Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Traditional MIPS Scoring Guide for the 2024 Performance Year

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

How to Use This Guide

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

Table of Contents

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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 payment tracks.

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

An APM is a customized payment approach developed by CMS, often designed to provide incentives to clinicians who are providing high-quality, high-value care. APMs can focus on specific clinical conditions, care episodes, or populations.

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

This guide will only cover **Merit-based Incentive Payment System (MIPS) participation in QPP**. For more information on participating in an Advanced APM, visit our Advanced APMs webpage and check out our APM related resources in the QPP Resource Library.

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

If you're eligible for MIPS in 2024:

- You have to report measure and activity data for the quality (PDF, 271KB), improvement activities (PDF, 298KB), and Promoting Interoperability (PDF, 244KB) performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances (EUC) or hardship exception. Detailed information will be available in the forthcoming 2024 Traditional MIPS Scoring Guide and 2024 APP Scoring Guide. These will be posted to the QPP Resource Library. The 2024 MIPS Value Pathways Implementation Guide (PDF, 1MB) is available now.
- We collect and calculate data for the cost (PDF, 348KB) performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, EUC and whether or not you meet the case minimum for any cost measures. Detailed information is available in the 2024 MIPS Cost Quick Start Guide and 2024 MIPS Value Pathways (MVPs) Implementation Guide (PDF, 1MB) and forthcoming in the 2024 Traditional MIPS Scoring Guide. These will be posted to the QPP Resource Library.

Continued on next slide.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

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

If you're eligible for MIPS in 2024 (Continued):

- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - Positive payment adjustment for clinicians with a 2024 final score above 75.
  - Neutral payment adjustment for clinicians with a 2024 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2024 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

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

There are **3 reporting options** available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Traditional MIPS Overview webpage to learn more.	• The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM)**. • Visit the APM Performance Pathway webpage to learn more.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for all applicable measures in the cost performance category for you.	• We collect and calculate data for you for all applicable cost measures included in the selected MVP and the population health measure you selected.	• Cost isn't evaluated under the APP.

Getting Started: Reviewing MIPS Terms

Collection Type*

Collection Type is a set of quality measures with comparable specifications and data completeness criteria, identified as:

- Electronic clinical quality measures (eCQMs).
- MIPS clinical quality measures (MIPS CQMs).
- Qualified Clinical Data Registry (QCDR) measures.
- Medicare Part B claims measures (available to small practices).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure (available to groups, virtual groups, and APM Entities with 2 or more clinicians).
- Administrative claims measures.

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

Submitter Type

Submitter Type refers to the MIPS eligible clinician, group, virtual group, APM Entity, or third party intermediary (acting on behalf of a MIPS eligible clinician, group, virtual group, or APM Entity) that submits data on measures for the quality and Promoting Interoperability performance categories and activities for the improvement activities performance category.

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 Program Interface, or API).
- Sign in and upload (attaching a file).
- Sign in and attest (manually entering data).
- Medicare Part B claims.

**There isn't a submission type for the cost performance category because we collect and calculate your cost measures from administrative claims data submitted for payment.

Data Aggregation and Multiple Submissions

Measures and activities submitted via multiple submission types can count toward a single performance category score, but there's some variation between performance categories. Please see **Data Aggregation and Multiple Submissions** within each performance category section for more information.

- Quality performance category
- Improvement activities performance category
- Promoting Interoperability performance category

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Traditional MIPS: Quality Performance Category

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What are the Traditional MIPS Quality Performance Category Requirements?

You can select from 198 available MIPS quality measures finalized for the 2024 performance period, in addition to hundreds of QCDR measures approved by CMS outside of rulemaking.

You'll need to collect and submit data for each quality measure for the entire calendar year of 2024 (January 1 – December 31, 2024.)

We'll aggregate MIPS quality measures collected through multiple collection types into a single quality performance category score.

To meet traditional MIPS quality performance category requirements, an individual, group, virtual group, or APM Entity can:

Submit at least 6 MIPS quality measures for the 12-month performance period:

- 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
- The CAHPS for MIPS Survey measure counts as 1 of the 6 measures for registered groups, virtual groups, and APM Entities and can be counted as a high priority measure if there aren't any applicable outcome measures.

OR

Submit a defined specialty measure set.

If the specialty measure set has fewer than 6 measures, you'll need to submit all measures within the specialty set to meet quality reporting requirements.

Individual, Group, and Virtual Group Participation

Quality

30% | **of MIPS Score**

APM Entity Participation

55% | **of MIPS Score**

Small Practices Not Submitting Promoting Interoperability Data

40% | **of MIPS Score**

What are the Traditional MIPS Quality Performance Category Requirements? (Continued)

There are also 4 MIPS quality measures that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

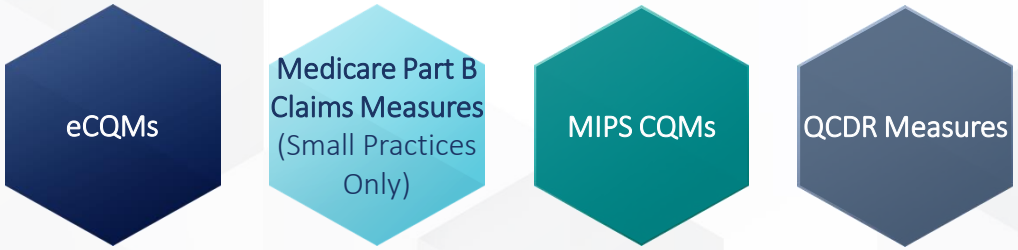
- Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under MIPS (ZIP, 1MB)
  - This measure has a case minimum of **21 cases** and will only apply to **groups, virtual groups, and APM Entities with at least 1 cardiologist**.
- Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for MIPS (ZIP, 568KB)
  - This measure has a case minimum of **25 cases** and will apply to **individuals, groups, virtual groups, and APM Entities**.
  - This measure has a **3-year performance period** (consecutive 36-month timeframe).
    - For the 2024 MIPS performance period, the Hip Arthroplasty and Knee Arthroplasty Complication Measure's performance period starts on October 1, 2021 (3 years prior to the performance period) and ends on September 30, 2024 (current performance period), with a 3-month numerator assessment period.
- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups (ZIP, 822KB)
  - This measure has a case minimum of **200 cases** and will apply to **groups, virtual groups, and APM Entities with at least 16 clinicians**.
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP, 5MB)
  - This measure has a case minimum of **18 cases** and will only apply to **groups, virtual groups and APM Entities with at least 16 clinicians.**

Quality Measure Scoring

How are Quality Measures Assessed and Scored?

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

Benchmarks are differentiated by collection type. There may be different benchmarks for the same measure if it can be reported through multiple collection types.



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 prior to 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.

For more information about the 2024 quality benchmarks, please review the information included in the 2024 Quality Benchmarks.

Administrative Claims Measures: We intend to calculate performance period benchmarks for the 4 administrative claims measures.

Did you know? If you submit eCQMs, you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eCQM data. The CEHRT used to collect the data must be certified to meet the Office of the National Coordinator for Health Information Technology (ONC) criteria by the time eCQM data is generated for submission.

CAHPS for MIPS Survey Measure:

We established historical benchmark for the summary survey measures (SSMs) in the CAHPS for MIPS Survey measure.

Refer to the 2024 Quality Benchmarks.

Each SSM with a benchmark is awarded 1 to 10 points by comparing performance to the benchmark.

The final CAHPS for MIPS Survey measure score is calculated as the average number of points across all scored SSMs.

Quality Measure Scoring (Continued)

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

For a measure without a historical benchmark, we'll try to calculate a benchmark based on performance data submitted for the 2024 performance period on those measures.

Performance period benchmarks can be calculated when 20 or more individuals, groups, virtual groups, or APM Entities submit the measure through the same collection type where the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured).
- Meets or exceeds the 75% data completeness criteria.
- Has a performance rate greater than 0% (or less than 100% for inverse measures).

Individuals, groups, virtual groups, and APM Entities must be included in MIPS (i.e., not voluntarily reporting) for their data to be used in the creation of a benchmark. This includes individual clinicians, groups, virtual groups and APM Entities that are opt-in eligible and elect to opt-in to MIPS participation.

When calculating performance period benchmarks, we use measure data submitted for traditional MIPS, the APP and MVPs.

Quality Measure Scoring (Continued)

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, **your submission must identify the total eligible population** (or denominator) as outlined in the measure's specification. (For small practices reporting Medicare Part B claims measures, we identify the eligible population based on the claims you submit.)
- To meet data completeness criteria, **you must then report performance data (performance met or not met, or denominator exceptions) for at least 75%** of the total eligible population (denominator).
- Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking"), wouldn't be considered true, accurate, or complete and may subject you to audit.
- Note that data completeness is specific to Medicare patients for Medicare Part B claims measures only; QCDR measures, MIPS CQMs and eCQMs should include all-payer data.
- **Measures that don't meet data completeness will earn zero points, unless you're a part of a small practice in which case the measure will earn 3 points**.

Note: The data completeness threshold will remain at 75% for the 2025 and 2026 performance periods.

Quality Measure Scoring (Continued)

Measure Achievement Points for the 2024 Performance Period

Measures that can be reliably scored

Measure achievement points are based on your performance for a measure in comparison to a benchmark. A measure can be reliably scored against a benchmark when:

- A benchmark (historical or performance period) is available.
- Data completeness and case minimum criteria are met.

7-10 points

You'll earn 7 – 10 points for new measures in their **first year** of the program that can be reliably scored against a benchmark.

5-10 points

You'll earn 5 – 10 points for new measures in their **second year** of the program that can be reliably scored against a benchmark.

1-10* points

You'll earn 1 – 10 points for measures in their **third year (or later)** of the program that can be reliably scored against a benchmark.

Did you know?
These measure scoring policies **don't** apply to administrative claims measures.

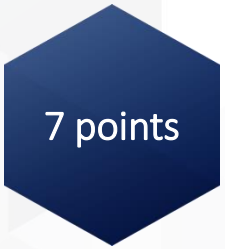
***Exception:** There are specified, topped out measures that are capped at 7 points. (These measures are identified in the 2024 Quality Benchmarks – see Column T).

Quality Measure Scoring (Continued)

Measure Achievement Points for the 2024 Performance Period (Continued)

Measures that can't be reliably scored

When a measure meets data completeness criteria but can't be reliably scored against a benchmark, it means either a benchmark (historical or performance period) is unavailable **OR** the measure didn't meet case minimum criteria.



You'll earn 7 points for new measures in their **first year** of the program that can't be reliably scored against a benchmark

You'll earn 5 points for new measures in their **second year** of the program that can't be reliably scored against a benchmark.

You'll earn 0 points for measures in their **third year** (or later) of the program that can't be reliably scored against a benchmark.
Small practices will continue to earn 3 points.

Did you know?
These measure scoring policies **don't** apply to administrative claims measures.

Quality Measure Scoring (Continued)

Measure Achievement Points for the 2024 Performance Period (Continued)

Required but unreported measures

You'll continue to receive 0 points for measures that are required, but unreported.

Note: This includes measures submitted without performance data. (You must report performance data for the measure to be considered reported.)

Measures that don't meet data completeness criteria

If you aren't in a small practice (small practices have 15 or fewer clinicians), you'll continue to receive 0 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

Small practices will continue to receive 3 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

Quality Performance Category Bonus Points

Measure Bonus Points

There are **no measure-level bonus points available.**

Small Practice Bonus

Small practices will continue to receive 6 bonus points, added to the numerator of the quality performance category, if they report at least one MIPS quality measure.

- This bonus is available to individuals, groups, virtual groups and APM Entities with the small practice special status.
- This bonus isn't available to small practices that receive a quality performance category score from facility-based measurement.

Quality Performance Category Scoring

What if I Submit More Than 6 Measures?

If you submit more than 6 measures, only 6 of those measures will contribute to the measure achievement points for your quality performance category score.

When determining which submitted measures are included in the top 6:

- We'll select the highest scoring outcome measure.
  - If no outcome measure is available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we'll select your 5 highest scoring measures, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85% performance rate, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

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

- **Example:** Your group submits 7 measures, and the 2 lowest scoring measures (after the outcome measure) were Measure 102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients and Measure 143: Oncology: Medical and Radiation - Pain Intensity Quantified, both earning 2.2 points. The Prostate Cancer measure will be included in the top 6 because its measure ID (102) has a lower value than the measure ID for the Oncology: Medical and Radiation - Pain Intensity Quantified measure (143).

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. We won't aggregate measure level performance data when the same measure is reported multiple times.

If you submit the same measure through multiple collection types (i.e., as a Medicare Part B claims measure and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points from 2 collection types of the same measure.

Quality Performance Category Scoring (Continued)

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

Maximum Points by Participation Level
Individuals:

- **60 points** — For 6 required MIPS quality measures
- **70 Points** — For 6 required MIPS quality measures + 1 administrative claim measure

Maximum Points by Participation Level
Groups/Virtual Groups/APM Entities:

- **60 points** — For 6 required MIPS quality measures
- **70 Points** — For 6 required MIPS quality measures + 1 administrative claims measure
- **80 Points** — For 6 required MIPS quality measures + 2 administrative claims measures
- **90 Points** — For 6 required MIPS quality measures + 3 administrative claims measures
- **100 Points** — For 6 required MIPS quality measures + 4 administrative claims measures

Individuals, groups, virtual groups, and APM Entities that don't submit at least 1 available measure will receive 0 points in this performance category unless you qualify for the performance category to be reweighted.

Quality Performance Category Scoring (Continued)

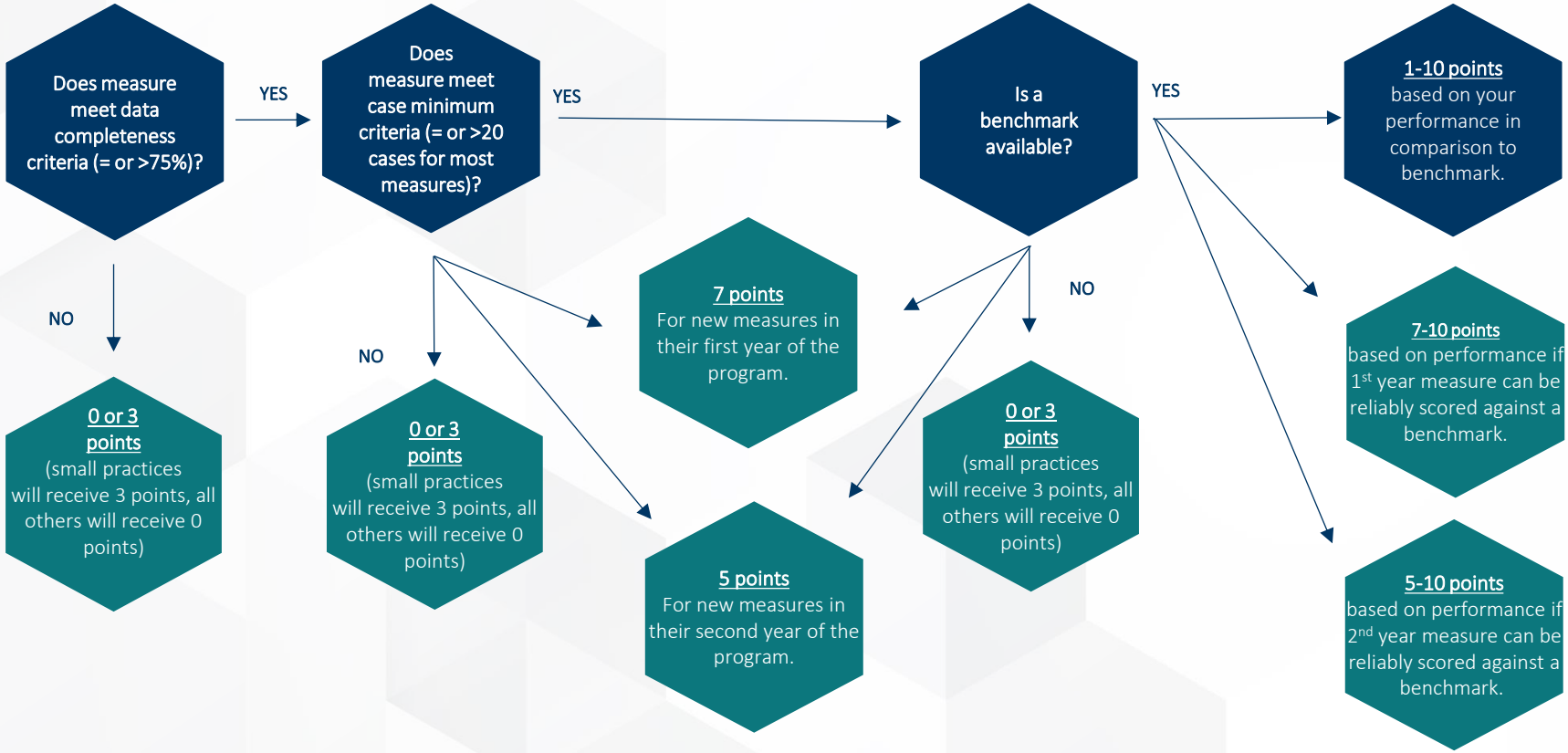
Can the Denominator (Maximum Number of Points) be Lower than 60 Points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower than 60 points.

IF…	THEN…
You submit a complete specialty measure set with fewer than 6 measures by either Medicare Part B claims or MIPS CQMs.	We'll lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B claims measures or MIPS CQMs **AND** the Eligible Measure Applicability (EMA) process (PDF, 736KB) determines no additional measures were available. **How?** We compare the measures you submitted with a predefined list of clinically related measures.	We'll lower the denominator by 10 points for each measure that isn't available. **NOTE:** If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the quality performance category and you'll earn a score of 0 out of 10 for each of these measures.
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. (Refer to slides 26 - 29 for suppressed measure scoring examples.) To the extent feasible, we'll identify suppressed measures via QPP listserv by the end of the submission period. Refer to Appendix D for a list of affected measures.	We'll lower the denominator by 10 points for each impacted measure that was submitted and meets data completeness and case minimum requirements. **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 held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we'll truncate the performance period and score the measure instead of suppressing the measure and reducing the denominator.
Your group, virtual group, or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements **AND** submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS Survey measure.

Quality Performance Category Scoring (Continued)

What Are the Steps to Score Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs?



Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.

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

Quality Performance Category Scoring (Continued)

The purpose of this slide is to highlight the difference between concepts impacting measure scoring and performance. Each concept below provides guidance on their function within MIPS.

Suppression – Scoring Flexibility

- Applied when data is not available for at least 9 consecutive months, or CMS determines that the measure may result in patient harm or misleading results.

Truncation – Submission Flexibility

- Applied when there is data available and can be reported without concerns for measure data integrity for 9 consecutive months of the 2024 performance period.
- Timeframe will be specified by CMS in the Truncated and Suppressed MIPS Quality Measures publication, if there are measures identified as being truncated.
- Does not apply to the eCQM collection type.
- Truncation to the 9-month period should be applied to the denominator criteria for the purposes of determining denominator eligibility. The numerator will function as currently specified for those patients that fall into the denominator during the 9-month period.

Benchmark Removal – Not a Scoring Flexibility

- Applies when proposed substantive changes are finalized through public notice and comment rulemaking no longer allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes.
- Benchmark removals are proposed and finalized within the upcoming MIPS performance year rules.

Quality Performance Category Scoring (Continued)

Suppressed Measures: Submission and Scoring Examples

MIPS eligible clinicians, groups, virtual groups, and APM Entities must submit data for all 6 measures (or all measures within a specialty measure set with fewer than 6 measures) to meet the reporting requirements for the quality performance category. When you submit one or more suppressed measures, your quality performance category score is based on the measures you submitted that aren't suppressed. Suppressed measures must still meet data completeness and case minimum requirements.

Example 1

You're reporting eCQMs collected in your CEHRT and have performance data for 6 measures. One of the measures you intend to submit has been suppressed for the 2024 performance period. (If any measures are suppressed for the 2024 performance period, they'll be identified in Appendix D.)

You submit the 5 measures that weren't suppressed and don't submit the one measure that was suppressed.

- **5 submitted measures**: Are scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **1 unsubmitted (suppressed) measure:** Receives 0 out of 10 points because it wasn't submitted (6 measures are required to be submitted, including suppressed measures, to meet the reporting requirements for the quality performance category).
- **Quality denominator:** 60 points/not reduced. No suppressed measures were submitted.

Quality Performance Category Scoring (Continued)

Example 2

Two of the 6 measures you intend to report have been suppressed for the 2024 performance period. (If any measures are suppressed for the 2024 performance period, they'll be identified in Appendix D.)

You submit the 6 measures, including the 2 measures that were suppressed.

- **4 submitted (not suppressed) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **2 submitted, suppressed measures:** Excluded from scoring because the measures were suppressed.
- **Quality denominator:** Reduced by 20 points (10 points for each submitted, suppressed measure). Quality denominator is 40 points unless you can be scored on any administrative claims measures.

Example 3

You're working with a qualified registry to report your quality measures.

Your registry submits 9 measures on your behalf, including 2 measures that are suppressed. (If any measures are suppressed for the 2024 performance period, they'll be identified in Appendix D).

- **Quality denominator**: Reduced by 20 points (10 points for each submitted, suppressed measure).
- **Quality numerator:** The 4 highest scoring measures out of the 7 measures that weren't suppressed.

The suppressed measure scoring policy is intended to hold clinicians harmless in the event that they've collected data for a suppressed measure and don't have enough measures to meet the requirement to report 6 measures.

The purpose of submitting a suppressed measure is to ensure the clinician gets credit for having met reporting requirements, even though the measure won't be scored.

If you have 6 non-suppressed measures available, you should submit those without submitting any suppressed measures.

Quality Performance Category Scoring (Continued)

Example 4

You submit 6 suppressed measures.

- The quality performance category isn't reweighted; you would receive a quality performance category score of zero points, regardless of whether you submitted additional measures that aren't suppressed.

TIP: If you submitted 6 suppressed measures because there were no other measures available, you can submit a Targeted Review (when final performance feedback is available) to request reweighting of the entire quality performance category.

Quality Performance Category Scoring (Continued)

Truncated Measures: Submission and Scoring Examples

A truncated measure will have performance assessed based on data from 9 consecutive months of the 2024 performance period. Measure data must be truncated prior to submission for MIPS CQMs. Truncated measures must still meet data completeness and case minimum requirements.

Example 1

One of the 6 MIPS CQMs you intend to submit has been truncated for the 2024 performance period. (If any measures are truncated for the 2024 performance period, they'll be identified in Appendix D).

You or your third party truncated the measure to 9 consecutive months of data (as specified in the truncation announcement) prior to submission. You submit the 6 measures.

- **6 submitted (non-truncated and truncated) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Quality denominator is 60 points unless you can be scored on any administrative claims measures. We don't reduce the quality denominator for truncated measures.

Example 2

A small practice is reporting 6 Medicare Part B claims measures, one of which has been truncated for the 2024 performance period. (If any measures are truncated for the 2024 performance period, they'll be identified in Appendix D).

You continue reporting the measures via Medicare Part B claims. We'll truncate the affected measure to 9 consecutive months of data (as specified in the truncation announcement) for you.

- **6 submitted (non-truncated and truncated) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Quality denominator is 60 points unless you can be scored on any administrative claims measures. We don't reduce the quality denominator for truncated measures.

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, Virtual Groups, and APM Entities

For individuals, groups, virtual groups, and APM entities that aren't a small practice, the quality performance category score is calculated as:

For individuals, groups, virtual groups, and APM Entities that are part of a **small practice**, the quality performance category score is calculated as:

*Total Available Measure Achievement Points = the number of required measures (including administrative claims measures) x 10

Calculating the Quality Performance Category Score (Continued)

Scoring for Individuals, Groups, Virtual Groups, and APM Entities (Continued)

- A total of **6 bonus points** will be added to the numerator of the quality performance category for MIPS eligible clinicians in **small practices who submit data on at least 1 quality measure** (these bonus points are available to small practices through individual, group, virtual group, and APM Entity participation).
- Your quality performance category score is then multiplied by the quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100% of the category weight.

- **When the quality performance category is weighted at 30%, there's a maximum of 30 points that the quality performance category can contribute to your MIPS final score.**

Calculating the Quality Performance Category Score (Continued)

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

Example 1 The MIPS eligible clinician, group, or virtual group is scored on all 4 MIPS performance categories.	81.9% x **30%** x 100 = **24.56** Points under the quality performance category contributing to the MIPS final score
Example 2 The MIPS eligible clinician, group, or virtual group can't be scored on the cost performance category.	81.9% x **55%** x 100 = **45.05** Points under the quality performance category contributing to the MIPS final score
Example 3 The MIPS eligible clinician, group, or virtual group is a small practice that receives automatic reweight of the Promoting Interoperability performance category.	81.9% x **40%** x 100 = **32.76** Points under the quality performance category contributing to the MIPS final score

Calculating the Quality Performance Category Score (Continued)

What is Improvement Scoring?

MIPS eligible clinicians can **earn up to 10 additional percentage points** in the quality performance category **based on the rate of their improvement in the quality performance category** from the previous year. The improvement score—calculated at the category level and represents 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 there's no improvement, the improvement score will be 0%. **The improvement score can't be negative.**

Eligibility for these additional percentage points is determined by meeting the following criteria:

1. Full participation in the quality category for the current performance period:
    - Submits 6 measures (with at least 1 outcome/high priority measure).
    - Submits a complete specialty measure set (which may have fewer than 6 measures; submits all measures in the set).
        - All submitted measures must meet data completeness requirements.
2. Data sufficiency standard is met, meaning there's data available and can be compared:
    - There's 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 in the performance period immediately prior to the current MIPS performance period.

Calculating the Quality Performance Category Score (Continued)

How is improvement scoring calculated?

Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2023) performance period to the quality performance category achievement percentage score for the current (2024) performance period.

Calculating the Quality Performance Category Score (Continued)

Scoring Example

A small practice, participating as a group, reports 2 Medicare Part B claims measures and 3 eCQMs. They also registered to administer the CAHPS for MIPS Survey but were unable to administer the survey because they didn't meet the Medicare patient sampling requirements.

Measure Type	Collection Type	Achievement Points
Outcome Measure #1	Medicare Part B claims	7.8
Process Measure	Medicare Part B claims	7.1
Process Measure	eCQM	6.9
Outcome Measure #2	eCQM	8.2
Process Measure	eCQM	6.1
Total Points		36.1 (out of 50)

The group's quality denominator is reduced by 10 points (from 60 to 50 points) because they registered, but didn't meet sampling requirements, for the CAHPS for MIPS Survey.

This example assumes that the group couldn't be scored on any administrative claims measures either.

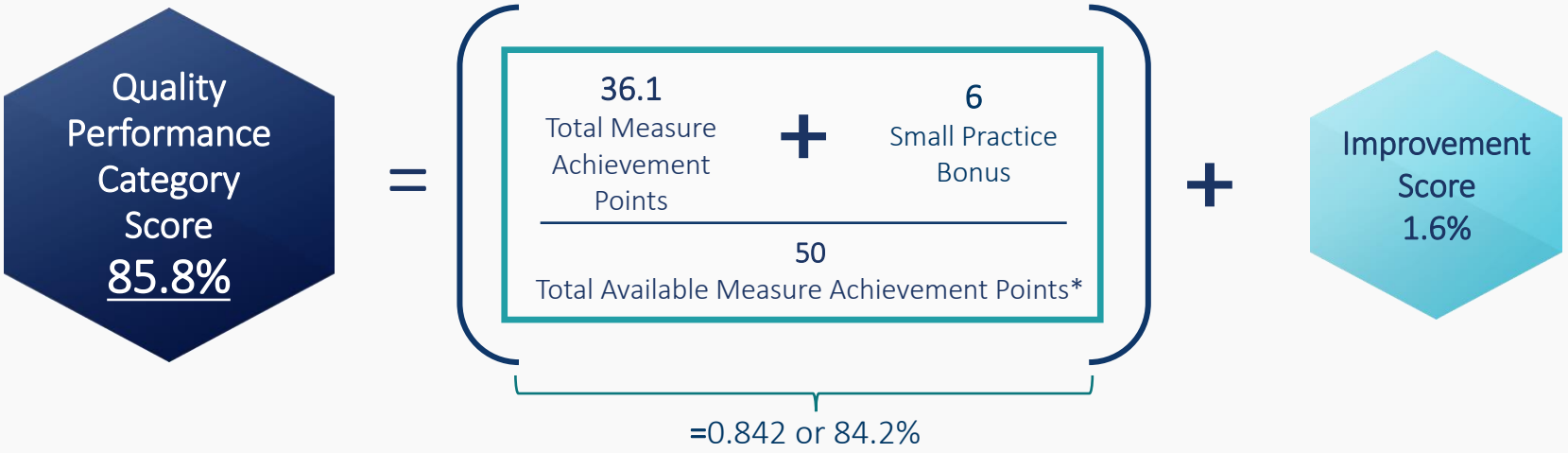
Because they're a **small practice**, they qualify for **6 bonus points**.

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

- Their 2024 achievement score = 36.1/50 = 72.2%
- Their 2023 achievement score = 62.2%
- The increase in their achievement score = 72.2% - 62.2% = 10%
- Their improvement score = (10% ÷ 62.2%) x 10 = 1.6%

Calculating the Quality Performance Category Score (Continued)

Scoring Example (Continued)



Why is Their Denominator 50?

The group registered for, but didn't meet the sampling requirements for, the CAHPS for MIPS Survey measure and submitted less than 6 quality measures, so we reduced the denominator by 1 required measure.

What is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility-based,
- You're attributed to a facility with a Fiscal Year 2025 Hospital VBP Program score (we won't know if a facility has a 2025 score until the end of the 2024 performance period), and
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

For more information on facility-based scoring, review the 2024 Facility-Based Quick Start Guide (PDF, 1MB).

Reweighting the Quality Performance Category

The quality performance category can be reweighted (and its weight redistributed to other categories) in 3 circumstances for traditional MIPS reporting:

1. **You don't have any available quality measures.**

   NOTE: We anticipate that reweighting of the quality performance category for lack of available measures would be a rare occurrence because there are quality measures applicable and available for most clinicians.
   Please contact QPP Service Center.

2. **Quality is reweighted due to extreme and uncontrollable circumstances.**

   NOTE: This can happen through an approved exception application or if you qualify for our automatic extreme and uncontrollable circumstances policy.

3. **UPDATED per the CY 2025 Medicare Physician Fee Schedule Final Rule: The third party intermediary (QCDR, Qualified Registry, or EHR vendor) you contracted with failed to submit your quality data.**

   NOTE: If your third party intermediary doesn't submit your quality data for the 2024 performance year, you can request reweighting for the quality performance category through the QPP Service Center (send an email to QPP@cms.hhs.gov) until November 1, 2025.

Please refer to Appendix B for more information about the redistribution of weights to other performance categories.

Traditional MIPS: Cost Performance Category

Quality Payment PROGRAM

What are the Cost Performance Category Data Submission Requirements?

There are no additional data submission requirements for this performance category. We use Medicare administrative claims data to calculate your cost measure performance.

How are MIPS Cost Measures Scored?

For a cost measure to be scored, an individual MIPS eligible clinician, group, or virtual group must meet or exceed the case minimum for that cost measure. Each of the 29 MIPS cost measures can earn a maximum of 10 achievement points. The table on the next page outlines the case minimum for each of the 29 MIPS cost measures.

Individual, Group, and Virtual Group Participation	
Cost	
	
30%	of MIPS Score
APM Entity Participation	
0%	of MIPS Score

How are MIPS Cost Measures Scored? (Continued)

MIPS Cost Measure	Episode-based Measure Type	Case Minimum
Total Per Capita Cost for All Attributed Beneficiaries (TPCC) Measure	N/A	20
Medicare Spending Per Beneficiary (MSPB Clinician) Measure	N/A	35
Elective Outpatient Percutaneous Coronary Intervention (PCI) Measure	Procedural	10
Knee Arthroplasty Measure	Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation Measure	Procedural	10
Screening/Surveillance Colonoscopy Measure	Procedural	10
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	10
Colon and Rectal Resection	Procedural	10
Elective Primary Hip Arthroplasty	Procedural	10
Femoral or Inguinal Hernia Repair	Procedural	10
Hemodialysis Access Creation	Procedural	10
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	10
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	10
Melanoma Resection	Procedural	10
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	10
Renal or Ureteral Stone Surgical Treatment	Procedural	10

How are MIPS Cost Measures Scored? (Continued)

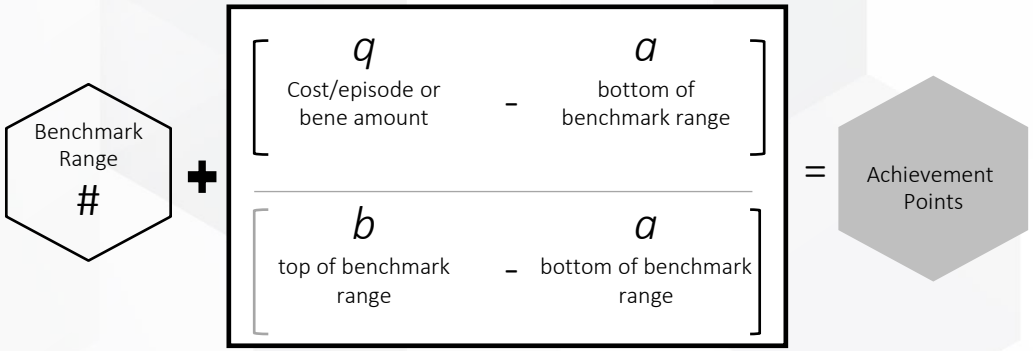
MIPS Cost Measure	Episode-based Measure Type	Case Minimum
Intracranial Hemorrhage or Cerebral Infarction Measure	Acute inpatient medical condition	20
Sepsis	Acute inpatient medical condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) Measure	Acute inpatient medical condition	20
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	20
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	20
Psychoses and Related Conditions	Acute inpatient medical condition	20
Diabetes	Chronic Condition	20
Asthma/COPD	Chronic Condition	20
Depression	Chronic Condition	20
Heart Failure	Chronic Condition	20
Low Back Pain	Chronic Condition	20
Emergency Medicine	Care Setting	20

How are MIPS Cost Measures Scored? (Continued)

To assess your MIPS cost measure performance, we'll:

- Establish a benchmark for each cost measure based on the performance period
  - There are no historical benchmarks established for cost measures.
- Compare the cost per episode or per beneficiary (expressed as a dollar amount) on each measure to the performance period benchmark(s).
- Assign 1 to 10 achievement points to each measure based on that comparison. The number of achievement points assigned is determined by identifying which benchmark range the individual or group's measure performance falls in between.

Achievement points are awarded to scored measures according to the following formula:



How are MIPS Cost Measures Scored? (Continued)

UPDATED 12/16/2024.

We finalized a change to our cost scoring methodology in the CY 2025 Medicare Physician Fee Schedule Final Rule. This change is effective beginning with the 2024 performance period, for cost scores provided in the performance feedback report that will be released in the summer of 2025.

The finalized cost scoring methodology will be based on standard deviation, median, and an achievement point value that is derived from the performance threshold. Specifically, under this new scoring methodology, the national median cost for a measure will be set at a score derived from the performance threshold established for that MIPS payment year.

- For example, for the 2024 performance period, **a clinician with costs equal to the national median cost for a measure will receive 7.5 achievement points for the cost performance category**, the performance threshold equivalent.
- The cut-offs for benchmark point ranges will be calculated based on standard deviations from the median cost.

The new cost scoring methodology will more appropriately incentivize or penalize clinicians with below or above national average spending.

How are MIPS Cost Measures Scored? (Continued)

UPDATED 12/16/2024.

Let's look at an example of how the finalized benchmark methodology will affect scoring.

Dr. Clark's average cost per episode for a cost measure is **$1,104**, and the national median for this measure is $969.72

- Under the old methodology, she'd receive between 2 and 2.9 points.
- Under the new methodology, she'll receive between 6 and 6.9 points.

OLD Methodology	
Points	Range of Costs Per Episode
1 - 1.9	$1330.65 - $1126.35
2 - 2.9	$1126.34 - $1062.93
3 - 3.9	$1062.92 - $1025.75
4 - 4.9	$1025.74 - $997.78
5 - 5.9	$997.77 - $969.73
6 - 6.9	$969.72 - $940.03
7 - 7.9	$940.02 - $904.83
8 - 8.9	$904.82 - $860.44
9 - 9.9	$860.43 - $779.69
10	$779.68

Dr. Clark's average cost per episode for a cost measure is $1,104.

The **national median cost** for this measure is $969.72.

NEW Methodology (Effective with PY 2024 Scoring)	
Points	Range of Costs Per Episode
1 - 1.9	$1,341.93 - $1,308.1
2 - 2.9	$1,308.09 - $1,274.26
3 - 3.9	$1,274.25 - $1,240.43
4 - 4.9	$1,240.42 - $1,172.75
5 - 5.9	$1,172.74 - $1,105.08
6 - 6.9	$1,105.07 - $1,037.4
7 - 7.9	$1,037.39 - $902.05
8 - 8.9	$902.04 - $834.38
9 - 9.9	$834.37 - $766.7
10	$766.69

Cost Improvement Scoring

How is improvement scoring calculated?

Cost improvement scoring is calculated by comparing the cost performance category score from the previous (2023) performance period to the cost performance category score for the current (2024) performance period.

Cost Improvement Scoring Example

The following provides an example of how we'll calculate the improvement percent score. We'll continue with the example of a small practice reporting as a group.

- For the **2023 performance period**, the group earned a cost performance category score of 60% (12 out 20 points).
- For the **2024 performance period,** they earned a cost performance category score of 70% (7 out 10 points).

- Your cost improvement score can't be negative – if your cost performance decreases, your improvement score will be 0%.
- The cost improvement score is capped at 1%.

$$\text{Improvement Score (\%)} = \left[\frac{\text{2024 Score (70\%)} - \text{2023 Score (60\%)} = \text{10\% (Increase from 2023)}}{\text{60\% (2023 Score)}} \right] / 100 = 0.17\%$$

Cost Performance Category Scoring

The cost performance category score is the equally weighted average of all scored measures plus the cost improvement score, not to exceed 1 percentage point. The cost performance category score is then multiplied by the category weight to determine the number of points the category contributes to the final score.

*Total Available Measure Points = # of scored cost measures x 10

Scoring Example

Let's continue with the previous example of the small practice reporting as a group. They only met the case minimum for the MSPB-Clinician measure. When evaluated against the performance period benchmark, they earn 7.0 points out of 10 points for the measure.

What is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility-based, and
- You're attributed to a facility with a Fiscal Year 2024 Hospital VBP Program score (we won't know if a facility has a 2024 score until the end of the 2023 performance period), and
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

For more information on facility-based scoring, review the 2024 Facility-Based Quick Start Guide (PDF, 1MB).

Can the Cost Performance Category be Reweighted?

Yes. You won't be score on this performance and it will be reweighted to 0% of your final score when:

- You can't be scored on any of the cost measures (you don't meet the case minimum for any of them, or we're unable to establish a benchmark for any of the measures for which you do meet the case minimum).
- You have an approved extreme and uncontrollable circumstance application that includes the cost performance category,
- You qualify for the automatic extreme and uncontrollable circumstance policy.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

Traditional MIPS: Improvement Activities Performance Category

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

You can earn up to 40 points in the improvement activities performance category by attesting to between 1 and 4 improvement activities.

To report (or "submit") an improvement activity, you simply attest to having completed it. No data needs to accompany the attestation as part of the submission.

You don't have to submit any supporting documentation when you attest to completing an improvement activity, but you must keep documentation of the efforts you (or the group or virtual group) undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the 2024 MIPS Data Validation Criteria (ZIP, 2MB).

Data Aggregation and Multiple Submissions

We'll combine improvement activities submitted through attestation, file upload, and/or direct submission into a single performance category score (not to exceed 100%). If you submit the same activity through multiple submission types, the improvement activity will be counted once.

Participating as a Group, Virtual Group or APM Entity

If reporting as a group, virtual group or APM Entity, at least 50% of the clinicians in the group, virtual group, or APM Entity must implement the same activity during any continuous 90-day period (or the period specified in the activity description) in the same performance year to attest to that activity.
(These clinicians don't have to perform the activity during the same period.)

Individual, Group, and Virtual Group Participation

Improvement Activities

15% of MIPS Score

APM Entity Participation

15% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data

(Promoting Interoperability Automatically Reweighted)

30% of MIPS Score

How are Activities Assessed and Scored?

Improvement activities are assigned to 1 of 2 categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities. High-weighted activities address areas with the greatest impact on patient care, safety, health, and well-being, or require **more** significant investment of time and resources.

Generally speaking, clinicians, groups, virtual groups, and APM Entities that don't have certain special status designation(s) will receive the following points for their submitted activities:

Medium-weighted activities = **10 points**

High-weighted activities = **20 points**

APM participants reporting traditional MIPS will **automatically receive 50% credit** for the improvement activities performance category for the 2024 performance year.

To earn the maximum score of 40 points for the improvement activities performance category, you can pick any of these:

4 Medium-weighted activities = **40 points**

2 medium-weighted activities + 1 high-weighted activity = **40 points**

2 high-weighted activities = **40 points**

How are Activities Assessed and Scored? (Continued)

MIPS eligible clinicians, groups, virtual groups, and APM Entities with certain special status designations will receive the following points for their submitted activities:

Medium-weighted activities = **20 points**

High-weighted activities = **40 points**

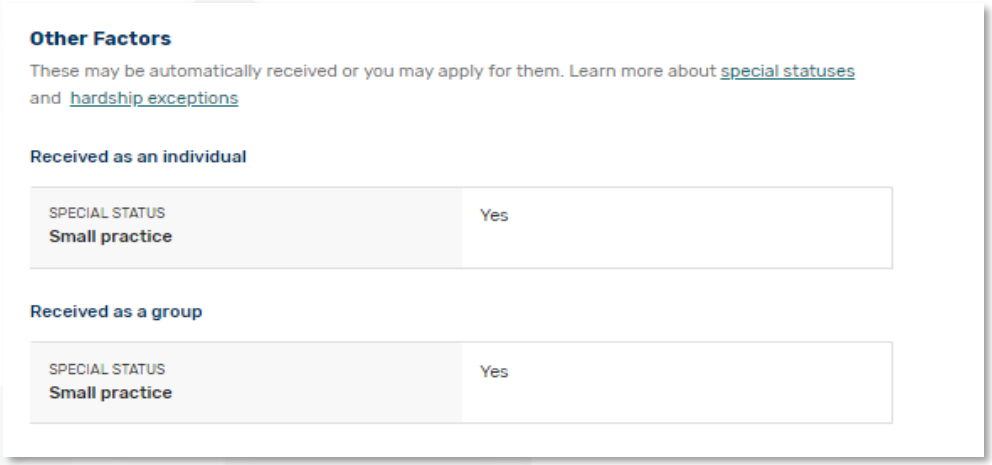
These points are assigned to activities submitted by clinicians, groups, virtual groups, and APM Entities identified on the QPP Participation Status Tool with the following special status designations:

1) a small practice (15 or fewer NPIs), **2)** non-patient facing, **3)** health professional shortage area (HPSA), or **4)** rural.

To learn more about available activities, review the 2024 Improvement Activities Inventory (ZIP, 2MB).

To earn the maximum 40 points for the improvement activity performance category, you can complete either:

40 points = 2 medium-weighted activities + OR 1 high-weighted activity



Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions

Received as an individual

SPECIAL STATUS	
Small practice	Yes

Received as a group

SPECIAL STATUS	
Small practice	Yes

How Many Points Can I Earn in the Improvement Activities Performance Category?

Clinicians, groups, virtual groups, and APM Entities can earn a maximum of 40 points in the improvement activities performance category, though the number of points it contributes to your MIPS final score varies according to the performance category's weight. The improvement activities score, like all performance categories, is capped at 100%.

Can the Maximum Number of Points be Lower than 40?

No, you'll always be scored out of 40 points in the improvement activities performance category, though you may receive more points per activity based on your special status.

How is My Improvement Activities Performance Category Score Calculated?

How is My Improvement Activities Performance Category Score Calculated? (Continued)

Scoring Example

Let's continue our previous example of the small practice reporting as a group. They can't attest to having participated in CAHPS as an improvement activity because they didn't meet patient sampling requirements. They selected 2 improvement activities, 1 medium-weighted and 1 high-weighted. Because they're a small practice, they earn double points for each activity reported.

Even if you submit additional activities, you can't earn more than 100% in the performance category.

How Does Scoring Work if I'm in a Patient-centered Medical Home?

If you're in a certified or recognized patient-centered medical home or comparable specialty practice, you'll earn full credit (100%) for the improvement activities performance category. You must attest (to activity "IA_PCMH") to your status as a patient-centered medical home or comparable specialty practice during the submission period for the 2024 performance year in order to receive full credit for the improvement activities performance category.

Additional Scoring Scenarios

Scenario 1:

You're a MIPS eligible clinician in a large practice (more than 15 clinicians) and complete 1 medium-weighted improvement activity for 10 of 40 points in the performance category.

10 points (1 medium-weighted activity) / 40 points (Available points: Improvement Activity) = 25% of available points for Improvement Activities

25% (Improvement Activities Score) X 15% (Improvement Activities Weight) = 3.75 Improvement Activities points contributing to MIPS final score

Scenario 2: (Small Practice)

You're a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 medium-weighted improvement activity for 20 of 40 points in the performance category. You don't submit Promoting Interoperability data, which means the Promoting Interoperability performance category is automatically weighted at 0% and the improvement activities performance category is weighted at 30%. The 30% weight assumes you can be scored on at least 1 cost measure.

20 points (1 medium-weighted activity) / 40 points (Available points: Improvement Activity) = 50% of available points for Improvement Activities

50% (Improvement Activities Score) X 30% (Improvement Activities Weight) = 15.00 Improvement Activities points contributing to MIPS final score

Additional Scoring Scenarios (Continued)

Scenario 3: (Small Practice)

You're a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 medium-weighted improvement activity for 20 of 40 points in the performance category. You don't submit Promoting Interoperability data, which means the Promoting Interoperability performance category is automatically weighted at 0%. You can't be scored on any cost measure, which means the cost performance category is automatically weighted at 0%. As a result, the improvement activities performance category is weighted at 50% of your final score, with the other 50% coming from the quality performance category.

NOTE: For more information on performance category redistribution policies for small practices please refer to the 2024 MIPS Quick Start Guide for Small Practices (PDF, 1MB) or visit the Special Statuses webpage.

Additional Scoring Scenarios (Continued)

Scenario 4: (Small Practice)

You're a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 high-weighted improvement activity and 1 medium-weighted improvement activity for 60 points in the performance category. However, you can't earn more than 40 points no matter how many activities are reported.

40 points (1 high- and 1 medium-weighted activity) / ~~60 points~~ 40 points (Available points: Improvement Activity) = 100% ~~150%~~ of available points for Improvement Activities

100% (Improvement Activities Score) x 15% (Improvement Activities Weight) = 15.00 Improvement Activities points contributing to MIPS final score

Scenario 5

You're a MIPS eligible clinician located in a rural area and participating in a MIPS APM. You complete 1 medium-weighted improvement activity for 40 points total—20 points for the medium-weighted activity and 20 automatic points for participating in a MIPS APM.

20 points (1 medium-weighted activity) + 20 points (automatic credit for MIPS APM participation) / 40 points (Available points: Improvement Activity) = 100% of available points for Improvement Activities

100% (Improvement Activities Score) x 15% (Improvement Activities Weight) = 15.00 Improvement Activities points contributing to MIPS final score

Reweighting the Improvement Activities Performance Category

The improvement activities performance category can be reweighted (and its weight redistributed to other categories) in 2 circumstances for traditional MIPS reporting:

1. **The performance category is reweighted due to extreme and uncontrollable circumstances.**

   NOTE: This can happen through an approved exception application or if you qualify for our automatic extreme and uncontrollable circumstances policy.

2. **UPDATED per the CY 2025 Medicare Physician Fee Schedule Final Rule: The third party intermediary (QCDR, Qualified Registry, or EHR vendor) you contracted with failed to submit your improvement activities data.**

   NOTE: If your third party intermediary doesn't submit your improvement activities data for the 2024 performance year, you can request reweighting for the improvement activities performance category through the QPP Service Center (send an email to QPP@cms.hhs.gov) until November 1, 2025.

Please refer to Appendix B for more information about the redistribution of weights to other performance categories.

Traditional MIPS: Promoting Interoperability Performance Category

Overview

The Promoting Interoperability performance category focuses on 4 objectives:

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

These objectives are comprised of 6 to 7 required measures (dependent on which measure(s) you choose to report for the HIE objective) in addition to the required attestations and optional measures.

- You must collect data for all required measures (unless you can claim an exclusion(s)) for the same **minimum continuous 180-day period in calendar year 2024**.
- The last 180-day performance period begins on **July 5, 2024**.

When participating as an APM Entity, the Entity will submit quality measures and improvement activities. MIPS eligible clinicians in the Entity may submit Promoting Interoperability data as individuals or as a group and we'll calculate an average score for this performance category. However, APM Entities also have the option to choose to report Promoting Interoperability data at the APM Entity level.

CEHRT functionality that meets ONC's certification criteria in 45 CFR 170.315 is required for participation in this performance category. For additional information, review the 2024 Promoting Interoperability Performance Category Quick Start Guide (PDF, 1MB).

Individual, Group, and Virtual Group Participation	
Promoting Interoperability	
	
25%	of MIPS Score
APM Entity Participation	
30%	of MIPS Score
Small Practices Not Submitting Promoting Interoperability Data (Promoting Interoperability Automatically Reweighted)	
0%	of MIPS Score

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

There's a single set of measures and objectives you must report for the 2024 performance period as outlined in the table below. When you report on required measures that have a numerator/denominator, you must submit at least a '1' in the numerator if you don't claim an exclusion.

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 or option 3 is reported
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Required unless an exclusion is claimed or option 2 or option 3 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)

There are 3 options for clinicians to meet the requirements of the Health Information Exchange objective.

You need to choose and report 1 of these 3 options.

When reporting the required measures in the Public Health and Clinical Data Exchange objective, you'll also need to submit your level of active engagement.

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

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

- Collect your data in CEHRT with the functionality that meets ONC's certification criteria in 45 CFR 170.315 (certified by the last day of the performance period) for a minimum of any continuous 180-day period in 2024.
- Submit a "yes" to the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Attestation (previously named the Prevention of Information Blocking attestation).
- Submit a "yes" to the ONC Direct Review Attestation.
- Submit a "yes" that you have completed the Security Risk Analysis Attestation measure in 2024.
- Submit a "yes" to the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guides Attestation measure. (Beginning with the 2024 performance period, a "no" will no longer satisfy this measure.)
- Submit your level of active engagement for the Public Health and Clinical Data Exchange measures you're reporting.
- Provide your Electronic Health Record (EHR)'s CMS identification code from the Certified Health IT Product List.

If any of these requirements **aren't met**, you'll get **0 points** in the Promoting Interoperability performance category.

ALERT: When reporting the required measures in the Public Health and Clinical Data Exchange objective, you'll need to submit a total of 2 entries for each measure: (1) a "yes" or "no" response to the measure, and (2) your level of active engagement (either Pre-production and Validation or Validated Data Production).

NOTE: Reporting to a QCDR or Qualified Registry may count for the optional Clinical Data Registry Reporting measure as long as the QCDR or Qualified Registry has publicly declared readiness as a clinical data registry and the registry uses the data for a public health purpose.

Data Aggregation and Multiple Submissions

UPDATED 12/16/2024. As finalized in the CY 2025 Medicare Physician Fee Schedule Final Rule:

When there are **multiple Promoting Interoperability submissions** for an individual, group, virtual group or subgroup, **we'll score each submission and assign the highest of the scores**.

How are Promoting Interoperability Measures Assessed and Scored?

Each required measure will be scored based on the performance data you report.

- For measures with a numerator and denominator, we calculate the performance rate on the submitted numerator and denominator.
- For measures that require a “yes” or “no” submission such as the Query of PDMP measure, we assign either full points or zero points.
- As a reminder, if you earn 0 points for any required measure or objective, you’ll receive a score of zero for the entire performance category.

Each measure will contribute to your total Promoting Interoperability performance category score.

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance.

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

How are Promoting Interoperability Measures Assessed and Scored? (Continued)

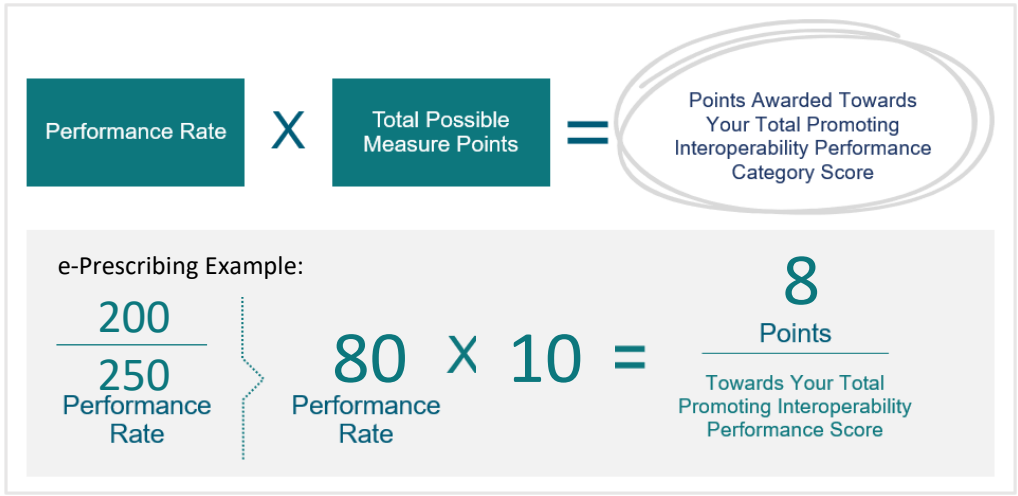
Objectives	Measures		Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES/NO
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required* (unless option 2 or option 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 option 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 option 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 (you also must submit your level of active engagement)
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting		Optional	5 bonus points (whether reporting 1, 2 or all 3 optional measures)	YES/NO (you also must submit your level of active engagement)

*For the HIE objective, you have the option to report data for the 2 supporting electronic referral loops measures and associated exclusions OR the HIE Bi-Directional Exchange measure OR the Enabling Exchange under TEFCA measure. You need to choose and report 1 of these 3 options.

Scoring Promoting Interoperability Measures Submitted with a Numerator/Denominator

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 e-Prescribing 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 as long as 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.

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.

*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 30 points for this objective when:

You submit a "yes" to participating in bi-directional exchange. OR You submit a "yes" to enabling exchange under 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. Please see Appendix C for detailed information about how points are reallocated when an exclusion(s) is claimed.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

We'll add the scores for each of the individual measures (or objectives) and then divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

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

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

APM Entity Participation

When reporting traditional MIPS 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

APM Entities can submit aggregated Promoting Interoperability data at the APM Entity level on behalf of all MIPS eligible clinicians in the Entity. The score is calculated the same way as for individuals and groups.

Promoting Interoperability Performance Category Score = Total Points Earned for Completed Measures / 100 Possible Measure Points

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%.

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

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)

Scoring Example

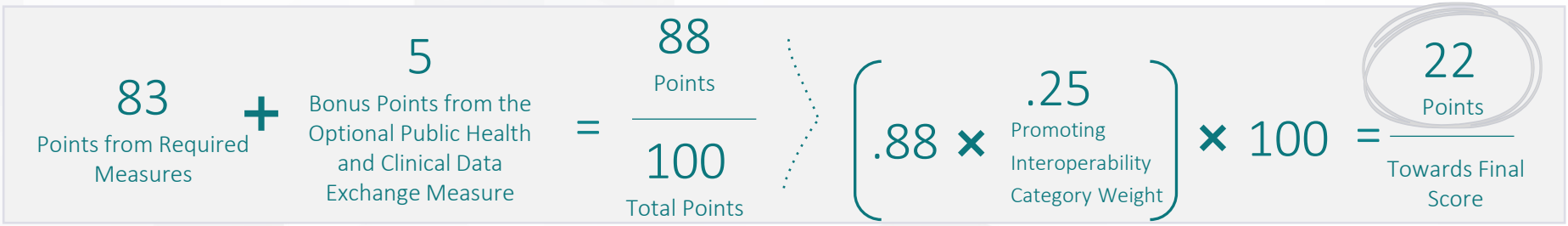
Let's continue our example of the small practice participating as a group. While small practices qualify for automatic reweighting of the Promoting Interoperability performance category, this small practice was able and chose to submit data for this performance category. The group has EHR technology that meets ONC's certification criteria in 45 CFR 170.315 and completed the required attestations and measures.

Objective	Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
e-Prescribing	e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
	Query of Prescription Drug Monitoring Program (PDMP)	Reported "yes" to PDMP measure	10 points	10
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	180 / 250 (0.72)	15 points → 20 points (5 points re-allocated from e-Prescribing)	0.72 x 20 = 14.4 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	176 / 200 (0.88)	15 points → 20 points (5 points re-allocated from e-Prescribing)	0.88 x 20 = 17.6 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	187 / 220 (0.85)	25 points	0.80 x 25 = 20 points
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	• Reported "yes" to Immunization Registry Reporting measure • Claimed exclusion for Clinical Data Registry Reporting measure	25 points	25 points (this objective is all or nothing)
	Bonus (optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Reported "yes" to the optional Public Health Registry Reporting measure	5 points	5 points
Required Measure Point Total				87 points
Optional Measure Point Total				5 points
Promoting Interoperability Performance Category Score				92 points / 100 points = 92%

Additional Scoring Scenarios

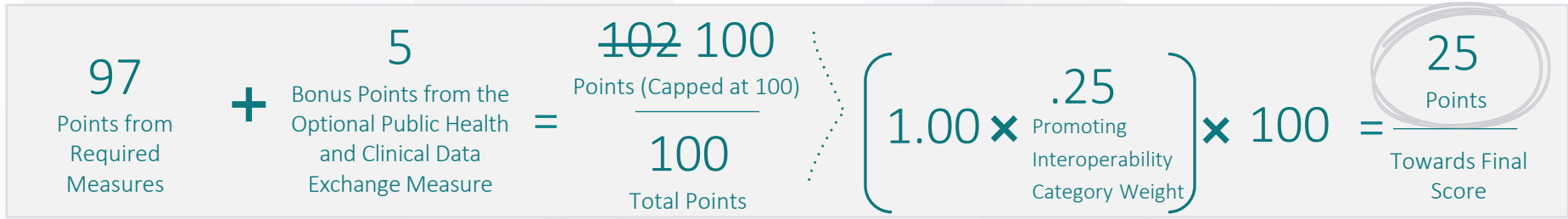
Scenario 1

If a clinician receives 83 points from the required Promoting Interoperability measures and 5 bonus points for submitting data on one of the optional Public Health and Clinical Data Exchange measures, then they would receive 22 points towards their MIPS final score for the Promoting Interoperability performance category. That's 1.25 more points towards their MIPS final score than they would have, if they didn't report the optional measure.



Scenario 2

A clinician receives 97 points from the required Promoting Interoperability measures and 5 bonus points for submitting data on one of the optional Public Health and Clinical Data Exchange measures. Adding the 5 bonus points to the points they received for their required measures equals 102 points. Since the performance category is capped at 100, the clinician would receive 100 points, which equals 25 points towards their MIPS final score for the Promoting Interoperability performance category.



Can the Promoting Interoperability Performance Category be Reweighted?

Yes. There are 4 ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

Note that a qualifying Promoting Interoperability data submission (all required data, measures, and attestations) will override any automatic or approved reweighting.

1. 1. You request reweighting for multiple performance categories through the MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application. Please check the 2024 Extreme and Uncontrollable Circumstances Exception Application Guide (PDF, 1MB) or the QPP Exception Applications webpage for more information.

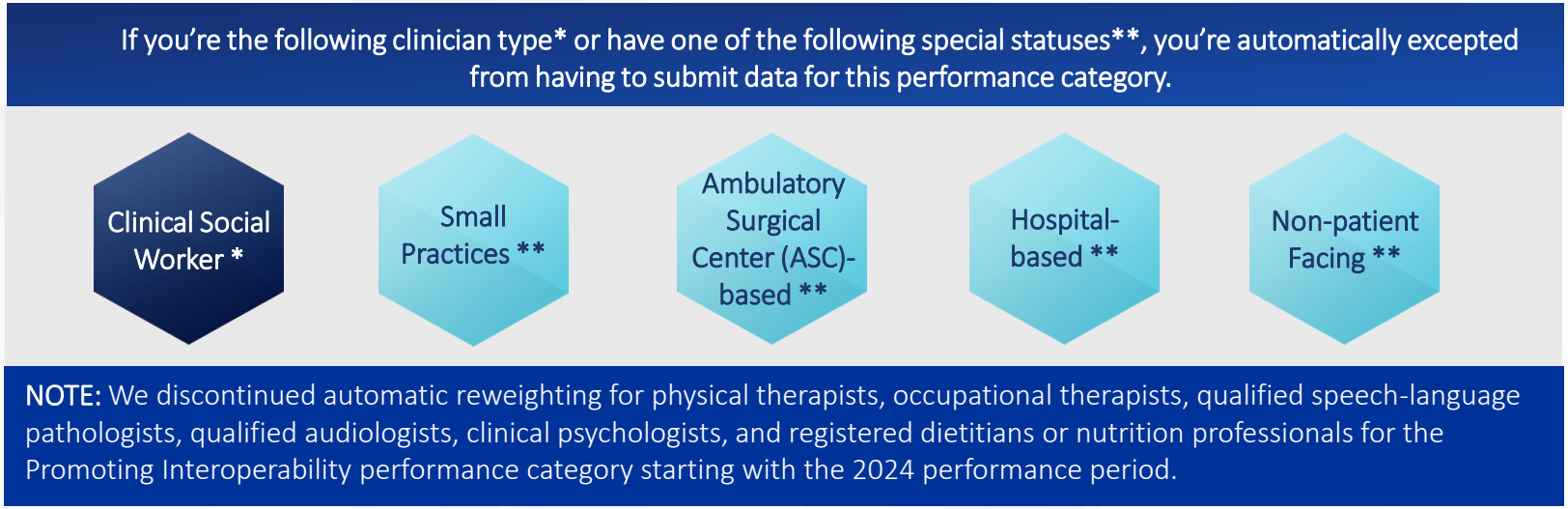
2. You submit a Promoting Interoperability Hardship Exception application, citing one of the following specified reasons for review and approval:

    - Insufficient internet connectivity
    - Extreme and uncontrollable circumstances
    - Lack of control over the availability of CEHRT
    - Decertified EHR (decertified under the ONC Health IT Certification Program)

    If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about Hardship Exceptions.

Can the Promoting Interoperability Performance Category be Reweighted?

3. You qualify for **automatic reweighting** because of your clinician type* or special status** (see the Other Reporting Factors on the QPP Participation Status Tool):



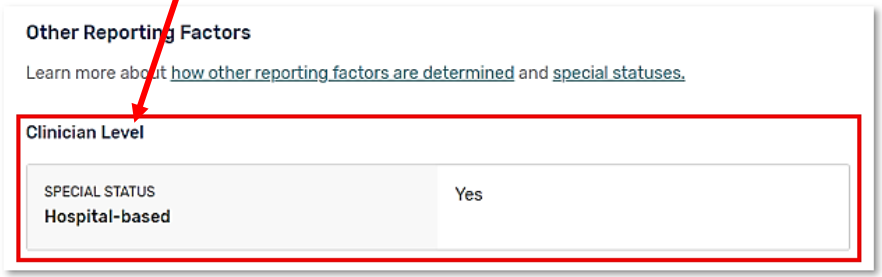
4. UPDATED per the CY 2025 Medicare Physician Fee Schedule Final Rule: The third party intermediary (QCDR, Qualified Registry, or EHR vendor) you contracted with failed to submit your Promoting Interoperability data.

   NOTE: If your third party intermediary doesn't submit your Promoting Interoperability data for the 2024 performance year, you can request reweighting for the Promoting Interoperability performance category through the QPP Service Center (send an email to QPP@cms.hhs.gov) until November 1, 2025.

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

Check the **Other Reporting Factors** section on the QPP Participation Status Tool and review the Special Statuses page of the QPP website.

Check '**Clinician Level**' if you're **reporting as an individual**



Check '**Practice Level**' if you're **reporting as a group**

NOTE: You can still report if you want to.

UPDATED 12/16/2024: A qualifying data submission (submitting all required data, attestations, and measures) will override reweighting, and the clinician will receive a Promoting Interoperability score. A partial submission (missing 1 or more required data elements) won't be scored and won't override previously approved reweighting.

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

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

They'll be excluded from the calculation when determining the APM Entity's score, but they'll still receive the APM Entity's score for this performance category.

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

MIPS Final Score

How is My Final Score Calculated?

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

Individuals, Groups, and Virtual Groups

Quality	+	Cost	+	Improvement Activities	+	Promoting Interoperability	+	Complex Patient Bonus		
Up to **30** points toward your MIPS final score		Up to **30** points toward your MIPS final score		Up to **15** points toward your MIPS final score		Up to **25** points toward your MIPS final score		Up to **10** points toward your MIPS final score		Up to **100** points toward your MIPS final score

APM Entities

Quality	+	Cost	+	Improvement Activities	+	Promoting Interoperability	+	Complex Patient Bonus		
Up to **55** points toward your MIPS final score		Up to **0** points toward your MIPS final score		Up to **15** points toward your MIPS final score		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

The MIPS final score can't exceed 100 points.

How is My Final Score Calculated? (Continued)

Small Practices

Standard Performance Category Weights for Small Practices (Promoting Interoperability Automatically Reweighted)

Individual, Group and Virtual Group Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

APM Entity Participation (with Small Practice Status)

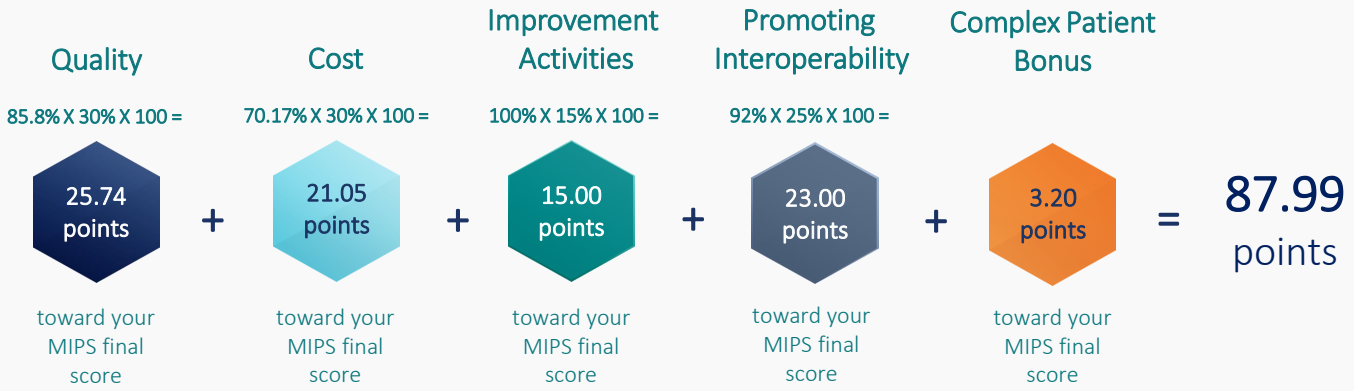
50% Quality	0% Cost	50% Improvement Activities	0% Promoting Interoperability

How is My Final Score Calculated? (Continued)

Scoring Example 1

Let's continue our example of the small practice reporting as a group and review how the final score is calculated. (As a reminder, small practices qualify for automatic reweighting of Promoting Interoperability, but the small practice in this example had CEHRT and chose to report data for this performance category.)

Traditional MIPS Performance Category Weights in 2024:

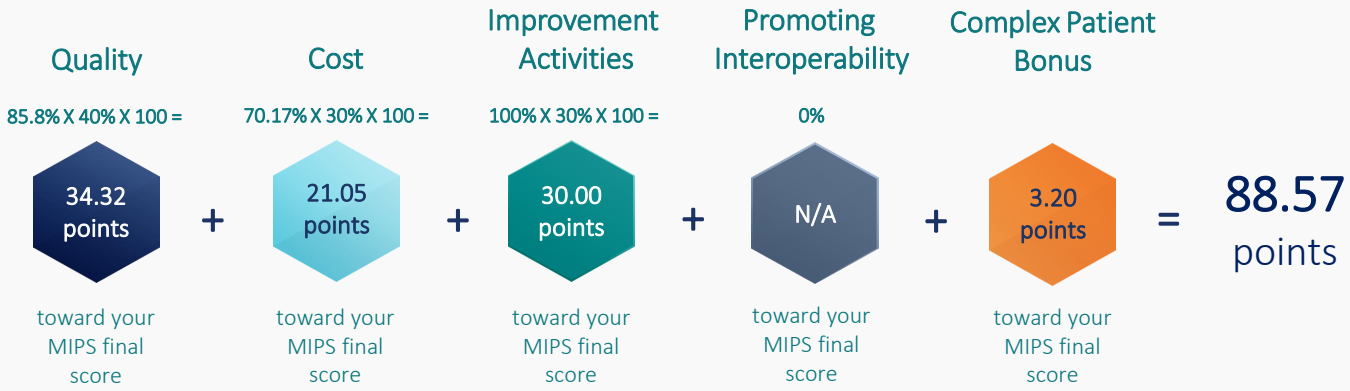


How is My Final Score Calculated? (Continued)

Scoring Example 2

Now let's look at what the small practice's final score would have been if they **didn't** report data for the Promoting Interoperability performance category. This performance category will automatically be weighted at 0% unless data is submitted. Small practices have a different redistribution of performance category weights when Promoting Interoperability is reweighted. See Appendix B, Table 2.

Small Practice Example – Promoting Interoperability Reweighted



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, virtual 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 (October 1, 2023 – September 30, 2024) of the 2024 MIPS determination period.

The complex patient bonus is limited to MIPS eligible clinicians, groups, virtual 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 the previous performance year.

We'll evaluate each MIPS eligible clinician, group, virtual 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 each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity) in the **2023 performance year.**

Step 2

We'll calculate the **average HCC risk score and dual eligibility ratio** for each MIPS eligible clinician, group, virtual group and APM Entity for the **2024 performance year**.

- **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).

Quality Payment PROGRAM

Calculating the Complex Patient Bonus for the 2023 Performance Year

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 each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity) in performance year 2023. (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.

MIPS Payment Adjustment

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment, 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, which generally means that the amount of the payment adjustments is dependent on the overall participation and performance of clinicians in the program for that year.

2024 Final Score	2026 Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (greater than -9% and less than 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 –100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

REMINDER:

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

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

MIPS Payment Adjustment

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

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

- More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease (lower positive adjustment amounts) 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 adjustment amounts) 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 year/2024 payment year was the last year the additional payment adjustment for exceptional performance was available.

Help, Acronyms, and Version History

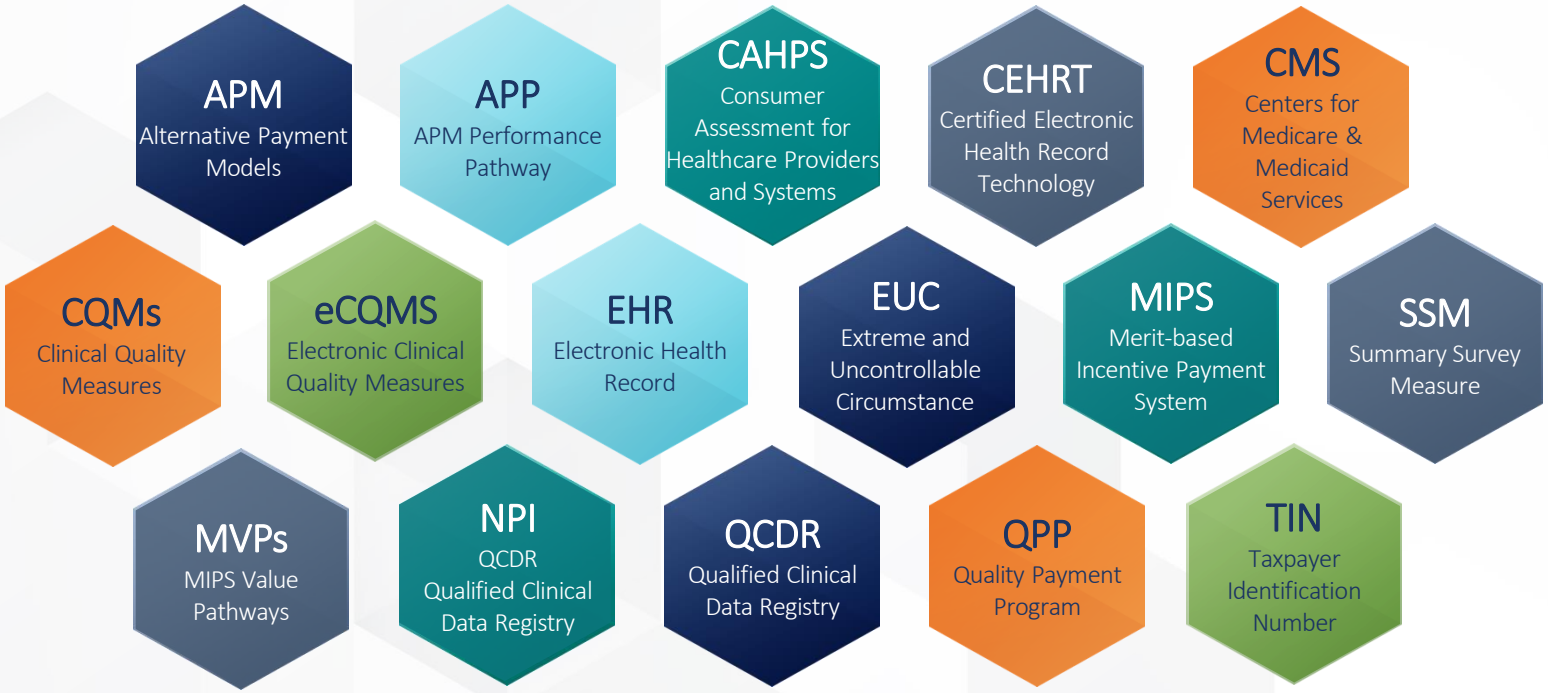
Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

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

Acronyms


APM
Alternative Payment Models
APP
APM Performance Pathway
CAHPS
Consumer Assessment for Healthcare Providers and Systems
CEHRT
Certified Electronic Health Record Technology
CMS
Centers for Medicare & Medicaid Services
CQMs
Clinical Quality Measures
eCQMS
Electronic Clinical Quality Measures
EHR
Electronic Health Record
EUC
Extreme and Uncontrollable Circumstance
MIPS
Merit-based Incentive Payment System
SSM
Summary Survey Measure
MVPs
MIPS Value Pathways
NPI
QCDR
Qualified Clinical Data Registry
QCDR
Qualified Clinical Data Registry
QPP
Quality Payment Program
TIN
Taxpayer Identification Number

Version History

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

DATE	DESCRIPTION
04/14/2025	Updated Appendix D to identify the suppressed measures announced via QPP listserv 3/21/2025.
01/13/2025	Updated slide 64 to clarify the ONC Direct Review Attestation is required.
12/16/2024	Revised text explaining quality performance category reweighting on slide 38; revised achievement points formula graphic on slide 43; added slides 44 and 45 on CY 2025 Medicare Physician Fee Schedule Final Rule changes to cost scoring methodology; reformatted slide 60 on improvement activities performance category reweighting; revised Data Aggregation and Multiple Submissions section on slide 65; added bullet point 4 on slide 74; reformatted slide 75 to add practice-level reporting and updated disclaimer; added table to Appendix D on slide 102; made minor copy edits throughout document
09/06/2024	Updated slide 66 to correct the header and the number of points received for the HIE objective.
06/03/2024	Original Posting.

Appendices

Appendix A: Scoring Quality Measures

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

1. **Find the benchmark and figure achievement points based on collection type for the measure.**
   - Achievement points are figured by mapping the performance rate to the benchmark for the measure, specific to collection type.
   - **Example:** A group submits Measure 226 as a MIPS CQM.

Measure Reported	Type of Measure	Collection Type	Measure Performance Rate	Cases Reported
Measure 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	MIPS CQM	82.74 (mapped to highlighted decile below)	90

Measure ID #	Collection Type	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
226	MIPS CQM	3.39 – 18.91	18.92 – 39.12	39.13 – 61.53	61.54 – 78.59	78.60 – 89.28	89.29 – 97.09	97.10 – 99.99	--	--	100
226	Medicare Part B Claims	14.29 – 78.16	78.17 – 95.93	95.94 – 99.99	--	--	--	--	--	--	100
226	eCQM	2.22 – 14.28	14.29 – 24.99	25.00 – 36.58	36.59 – 49.77	49.78 – 61.53	61.54 – 74.41	74.42 – 85.70	85.71 – 94.02	94.03 – 99.99	100

* This is an extract from the 2024 quality benchmarks showing the range of performance rates associated with each decile for each collection type:

Appendix A: Scoring Quality Measures (Continued)

2. Figure achievement points in a decile.
   - Determine the decile that the performance rate falls in:
   - Measure performance rate = 82.74

Measure Name	Controlling High Blood Pressure
Measure ID#	226
Collection Type	MIPS CQM
Decile 1	3.39 – 18.91
Decile 2	18.92 – 39.12
Decile 3	39.13 – 61.53
Decile 4	61.54 – 78.59
Decile 5	78.60 – 89.28
Decile 6	89.29 – 97.09
Decile 7	97.10 – 99.99
Decile 8	--
Decile 9	--
Decile 10	100

Apply the following formula based on the measure's performance rate and decile range:

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

NOTE: Partial achievement points are truncated to the hundredths digit for partial points.

$$\text{decile \#}\ 5 + \frac{[\,82.74 - 78.60\,]}{[\,89.29 - 78.60\,]} = 0.387\ldots = 5.39$$

...which is truncated to 0.39

Appendix A: Scoring Quality Measures (Continued)

3. **Repeat assignment of achievement points for each submitted measure.**
   - **Example:** A group (not a small practice) submits 5 MIPS CQMs and 3 eCQMs meeting data completeness for all measures

Measures Reported	Collection Type	Types of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
Measure 236 Controlling High Blood Pressure	MIPS CQM	Outcome	72.33	86	8.23	Compare to benchmark; required outcome measure.
Measure 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	MIPS CQM	Process	82.74	90	5.39	Compare to benchmark.
Measure 117 Diabetes: Eye Exam	eCQM	Process	84.55	112	6.68	Compare to benchmark.
Measure 117 Diabetes: Eye Exam	MIPS CQM	Process	61.40	18	0.00	Doesn't meet case minimum.
Measure 374 Closing the Referral Loop: Receipt of Specialist Report	eCQM	Process	82.77	90	9.62	Compare to benchmark.
Measure 126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	MIPS CQM	Process	93.51	107	4.50	Compare to benchmark.
Measure 102 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	eCQM	Process	89.99	32	0.00	No historical benchmark available. Earns 0 points (unless a performance period benchmark is created following submission period).
Measure 498 Connection to Community Service Provider	MIPS CQM	Process	29.87	22	7.00	Measure in its first year in the program, earns 7 points (unless a performance period benchmark is created following submission period).

Appendix A: Scoring Quality Measures (Continued)

4. Sort and group measures based on achievement.

- First identify the highest scoring outcome measure based on achievement points, then identify the next 5 highest scoring measures based on achievement points.

The following measures contribute achievement points toward the quality performance category score.			
Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points
1. Outcome/High-priority: **Measure 236**	MIPS CQM	72.33	8.23
2. **Measure 374**	eCQM	82.77	9.62
3. **Measure 498**	MIPS CQM	29.87	7.00
4. **Measure 117**	eCQM	84.55	6.68
5. **Measure 226**	MIPS CQM	82.74	5.39
6. **Measure 126**	MIPS CQM	93.51	4.50

- Identify measures that won't contribute any points to the quality performance category score.

The following measure don't contribute achievement points toward the quality performance category score.				
Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Comment
Measure 117	MIPS CQM	61.40	0.00	Not one of the top 6 scored measures
Measure 102	eCQM	89.99	0.00	Not one of the top 6 scored measures

Appendix B: Reweighting the Performance Categories

Table 1. Performance Category Weight Redistribution (Excluding Small Practices)

Table 1 outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Performance Category Redistribution for the 2024 Performance Year/2026 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
No Reweighting Needed				
General weighting for all 4 performance categories	30%	30%	15%	25%
Reweighting 1 Performance Category				
No Cost: Cost → Quality and PI	55%	0%	15%	30%
No Promoting Interoperability: PI → Quality	55%	30%	15%	0%
No Quality: Quality → PI	0%	30%	15%	55%
No Improvement Activities: IA → Quality	45%	30%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability Cost and PI → Quality	85%	0%	15%	0%
No Cost and No Quality Cost and Quality → PI	0%	0%	15%	85%
No Cost and No Improvement Activities Cost and IA → Quality and PI	70%	0%	0%	30%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities PI and IA → Quality	70%	30%	0%	0%
No Quality and No Improvement Activities Quality and IA → PI	0%	30%	0%	70%

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

Appendix B: Reweighting the Performance Categories (Continued)

Table 2. Performance Category Weight Redistribution (Small Practices)

Table 2 reviews the performance category redistribution policies that apply to small practices in the 2024 performance year.

Standard weighting for small practices **(Promoting Interoperability automatically reweighted)**

Quality	Cost	Improvement Activities	Promoting Interoperability
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

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

Quality	Cost	Improvement Activities	Promoting Interoperability
50% of MIPS Score	0% of MIPS Score	50% of MIPS Score	0% of MIPS Score

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

Appendix B: Reweighting the Performance Categories (Continued)

Table 2. Performance Category Weight Redistribution (Small Practices) (Continued)

Table 2 reviews the performance category redistribution policies that apply to small practices in the 2024 performance year.

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

Quality	Cost	Improvement Activities	Promoting Interoperability
0% of MIPS Score	50% of MIPS Score	50% of MIPS Score	0% of MIPS Score

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

Quality	Cost	Improvement Activities	Promoting Interoperability
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

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

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

When an Exclusion is Claimed

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

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed…
e-Prescribing	e-Prescribing		Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure 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 TEFCA	No	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: Reallocation of Points for Promoting Interoperability Measure(s) (Continued)

When an Exclusion is Claimed (Continued)

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed…
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No	N/A
Public Health and Clinical Data Exchange	Report 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 2 exclusions**.
	Bonus (optional): • 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 D: Quality Measures with MIPS Scoring or Submission Changes

This table identifies any measures affected by specification or coding issues, clinical guideline changes during the 2024 performance period, or specifications determined during or after the performance period to have substantive changes.

This list will be updated if additional measures are identified for suppression or truncation in the 2024 performance period.

Quality Measure Number/ Title	Impact Collection Type(s)	Reason for Measure Change	Result	Impact to Scoring Submission and Feedback Expectations
Measure 185: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period those reporting this measure should only include denominator eligible procedures from the first 9 months of the performance period (January 1 September 30, 2024) in their submission.
Measure 389: Cataract Surgery: Difference Between Planned and Final Refraction	MIPS CQM	Quality measure implementation resulting in misleading results	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 488: Kidney Health Evaluation	eCQM (CMS951v2)	Quality measure implementation resulting in misleading results	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.