interface	Performance Period 2024 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs	Reporting via the CMS Web Interface requires that you submit data on a sample of Medicare FFS beneficiaries for each measure within the application. Performance data reporting requires that you must confirm and completely report on 248 (or all eligible patients, if there are less than 248) consecutively ranked patients. The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface.	• APM Entities (Shared Savings Program ACOs only)

REMINDER: The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface.

Appendix C: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
Medicare CQM	2024 Medicare CQMs Specifications and Supporting Documents for Accountable Care Organizations Participating in the Medicare Shared Savings Program Medicare Shared Savings Program: Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Pathway (PDF, 865KB) 2024 Medicare CQMs for Shared Savings Program Accountable Care Organizations Checklist	Data is reported on the ACO's Medicare FFS beneficiaries that meet the definition of a beneficiary eligible for Medicare CQMs at 42 CFR 425.20, instead of reporting on their all payer/all patient population. Performance data must be reported for at least 75% of the eligible population. You can collect and submit these measures yourself or with the help of a third-party intermediary such as a Qualified Registry.	• APM Entities (Shared Savings Program ACOs only)
CAHPS for MIPS Survey	2023 CAHPS for MIPS Overview Fact Sheet	Groups and APM Entities must register between April 1, 2024 and July 1, 2024 to administer the CAHPS for MIPS Survey, a survey measuring patient experience and care within a group or APM Entity. This survey must be administered by a CMS Approved Survey Vendor. Shared Savings Program ACOs don't have to register to administer CAHPS for MIPS Survey. They're automatically registered. **NEW:** Beginning with the 2024 performance period, registered groups and APM Entities (including Shared Savings Program ACOs) are required to contract with a CAHPS for MIPS Survey vendor to administer the Spanish translation of the survey to Spanish-preferring patients.	• Groups (registered groups with 2 or more clinicians) • APM Entities (registered APM Entities with 25 or more clinicians)