Quality Payment
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# Merit-based Incentive Payment System (MIPS)

## 2024 Traditional MIPS Data Submission User Guide

# MIPS EUC Exception Application Reopening and Submission Extension Due to National IV Fluid Shortage

On March 24, 2025, the Centers for Medicare & Medicaid Services (CMS) announced via QPP listserv that it will reopen the 2024 Merit-based Incentive Payment System (MIPS) Extreme and Uncontrollable Circumstances (EUC) Exception Application to provide relief to practices in response to the ongoing national intravenous (IV) fluid shortage.

- The application will reopen Monday, March 31, 2025, at 10 a.m. ET, and will close April 14, 2025, at 8 p.m. ET.
  - CMS is reopening the 2024 MIPS EUC Exception Application window in response to the national IV fluid shortage; therefore, CMS will only accept applications citing the shortage as the basis for requesting reweighting under the MIPS EUC Exception. Any applications submitted for reasons outside of the national IV fluid shortage will be denied.

- CMS is also extending the MIPS data submission deadline until April 14, 2025, at 8 p.m. ET.
  - **IMPORTANT!** The deadline for certain clinicians, groups, and Alternative Payment Model (APM) Entities to elect to participate in MIPS – because they are opt-in eligible due to the low-volume threshold or are partially qualifying APM participants (Partial QPs) – is still March 31, 2025, at 8 p.m. ET.

For more information, please review this fact sheet: 2024 MIPS Data Submission Deadline Extended and EUC Applications to Reopen in Response to National IV Fluid Shortage (PDF, 285KB)

# Table of Contents



**Need More Help?**

- File upload troubleshooting
- Contact the Quality Payment Program

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# How to Use This Guide

### Table of Contents

**Click this icon** (on the bottom left of each page) **to return to the table of contents.**

### Hyperlinks

Hyperlinks to the Quality Payment Program website and downloadable resources are included throughout the guide to direct the reader to more information and resources.

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

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# Getting Started

# What to Expect During 2024 Submission

As a reminder, we eliminated the Preliminary Score and preliminary category level scores from the submission experience beginning with the data submission period for the 2023 performance year. The increasing volume of scoring information that can change after the submission period made this information too unreliable.

**What should we expect during submission?**

When you sign into the QPP website during the submission period, you'll see:

- Measure-level scores for the quality measures you've submitted to date, and a sub-total of points earned for these measures.
  - Note: You **won't** see administrative claims measures or the CAHPS for MIPS measure during the submission period.
  - If applicable, these measures will be added to performance feedback when we release final scores in June 2025.
- Activity-level scores for the improvement activities you've submitted to date, and a sub-total of points earned for these activities.
- Measure-level scores for the Promoting Interoperability measures you've submitted to date, and a sub-total of points earned for these measures.
- The number of objectives you've reported completely for the Promoting Interoperability performance category.
- An indicator of any performance categories that will be reweighted (if applicable).

# What to Expect During 2024 Submission (Continued)

**What can change after the submission period?**

Several things can change between the close of the submission period and the release of final scores, most of which affect the quality performance category. For example:

| What Can Change | How This Can Affect Your Score |
|---|---|
| Ex. Administrative claims quality measures are calculated | If you can be scored on any of these measures, this will increase the number of measures your quality score is based on. |
| Ex. CAHPS for MIPS measure is submitted | If your practice administered the CAHPS for MIPS Survey measure, this measure will be added to your score after the submission period. |
| Ex. Performance period benchmarks are calculated for quality measures without a historical benchmark | If a measure didn't have a historical benchmark and we can calculate a performance period benchmark, this will change the measure-level score.<br><br>If you submitted more than 6 measures, performance period benchmarks can change which measures count towards your quality score. |

**When will our 2024 final score be available?**

Final scores will be available in mid-June 2025, and your payment adjustment will be available in mid-July 2025.

# Purpose

This guide reviews the data submission process and troubleshooting for **traditional MIPS.**

- For more information about data submission for a **MIPS Value Pathway (MVP)**, review the 2024 MVP Data Submission User Guide (PDF).
- For more information about data submission for the **APM Performance Pathway (APP)**, review the 2024 APP Data Submission User Guide (PDF).

# Accessing the System

In order to sign in to the QPP website and submit Performance Year 2024 data and/or view data submitted on your behalf, you need:

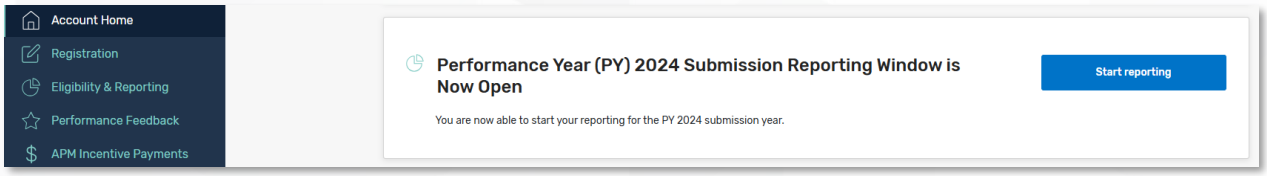
- An account (user ID and password)
- Access to an organization (a role)

**Make sure you sign in during the submission period to review data submitted on your behalf.**

**You can't submit new or corrected data after the submission period closes.**

If you don't already have an account or access, review the following documentation in the QPP Access User Guide (ZIP, 4MB) so you can sign in to submit, or view, data:

Once you sign in, you can select **Start Reporting** on the main page or **Eligibility & Reporting** from the left-hand navigation bar.




**DISCLAIMER:**

- All screenshots include fictitious patients and organizations. Screenshots were captured from a test environment, so there may be slight variations between the screenshots included in this guide (including dates) and the user interface in the production system.

**Before You Begin**

Make sure you are using the most recent version of your browser:

- Chrome
- Edge

**Note:** Internet Explorer, Safari, Firefox aren't fully supported by QPP.

# Accessing the System

From here, you'll see the organizations you have permission to access. Most users will only have access to one organization type:

- Registry (includes Qualified Registries and QCDRs) or
- Practice (individual and/or group reporting, all performance categories) or

Learn how to connect to an organization as a practice.

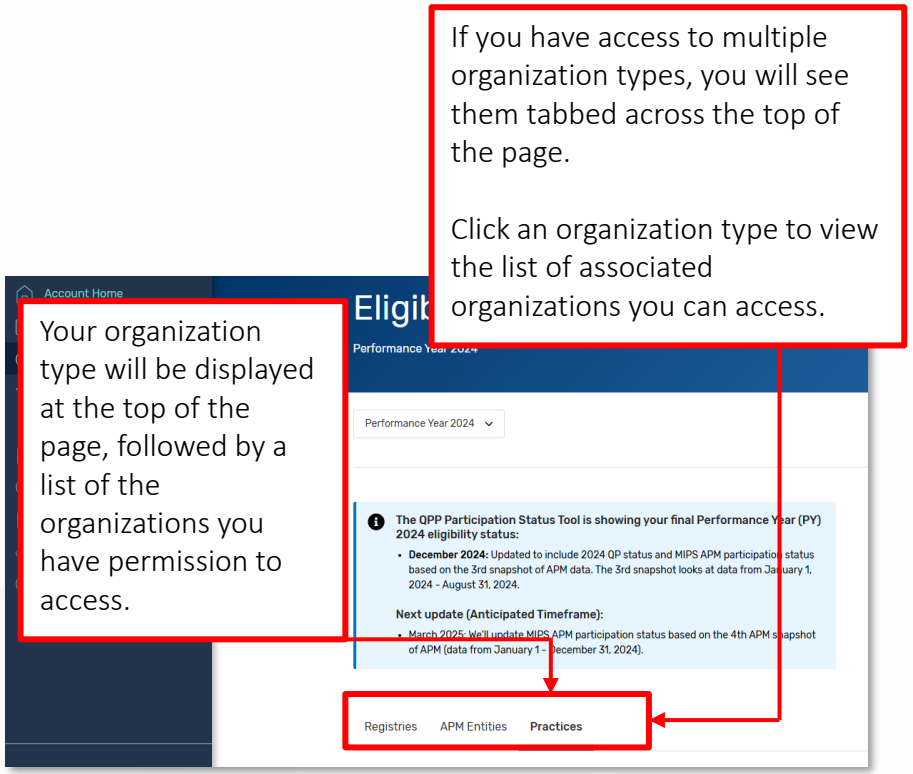
- APM Entity (APM Entity-level quality and improvement activities performance categories data submission) or

Learn how to connect to an organization as an APM Entity.

- Virtual Group (virtual group reporting, all performance categories)

**Helpful Hint**

Click the links, or jump to Appendix B, to review what users associated with each organization type can and can't do and view during the submission period.



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# Preparing to Submit Your Data

# Overview

This section reviews the information that can be accessed and viewed by users with the staff user or security official roles for different organization types – registries, practices, APM Entities, and virtual groups.

This section also reviews which performance data can be submitted for APM Entities versus the practices that include clinicians in the Entity.

Skip ahead to:


- Practice Representatives
- APM Entity Representatives
- Virtual Group Representatives

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# Preparing to Submit Your Data:
# Registry Representatives

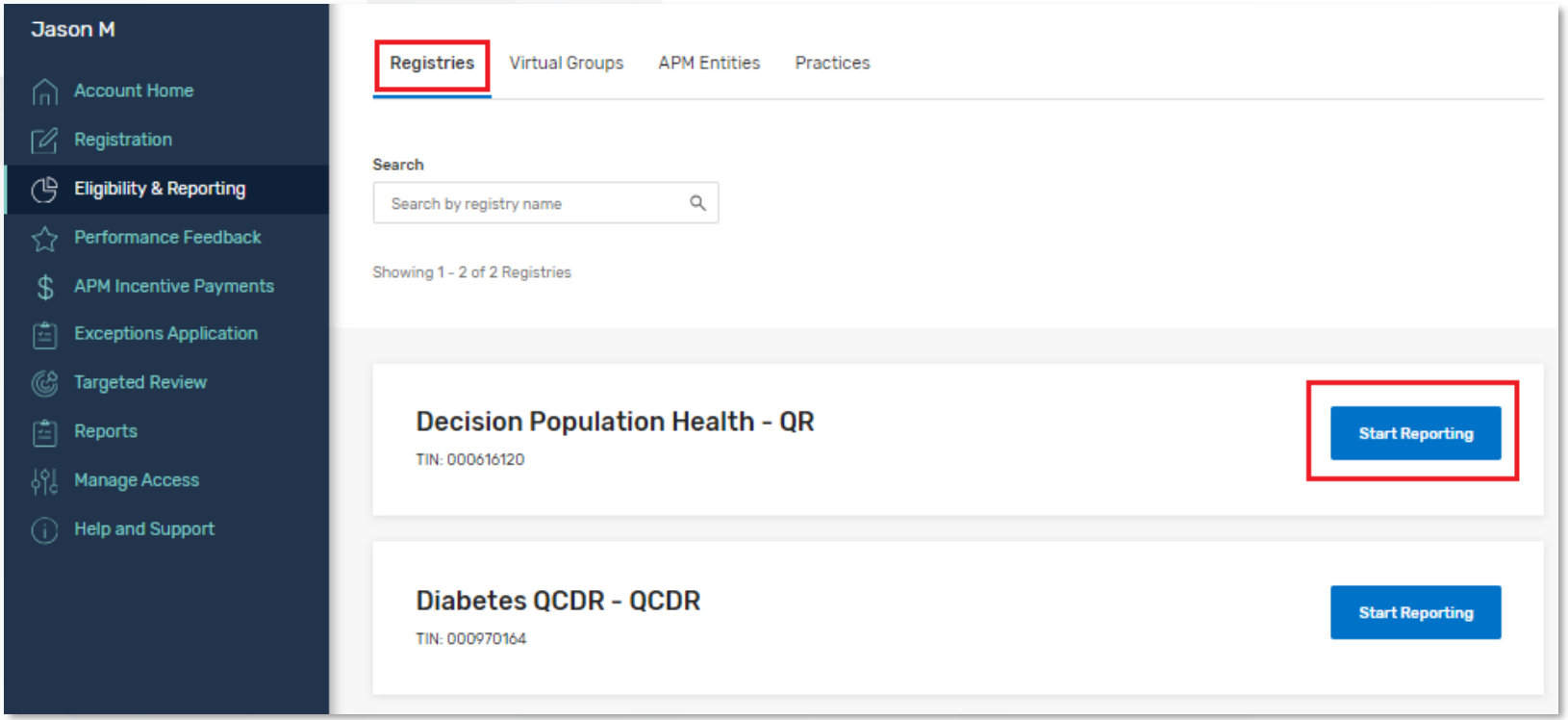
# Registry Representatives

This section includes information for users with a Staff User or Security Official role for a **Registry organization** – Qualified Registry or QCDR – identified by Taxpayer Identification Number (TIN).

| With this Access | You CAN do this during and after the submission period | You CAN'T do this during or after the submission period |
|---|---|---|
| Staff User or Security Official for a **Registry** (QCDR or Qualified Registry) | ✓ Download your API token (security officials only)<br>✓ Upload a submission file on behalf of your clients (groups and/or individuals)<br>✓ Submit opt-in elections on behalf of your clients<br>✓ View measure and activity level scores for your clients based on the data your organization submitted for them | ✗ View data submitted directly by your clients<br>✗ View data submitted by another third party on behalf of your clients<br>✗ View data collected and calculated by CMS on behalf of your clients<br>• Cost and administrative claims quality measures (if applicable)<br>✗ View preliminary category level scores |

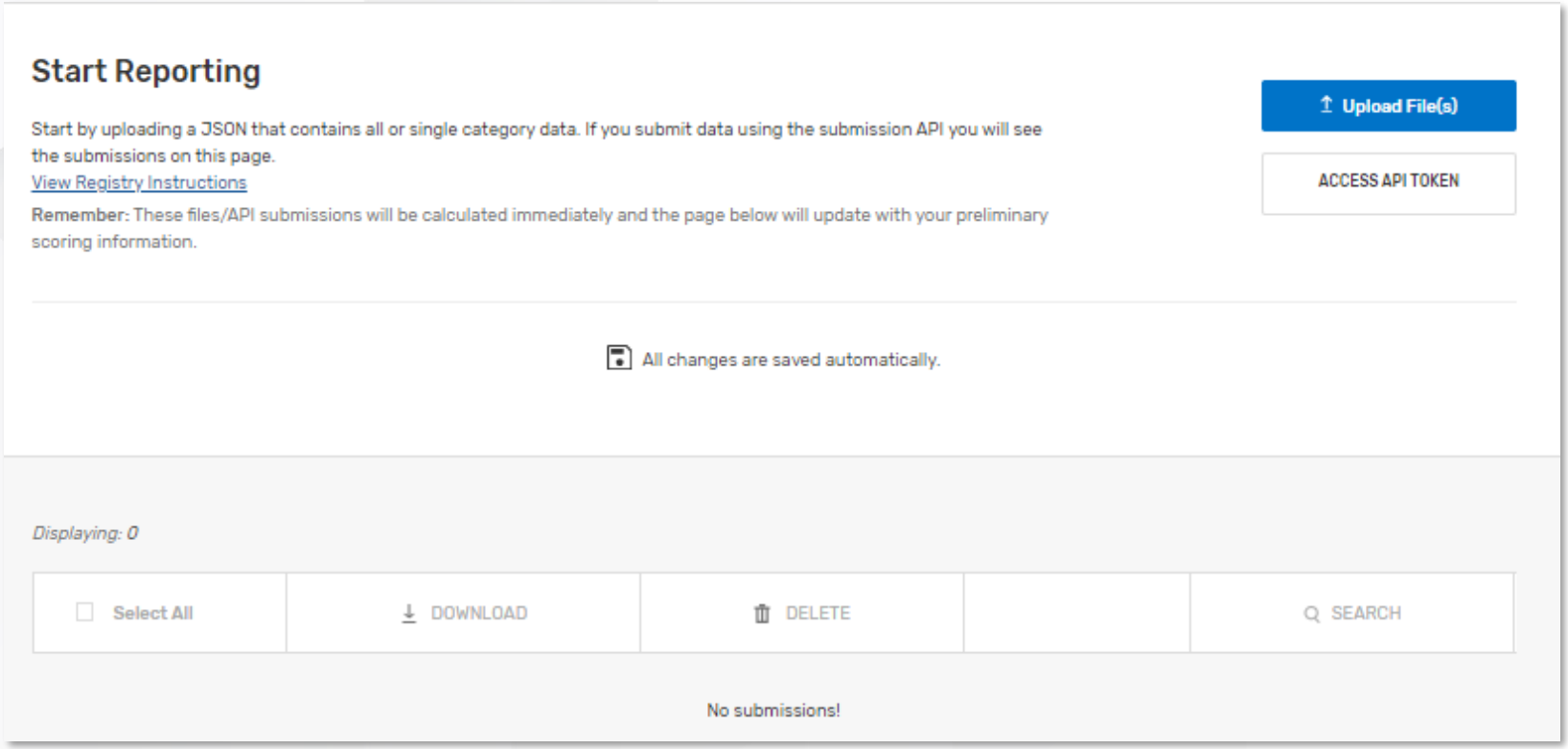
# Registry Representatives (Continued)

From the Eligibility & Reporting page, make sure you click the Registries tab if you access to multiple organization types and select Start Reporting next to your registry's name to open your dashboard and start uploading files.



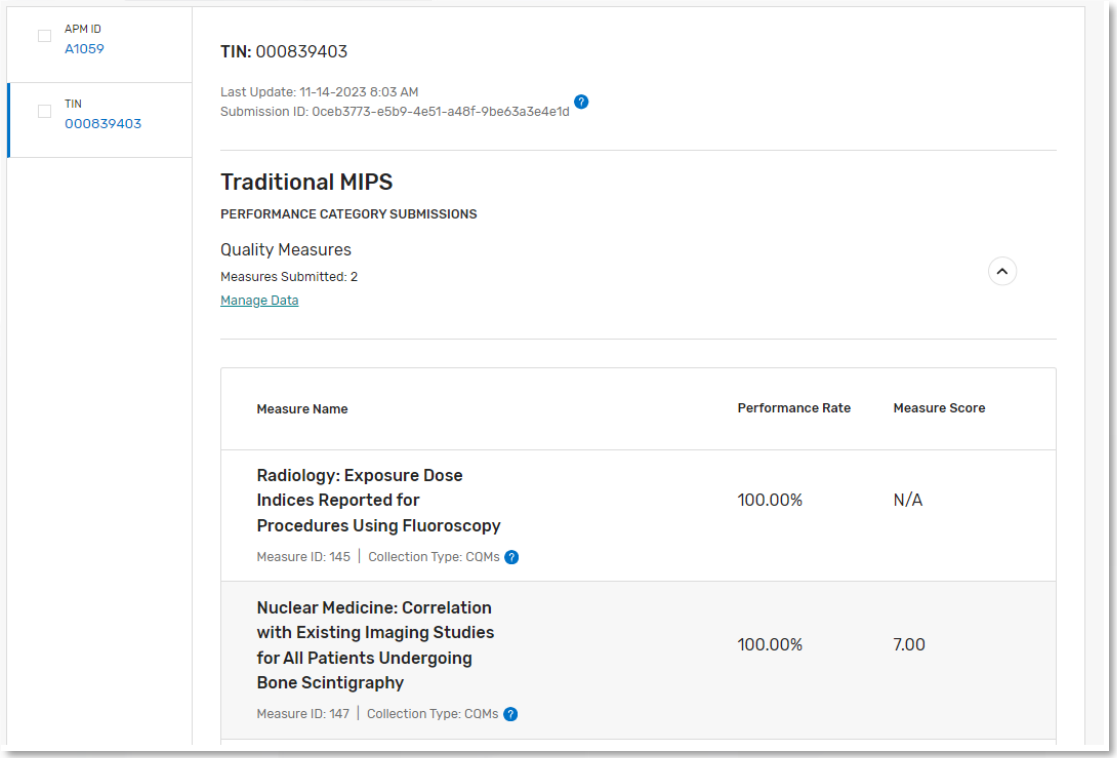
# Registry Representatives (Continued)

You won't see any information until you've submitted data.



# Registry Representatives (Continued)

Once you've started submitting data, you will see a list of Taxpayer Identification Numbers (TINs) – for group submissions – and TIN/National Provider Identifiers (TIN/NPIs) – for individual submissions.



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# Preparing to Submit Your Data:
# Practice Representatives

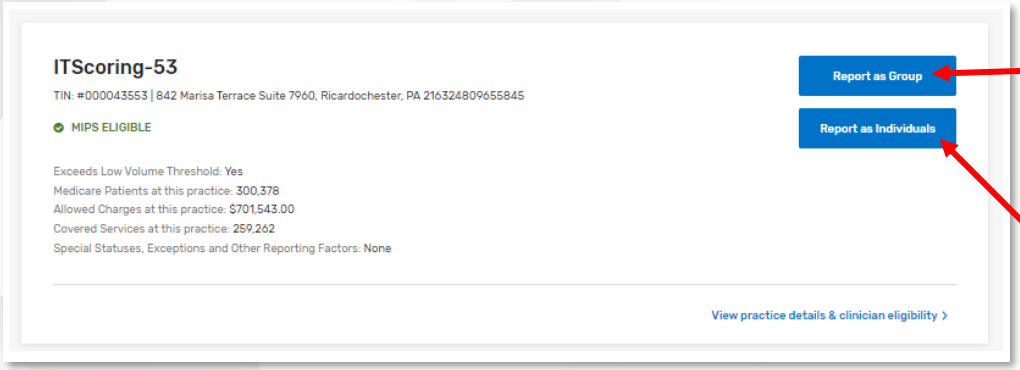
# Practice Representatives

This section includes information for users with a Staff User or Security Official role for a **Practice organization**, identified by Taxpayer Identification Number (TIN).

| With this Access | You CAN do this during and after the submission period | You CAN'T do this during or after the submission period |
|---|---|---|
| Staff User or Security Official for a **Practice**<br><br>(includes solo practitioners) | ✓ Access information about eligibility and special status at the individual clinician and group level<br><br>✓ View information about performance category reweighting (including from approved exception applications)<br><br>✓ Submit data on behalf of your practice (as a group and/or individuals)<br>• Includes Promoting Interoperability data for MIPS APM participants<br><br>✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals)<br><br>✓ View data submitted on behalf of your practice (group and/or individual)<br><br>✓ View measure-level scoring for Part B claims measures reported throughout the performance period<br>• This data will be updated during the submission period to account for claims received by CMS until March 1, 2025<br>• **REMINDER**: We'll only score small practices as a group if they submit data at the group level for another performance category)<br><br>✓ View measure and activity-level scores and a sub-total of points for the group and individual clinicians | ✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable)<br><br>✗ View cost measures feedback (if applicable)<br>• Cost data won't be available during the submission period<br><br>✗ View facility-based scoring for quality / cost (if applicable)<br><br>✗ View data submitted by your APM Entity<br>• **Example:** If you're a Participant TIN in a Shared Savings Program ACO, you won't be able to view the quality data reported by the ACO through the CMS Web Interface<br><br>✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group)<br><br>✗ Overall preliminary score or preliminary performance category scores |

# Practice Representatives

## Group vs Individual Reporting




**As a group.** You're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

**As Individuals.** You're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

## Practices that Registered to Report an MVP

If the group registered to report an MVP, they can still report traditional MIPS instead of the MVP they registered for or in addition to the MVP they registered for.

- Select **Start Reporting** on the Traditional MIPS card to report traditional MIPS.
- For more information about MVP data submission, review the 2024 MVP Data Submission User Guide (PDF).

## Practices with MIPS APM Participants

If your practice includes clinicians who participate in a MIPS APM, you'll see the option to report the APM Performance Pathway (APP) and traditional MIPS.

- Select **Start Reporting** on the Traditional MIPS card to report traditional MIPS.
- For more information about APP data submission, review the 2024 APP Data Submission User Guide (PDF).

# Practice Representatives (Continued)

Did you know?

The level at which you participate in MIPS (individual or group) applies to all performance categories. We won't combine data submitted at the individual and group level into a single final score.

For example:

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

**REMINDER:** We'll **only** calculate a quality score at the group level for small practices reporting Medicare Part B claims measures for their MIPS eligible clinicians if the practice also submits data at the group level for another performance category.

# Practice Representatives (Continued)

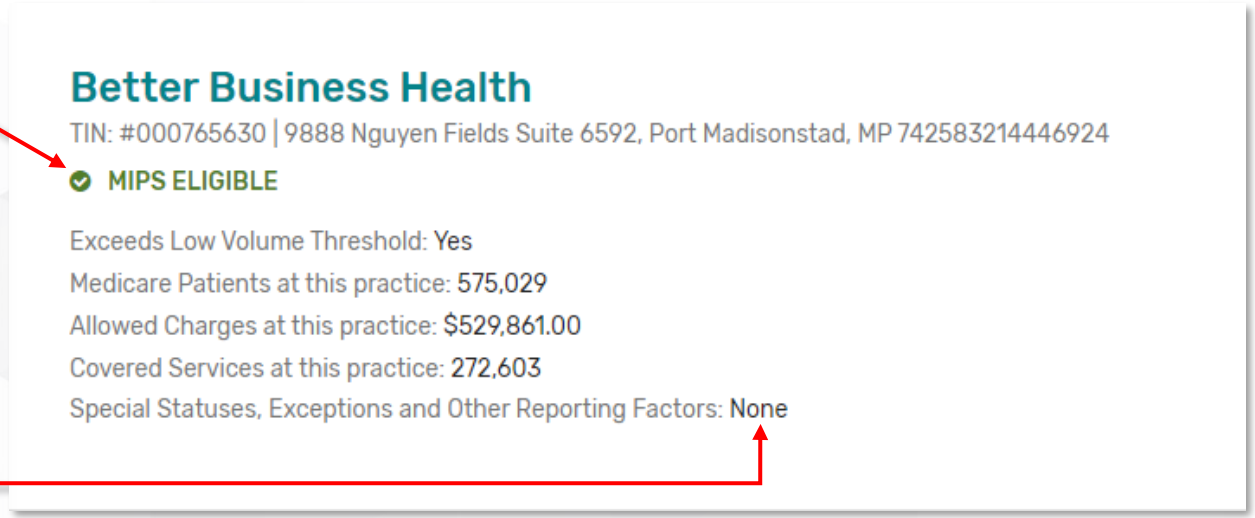
## Reporting as a Group

When you report as a group, you're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

From the Eligibility & Reporting page, you can view eligibility and special statuses at the practice level, which are applicable to group reporting.

Practice-level eligibility (applies to group reporting only)

Practice-level **special statuses** and **exception applications** (applies to group reporting only)



# Practice Representatives (Continued)

Eligibility Refresher (Group Reporting)

| You See | This Means |
|---|---|
| PRACTICE LEVEL (Applies to Group Reporting) | |
| ✓ MIPS ELIGIBLE | If you choose to report as a group, all of your MIPS eligible clinicians (including those who are individually below the low-volume threshold) will receive a payment adjustment based on your group submission |
| ⊘ MIPS EXEMPT | You can choose to voluntarily report as a group, but none of your clinicians will receive a payment adjustment<br>You will also see this status when your group was "opt-in eligible" and a practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to voluntarily report. |
| Opt-in Option: Opt-in eligible as group | Your practice isn't eligible for MIPS and your clinicians will not receive a MIPS payment adjustment from group reporting **unless** you make an election to Opt-In as a group.<br>**No action is needed if you don't want to submit data.**<br>If you want to submit group-level data, you will be prompted to make an election before you can submit data.<br>• **Opt-In to MIPS** and your clinicians will receive a MIPS payment adjustment (even if no data is submitted)<br>• **Voluntarily Report** and your clinicians will NOT receive a MIPS payment adjustment based on any data submitted |
| ✓ MIPS ELIGIBLE VIA OPT-IN | A practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to opt-in to MIPS.<br>Your MIPS eligible clinicians will receive a payment adjustment. |

If your practice is **"MIPS eligible"** or **"MIPS exempt"** as a group, clicking Report as a Group will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.

# Practice Representatives (Continued)

### Opt-in Eligible

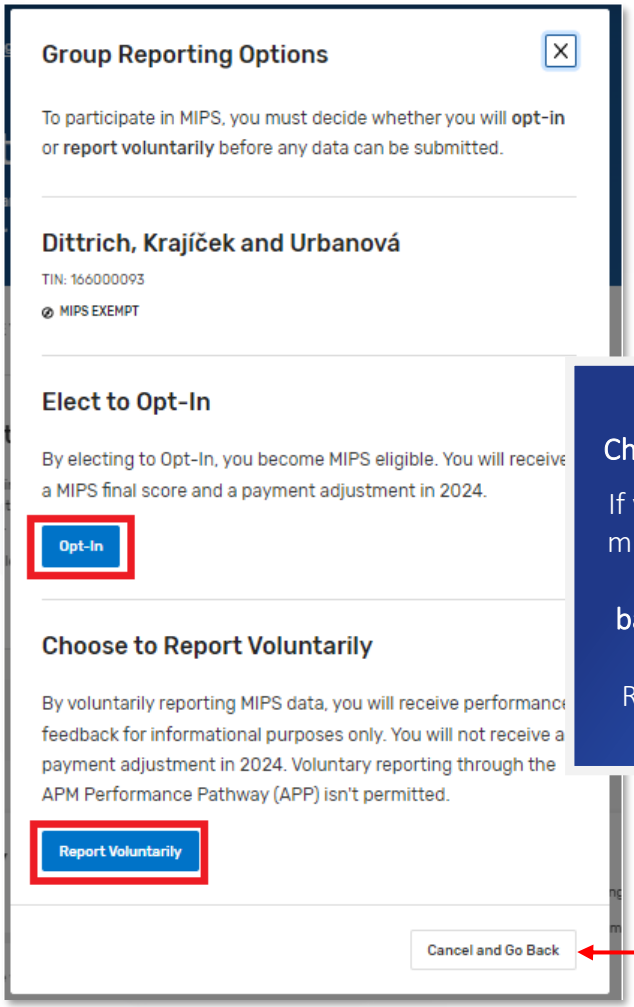
If your practice is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election can't be changed.

Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the practice to receive a MIPS final score based on a group submission and for all MIPS eligible clinicians to receive a payment adjustment.
- Select **Report Voluntarily** if you're electing for the practice to receive a MIPS final score based on a group submission, but no payment adjustment for your clinicians.

**Note:** You can't voluntarily report the APM Performance Pathway.

Review the 2024 MIPS Opt-In and Voluntary Reporting Election Guide (PDF, 1MB) for more information.




**Change Your Mind?**

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page

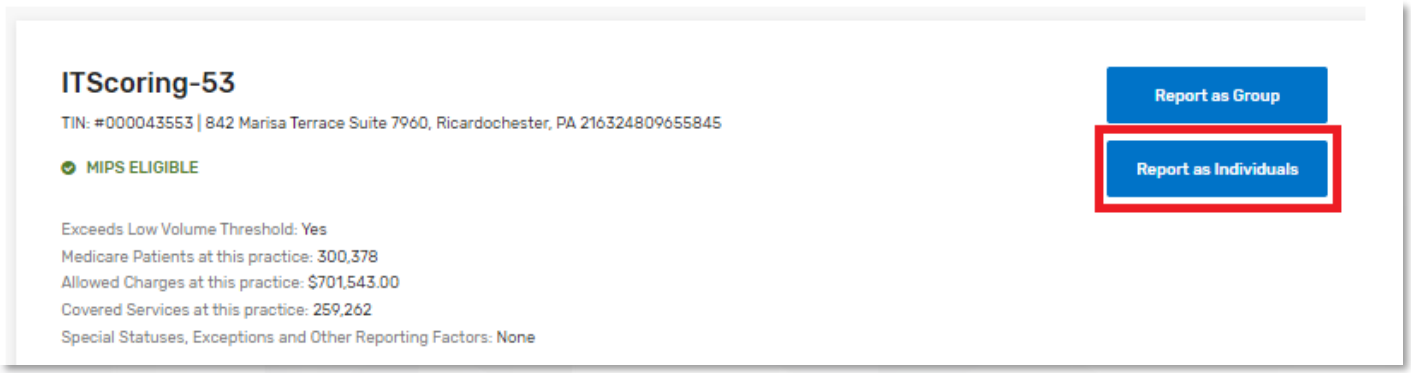
# Practice Representatives (Continued)

## Reporting as Individuals

When you're reporting as individuals, you're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

Users with access to their practice can view eligibility and special statuses at the individual level, which are applicable to the specific clinician for individual reporting.

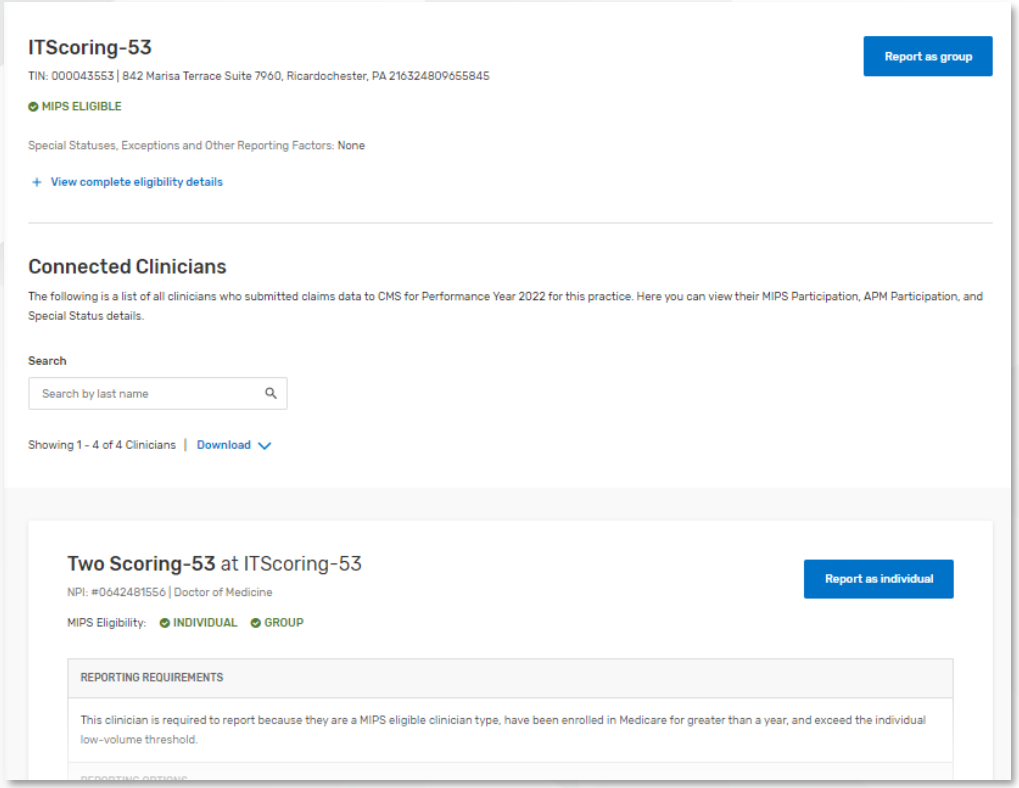
Click **Report as Individuals** or **View Clinician Eligibility** (under the option to Report as Individuals) to access Practice Details and Clinicians.




This page displays the clinicians who (identified by National Provider Identifier, or NPI) billed services under your practice's TIN **with dates of service between October 1, 2023, and September 30, 2024,** and received by CMS by October 30, 2024.

- This includes clinicians who left your practice and/or have terminated the reassignment of their billing rights to your practice's TIN in PECOS during this timeframe.

# Practice Representatives (Continued)



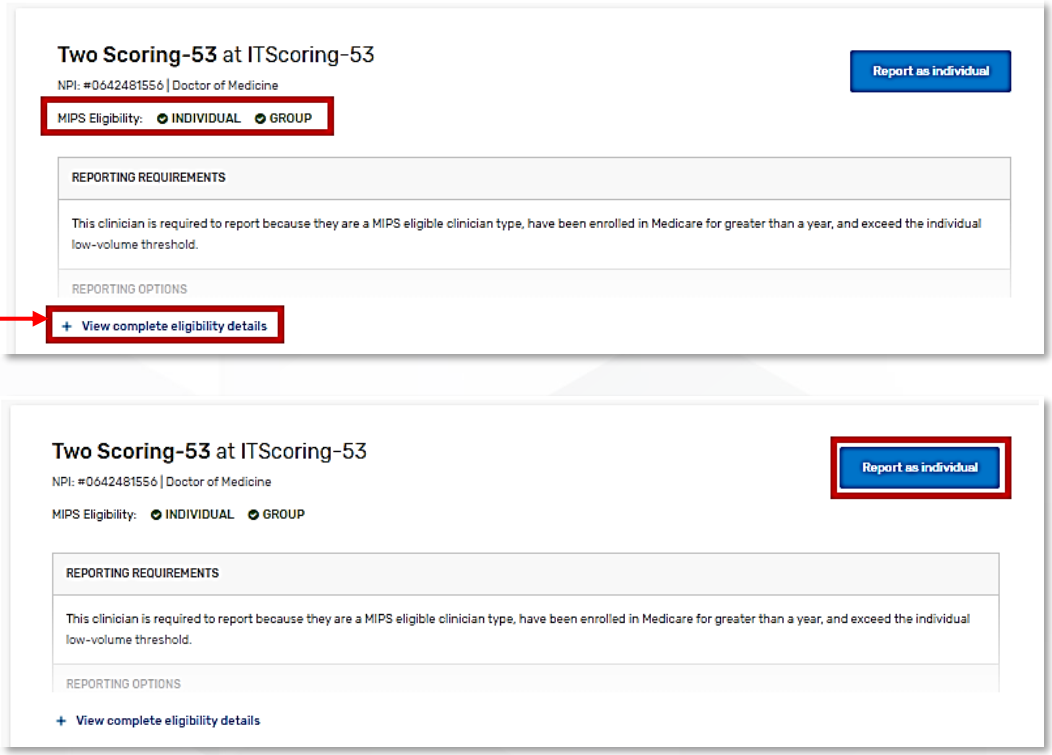

**Did you know?**

Clinicians who started billing for services under your Taxpayer Identification Number (TIN) between October 1 and December 31, 2024 **won't** appear on the QPP website during the submission period.

- These clinicians will be added to your practice's downloadable Payment Adjustment CSV when payment adjustments are released in summer 2025:
  - They'll receive a neutral MIPS payment adjustment if your practice reported as individuals; or
  - They'll receive a MIPS payment adjustment based on the group's final score (provided they are otherwise eligible for MIPS) if your practice reported as a group.

# Practice Representatives (Continued)

Each clinician will have an eligibility indicator at the individual and group level. If your practice is reporting as individuals, click **View complete eligibility** details to better understand the clinician's reporting requirements, reporting options and payment adjustment information




If the clinician is "**MIPS eligible**" or "**MIPS exempt**" as an individual, clicking Report as Individuals will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.

# Practice Representatives (Continued)

## Opt-in Eligible

If the clinician is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election **can't** be changed.

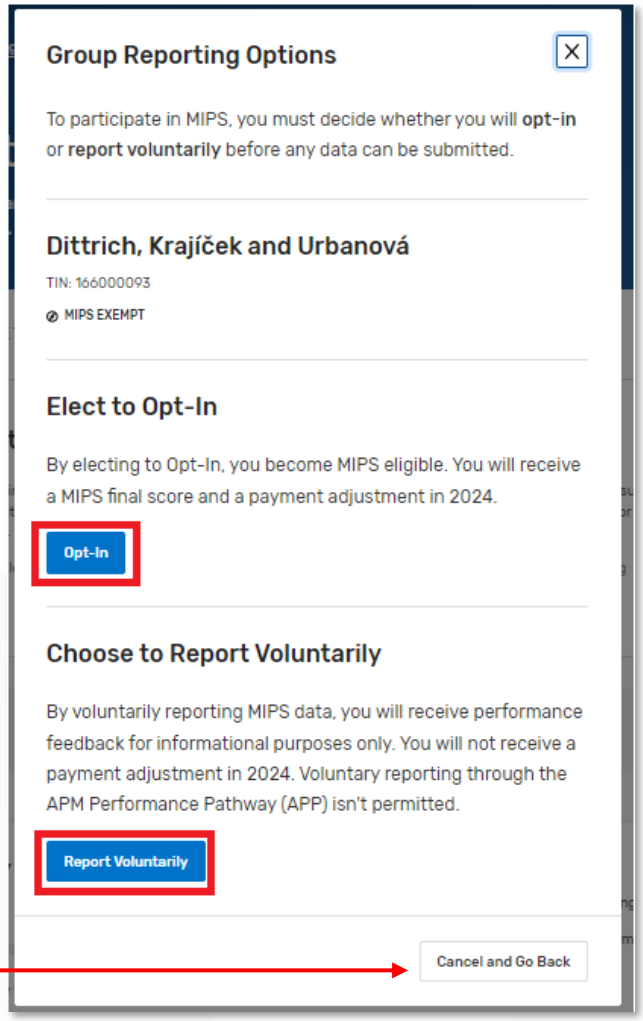
Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the clinician to receive a MIPS payment adjustment.
- Select **Report Voluntarily** if you're electing for the clinician to receive a MIPS final score but no payment adjustment.
  - Note: You can't voluntarily report the APM Performance Pathway.

## Change Your Mind?

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page.

Review the 2024 MIPS Opt-In and Voluntary Reporting Election Guide (PDF, 1MB) for more information.



# Preparing to Submit Your Data:
# APM Entity Representatives

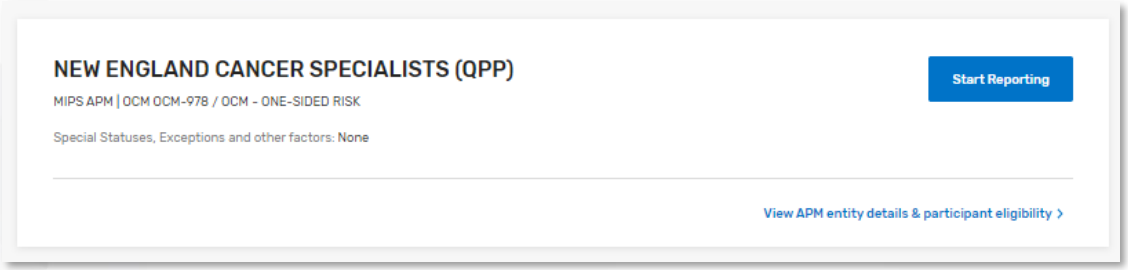
# APM Entity Representatives

This section includes information for users with a Staff User or Security Official role for an **APM Entity organization**, identified by an APM Entity ID.

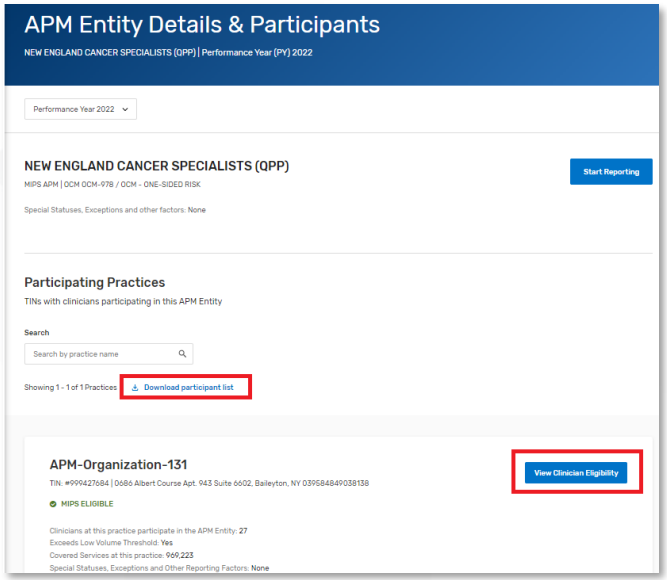
| With this access | You CAN do this during the submission period | You CAN'T do this during the submission period |
|---|---|---|
| Staff User or Security Official for an **APM Entity** | ✓ Access a list of the practices (TINs) and clinicians participating in the APM Entity<br>✓ **NEW:** Submit a Partial QP Election **(Security Officials Only)**<br>✓ View information about performance category reweighting (including from approved exception applications)<br>✓ Submit quality data through the CMS Web Interface (Shared Savings Program ACOs)<br>✓ Upload a QRDAIII file with your eCQM data to meet your model-specific requirements (Primary Care First practice sites)<br>✓ Upload a file of APM Entity-level quality and/or Promoting Interoperability measure data (all APM Entities in MIPS APMs)<br>✓ View measure and activity-level scores along with a sub-total of points on **quality** (and improvement activities if applicable) data submitted by or on behalf of the APM Entity | ✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable)<br>✗ View the Promoting Interoperability data reported by clinicians and groups in your APM Entity<br>✗ View preliminary quality performance category score |

# APM Entity Representatives (Continued)

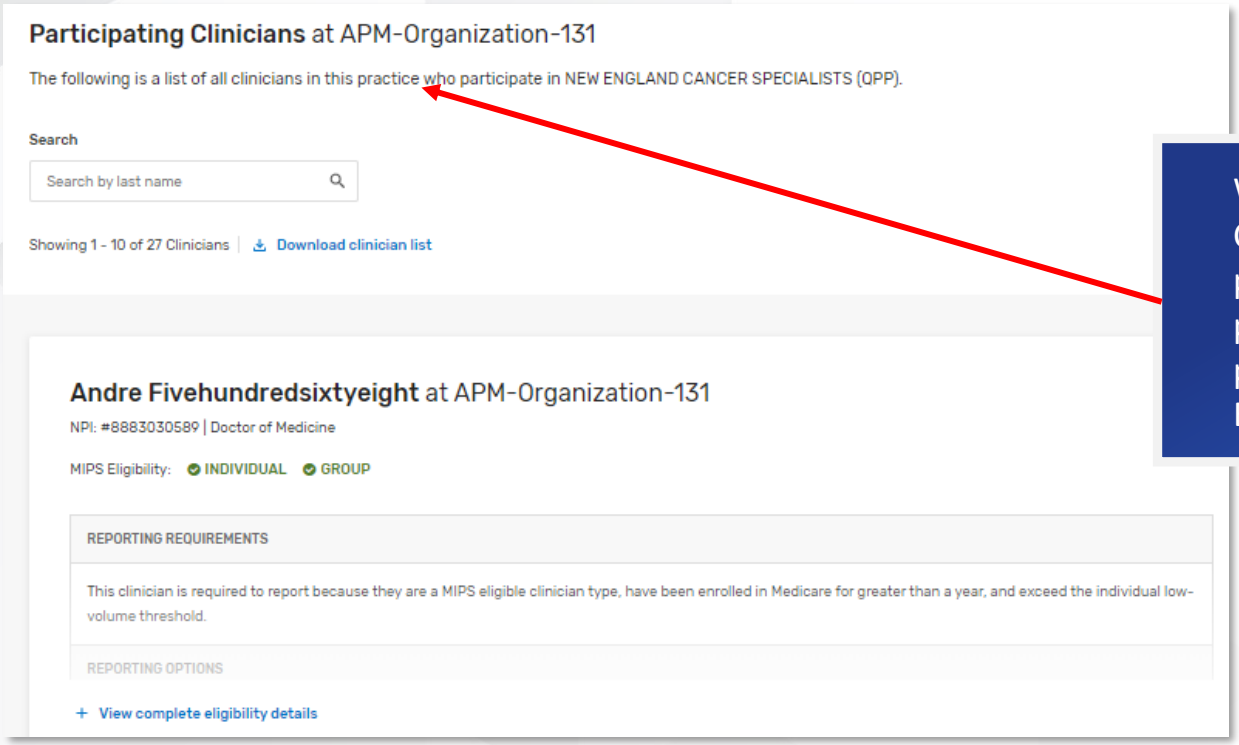
After signing in and clicking **Eligibility & Reporting** from the left-hand navigation, users with access to their APM Entity can access a list of the clinicians participating in the Entity by clicking **View Participant Eligibility** beneath Start Reporting.




From the **APM Entity Details & Participants** page, you will be able to **download** a list of all your participants or **view** participants by Practice. This is a list of the clinicians identified as participating in your APM Entity on the 1st, 2nd or 3rd APM Snapshot dates (March 31, June 30, and August 31, 2024).



# APM Entity Representatives (Continued)



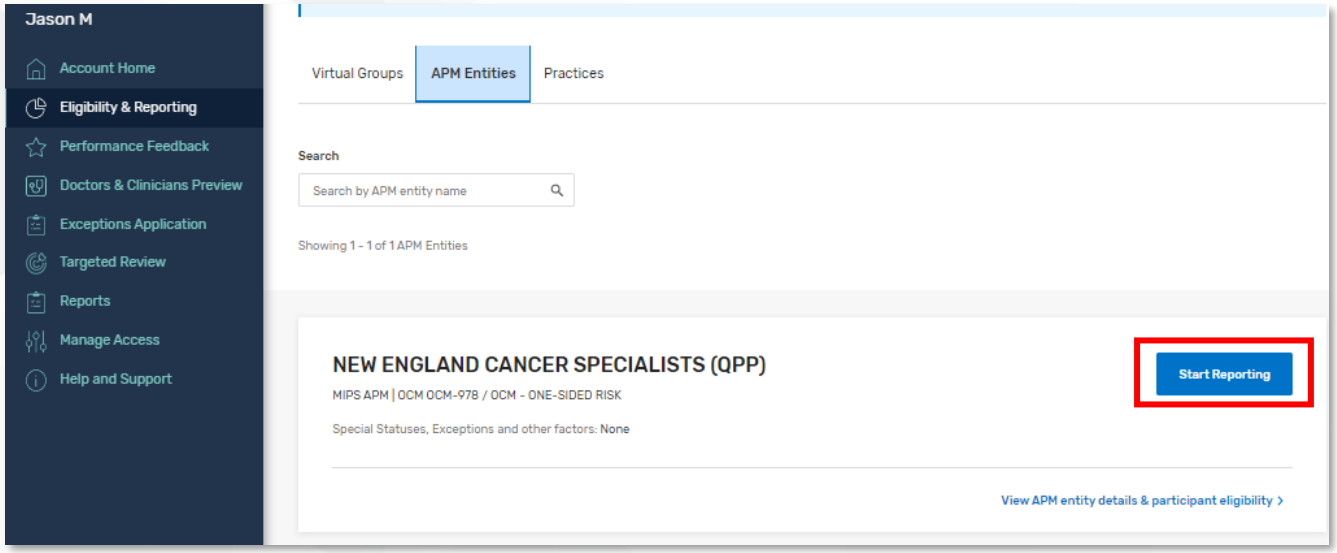

When you select View Clinician Eligibility by practice, only clinicians in the practice who are also participating in the APM Entity will be listed.

# APM Entity Representatives (Continued)

## Reporting Options

Once logged in, you will see the Account Dashboard, which will list all the APM Entities for which you can report data. This is based on the permissions/roles associated with your account.

From the Eligibility & Reporting page, select Start Reporting next to the APM Entity for which you'd like to report data.




From here, you'll be directed to a new Reporting Options page which outlines any required or optional reporting.

# APM Entity Representatives (Continued)

## Partial QP Elections

APM Entities with Partial Qualifying APM Participation (QP) Status will see the option to **Make a QP Election** beneath **Start Reporting**.

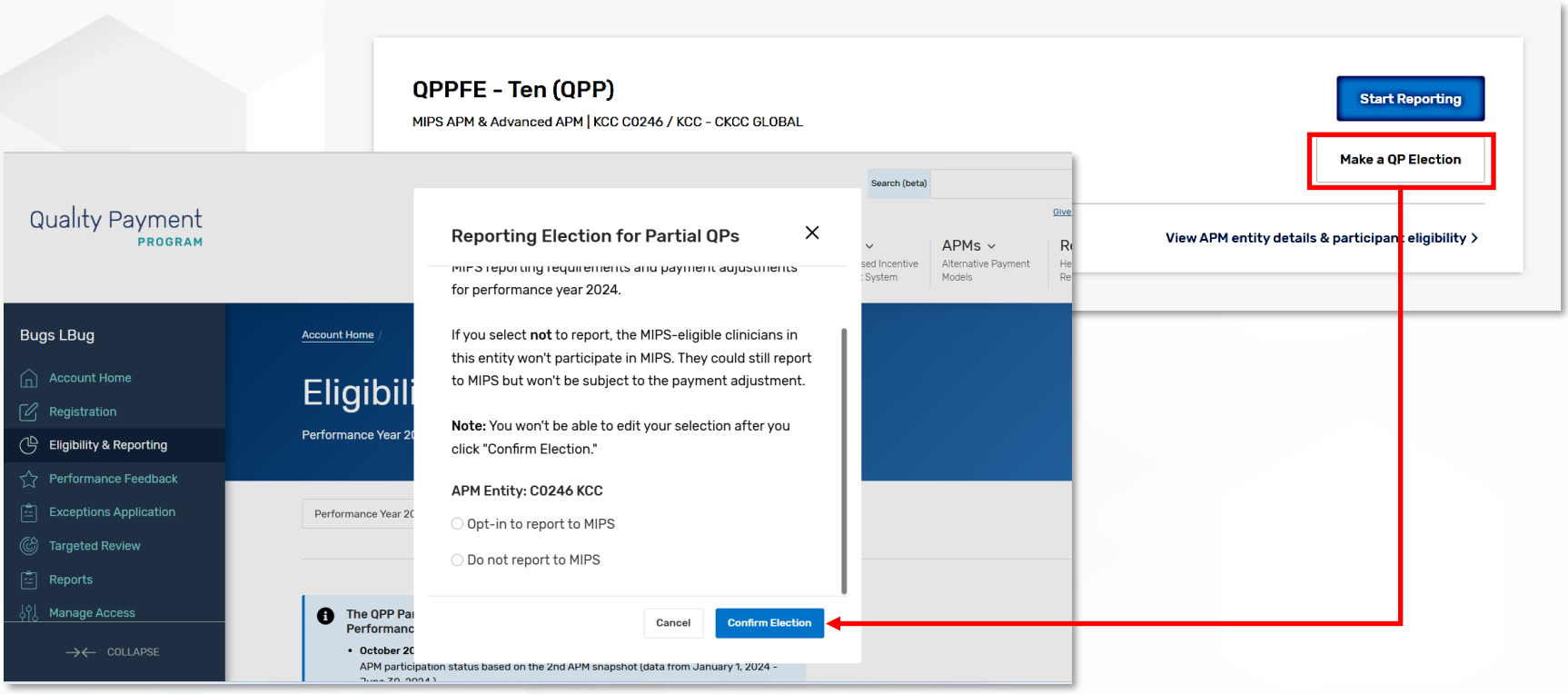

UPDATED 3/31/2025: Partial QPs who want to report MIPS data and get a MIPS payment adjustment must complete their Partial QP election by March 31, 2025, at 8 p.m. ET. (Data must be submitted by April 14, 2025, at 8 p.m. ET.)

# APM Entity Representatives (Continued)

UPDATED 3/31/2025: Partial QPs who want to report MIPS data and get a MIPS payment adjustment must complete their Partial QP election by March 31, 2025, at 8 p.m. ET. (Data must be submitted by April 14, 2025, at 8 p.m. ET.)

## Partial QP Elections (Continued)

Click **Make a QP Election** to open a pop-up window which will allow you to make the Partial QP Election on behalf of your MIPS eligible clinicians.



# APM Entity Representatives (Continued)

## Partial QP Elections (Continued)

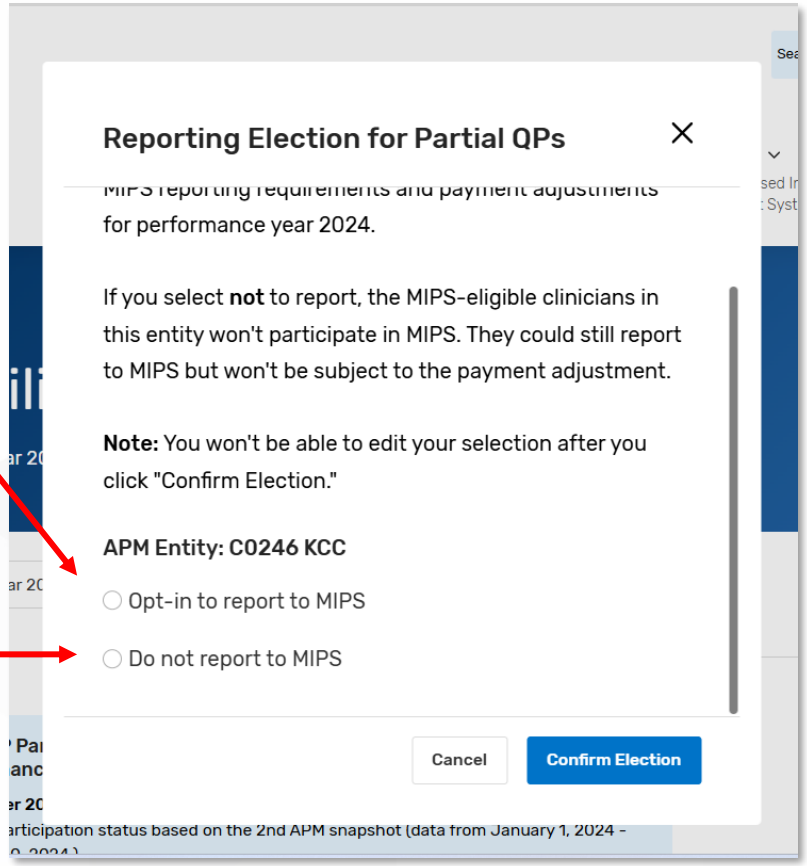
### Opt-in to report to MIPS

- Select this if you want the MIPS eligible clinicians in your APM Entity to **receive a MIPS payment adjustment** for the 2024 performance period/2026 MIPS payment year.

UPDATED 3/31/2025: Partial QPs who want to report MIPS data and get a MIPS payment adjustment must complete their Partial QP election by March 31, 2025, at 8 p.m. ET. (Data must be submitted by April 14, 2025, at 8 p.m. ET.)

### Do not report to MIPS

- Select this if you **don't want** the MIPS eligible clinicians in your APM Entity **to receive a MIPS payment adjustment** for the 2024 performance period/2026 MIPS payment year.

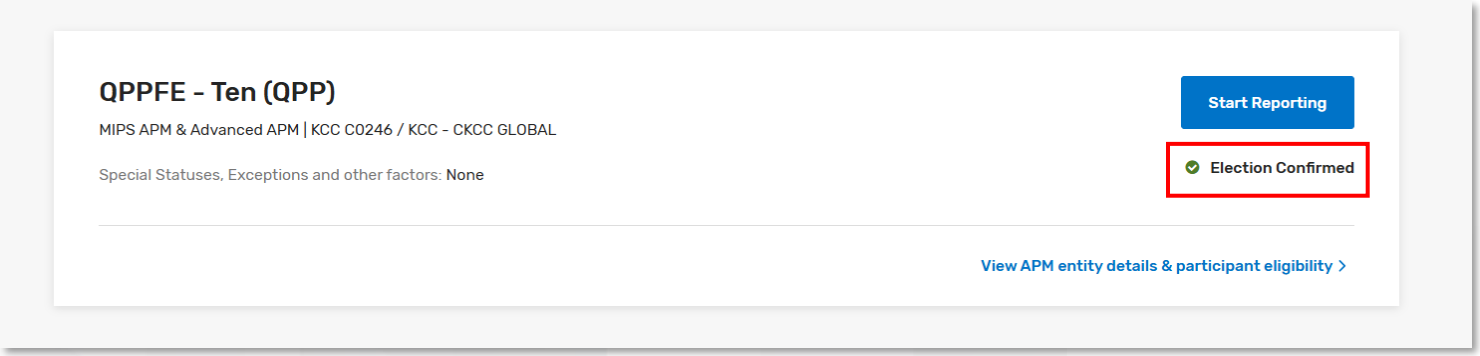



For more information about Partial QP status, review the 2024 Learning Resources for QP Status and APM Incentive Payments (ZIP, 3MB).

# APM Entity Representatives (Continued)

## Partial QP Elections (Continued)

Once you've made and confirmed your election, you'll see an **Election Confirmed** indicator below Start Reporting.

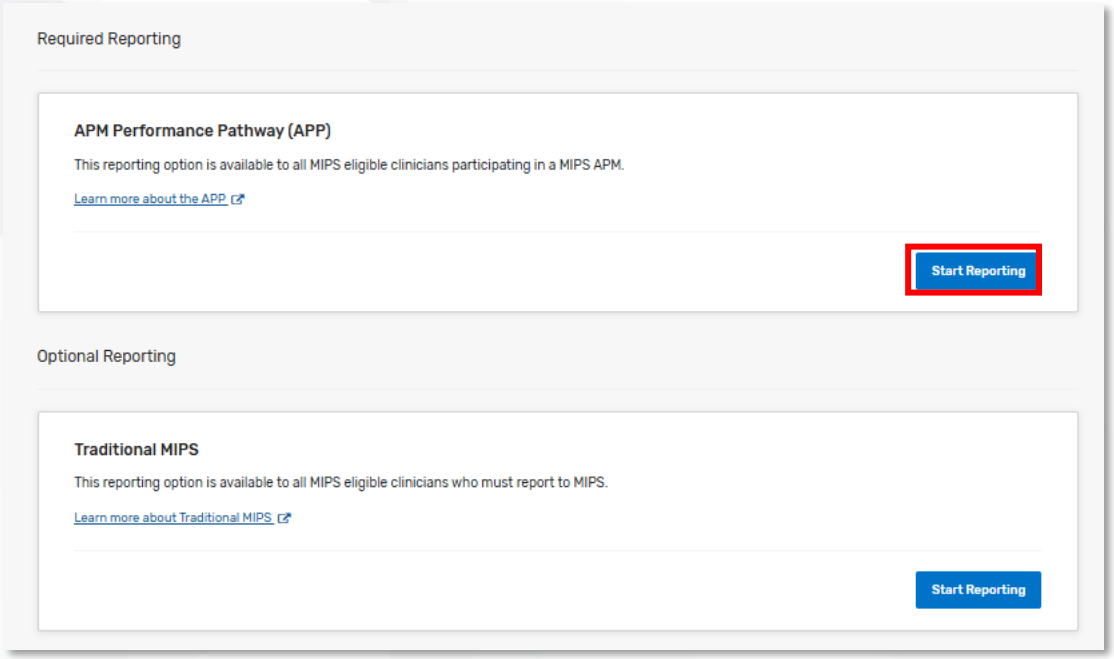



UPDATED 3/31/2025: Partial QPs who want to report MIPS data and get a MIPS payment adjustment must complete their Partial QP election by March 31, 2025, at 8 p.m. ET. (Data must be submitted by April 14, 2025, at 8 p.m. ET.)

# APM Entity Representatives (Continued)

## Shared Savings Program ACOs

Shared Savings Program ACOs are required to report the APP quality measure set as part of their participation in the Shared Savings Program. From the Reporting Options page, you'll select **Start Reporting** underneath the **APM Performance Pathway (APP)** option, and then you'll click **Report APP** on the subsequent pop-up modal. Please refer to the 2024 APP Submission Guide (PDF) for more information.

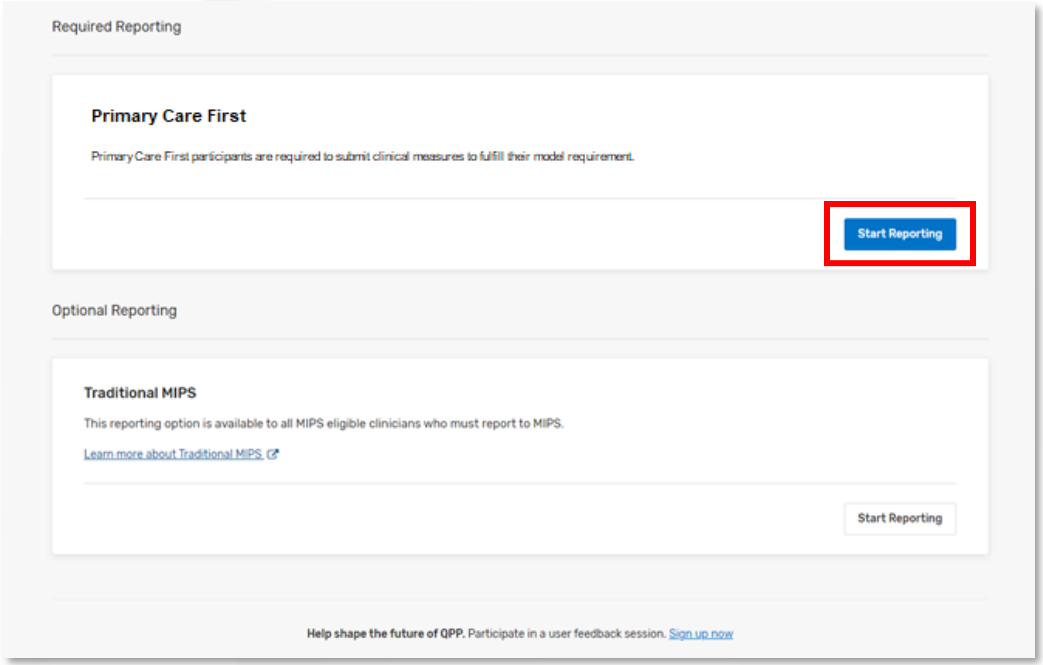



Learn how to report eCQMs or MIPS CQMs as a Medicare Shared Savings Program ACO for the APP.

# APM Entity Representatives (Continued)

## Primary Care First Practice Sites

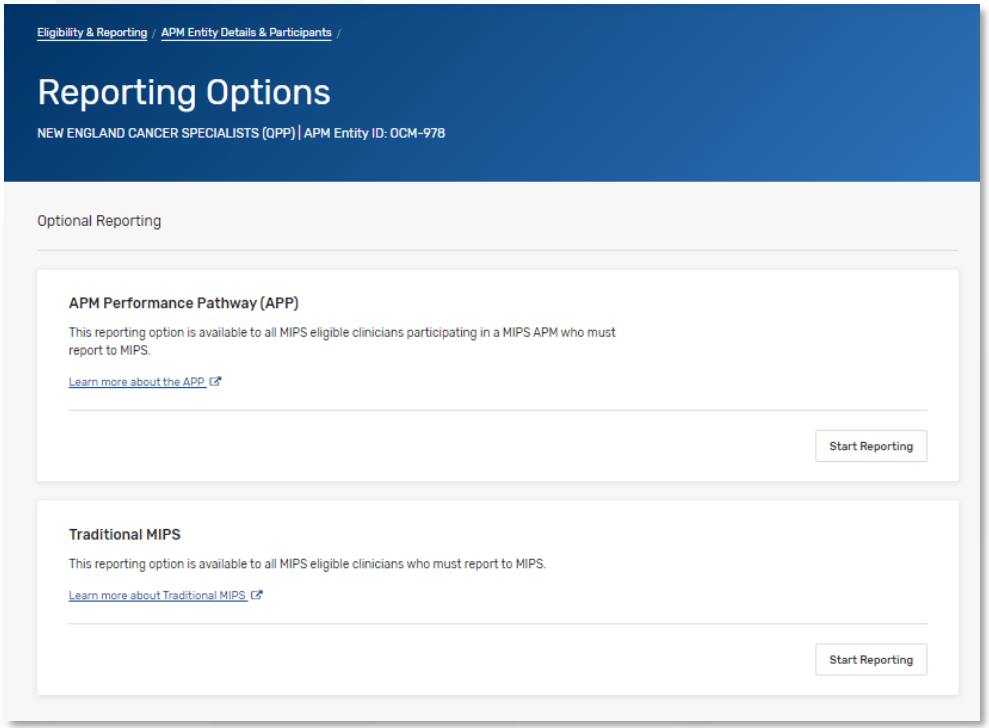
You'll see your model-specific reporting identified as Required Reporting, with the APM Performance Pathway (if your organization qualifies as a MIPS APM) and traditional MIPS listed as optional. In the screenshot below, the practice site isn't a MIPS APM and therefore doesn't have the option to report the APM Performance Pathway.



# APM Entity Representatives (Continued)

## APM Entities in All Other Models

If your organization qualifies as a MIPS APM, you'll see both traditional MIPS and the APM Performance Pathway listed as optional.



Quality Payment
PROGRAM

# Preparing to Submit Your Data:
# Virtual Group Representatives

# Virtual Group Representatives

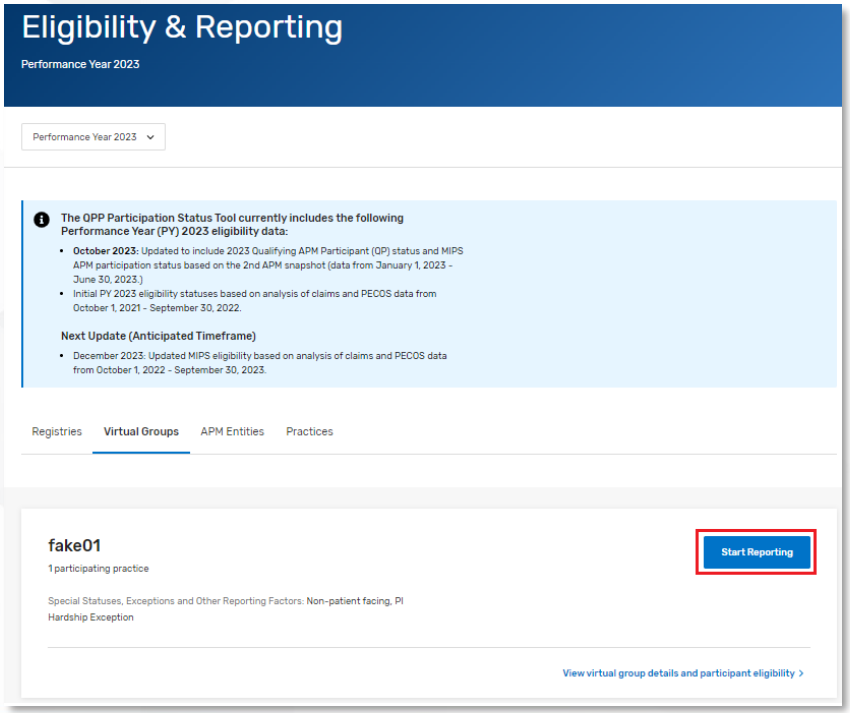
This section includes information for users with a Staff User or Security Official role for a **Virtual Group organization**, identified by Virtual Group ID.

| With this access | You CAN do this during the submission period | You CAN'T do this during the submission period |
|---|---|---|
| Staff User or Security Official for a Virtual Group | ✓ Access information about the practices (TINs) and clinicians participating in the virtual group<br>✓ View information about performance category reweighting (including from approved exception applications)<br>✓ Submit data on behalf of your virtual group<br>✓ View data submitted on behalf of your virtual group<br>✓ View measure-level scores for the virtual group | ✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable)<br>✗ View your cost feedback (if applicable)<br>• Cost data won't be available during the submission period<br>✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission)<br>✗ View preliminary overall score or preliminary performance category scores |

# Virtual Group Representatives (Continued)

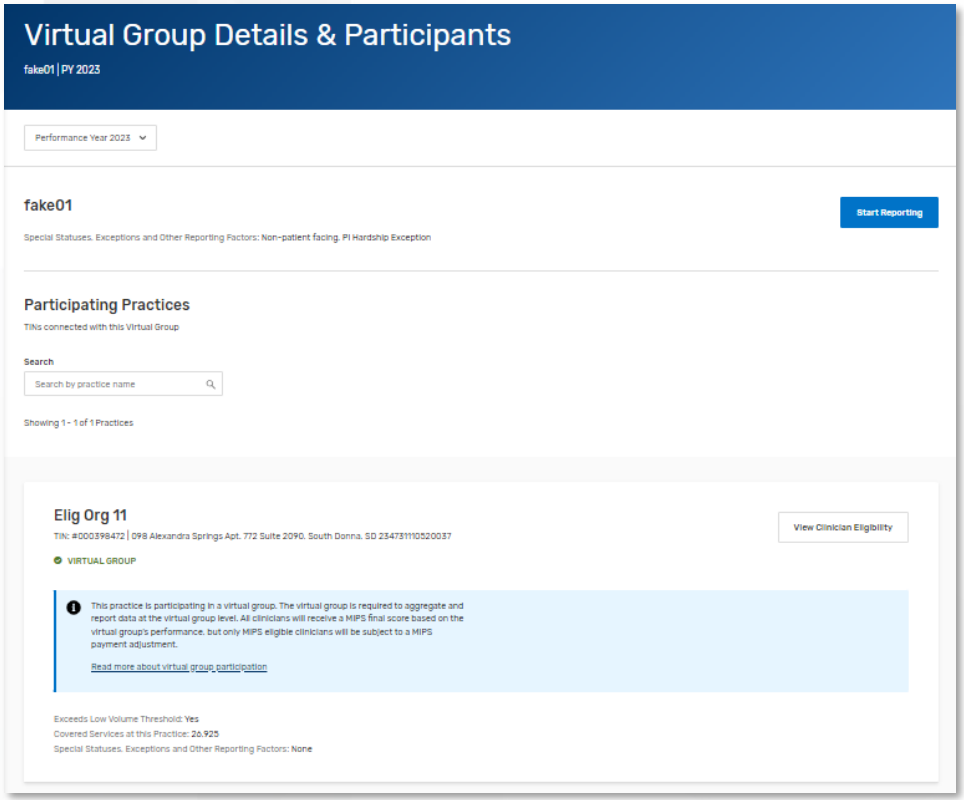
From the Eligibility & Reporting page, users with access to their virtual group can review any **special statuses and other reporting factors** attributed to the virtual group.

They can also access a list of the practices and clinicians participating in the virtual group by selecting **View participant eligibility**.



# Virtual Group Representatives (Continued)

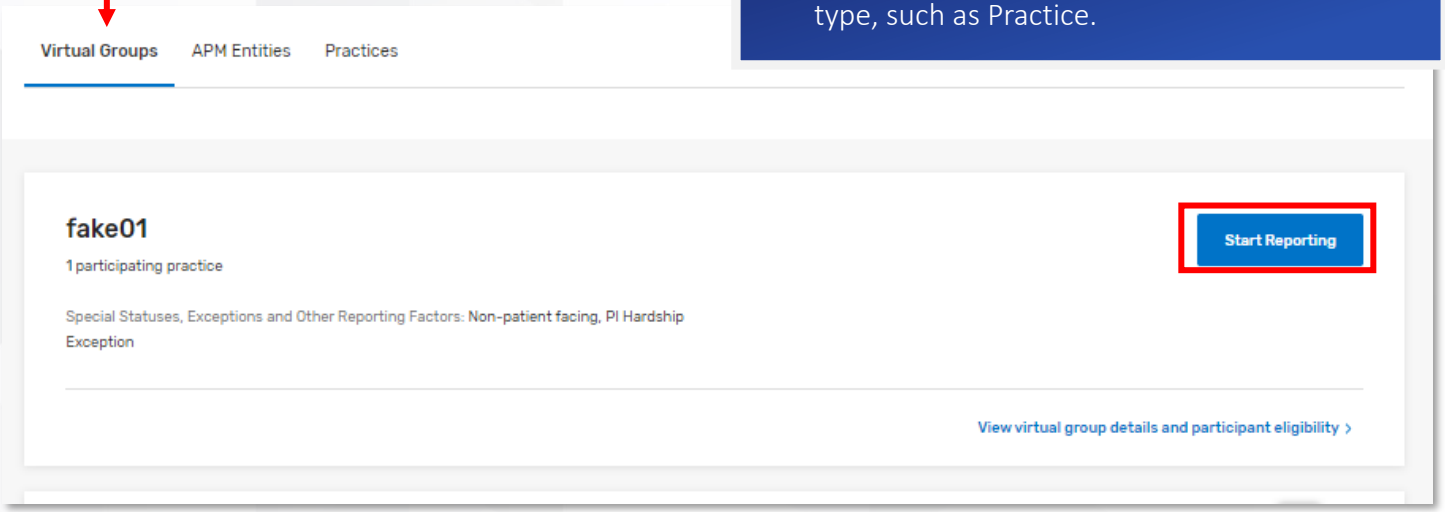
From the Participating Practices page, you can access a list of clinicians in each participating practice but can't download a list of all clinicians participating in the virtual group.



# Virtual Group Representatives (Continued)

From the Eligibility & Reporting page, select **Start Reporting** next to the appropriate Virtual Group organization.

Make sure you see **Virtual Groups** as your organization type or click **Virtual Groups** if you have access to another organization type, such as Practice.




**Did you know?**

- Data submitted by Practices participating in the Virtual Group will be considered voluntary reporting (both individual and group submissions).
- Appendix B offers helpful information about Virtual Group access.

Quality Payment
PROGRAM

# Submitting Data: Reporting Overview Page

# Reporting Overview Page

From the Reporting Overview page, you'll be able to:

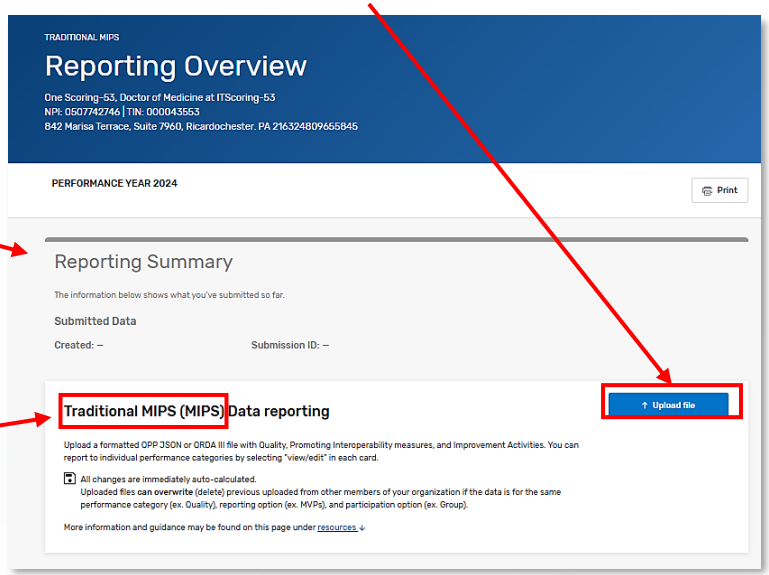
- Upload a file
- Access previously submitted data (by you or a third party)

## Upload a File

You can upload a Quality Reporting Data Architecture Category III (QRDA III) or QPP JavaScript Object Notation (JSON) file with data for any or all performance categories by selecting **Upload File**.

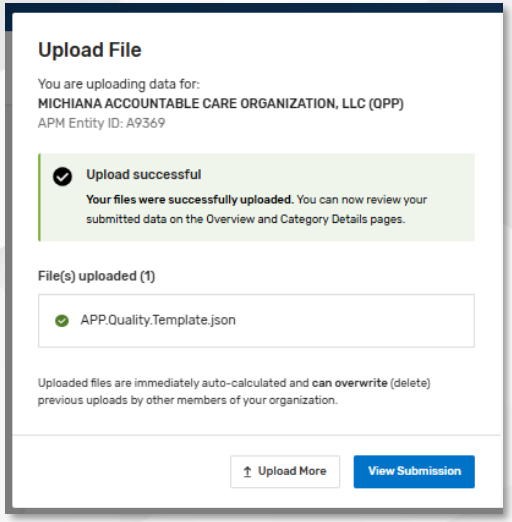
**NEW:** We added a Reporting Summary at the top of the page so you can easily determine if any data has been submitted. This section will be greyed out if no data have been submitted.

We also added the reporting option so you can easily determine that data is being/has been submitted for **traditional MIPS.**



# Reporting Overview Page (Continued)

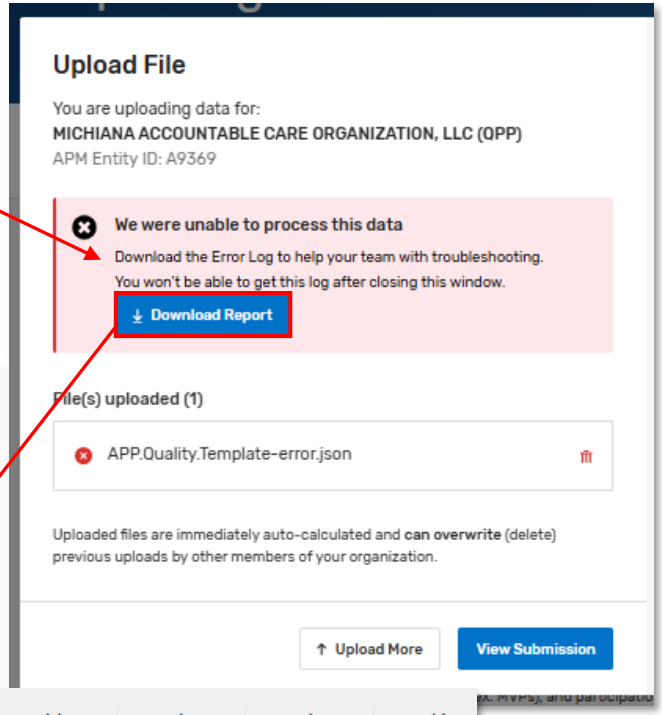
Once you've uploaded your file, you will see an indicator of success or error.

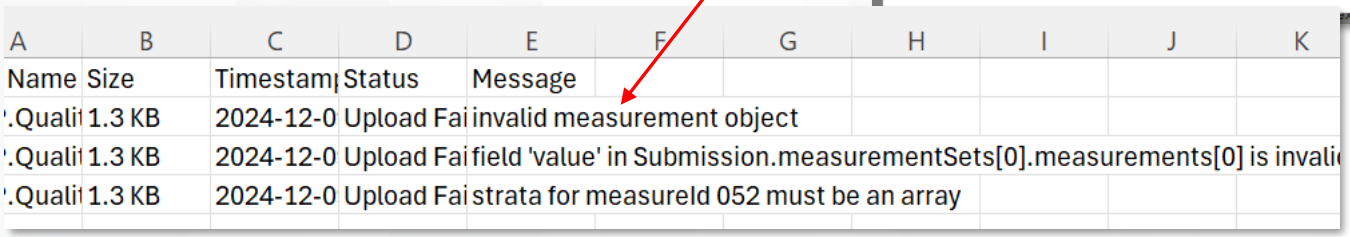



If there's an error with your file, you'll see a message indicating that the data couldn't be processed and have access to a detailed error report. Click Download Report for details of the submission issue.

You can contact the QPP Service Center with questions.

- **By Email:** qpp@cms.hhs.gov
- **By Phone:** 1-866-288-8292 (711 for TRS)

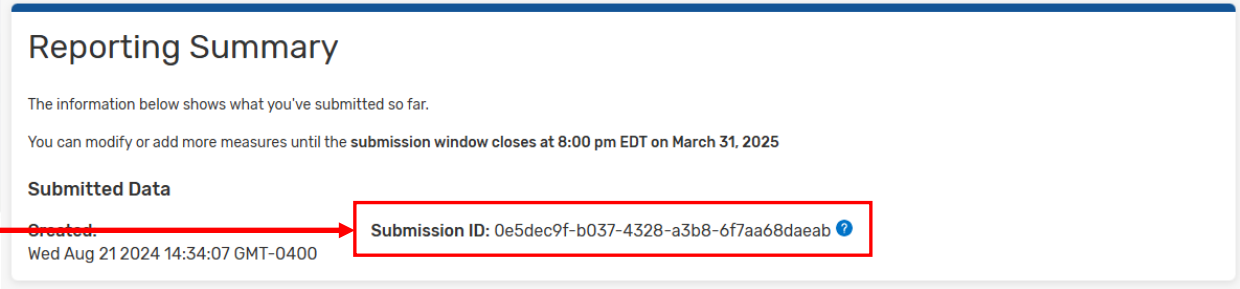


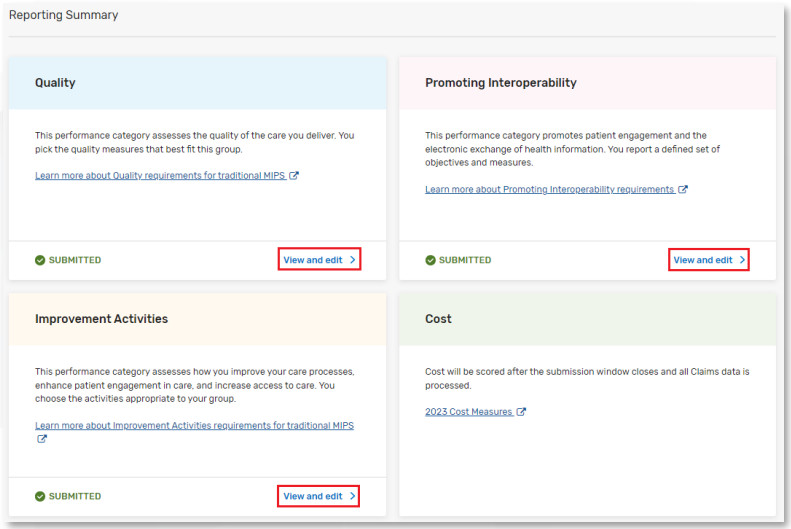
| A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| Name | Size | Timestam | Status | Message | | | | | | |
| .Quali | 1.3 KB | 2024-12-0 | Upload Fai | invalid measurement object | | | | | | |
| .Quali | 1.3 KB | 2024-12-0 | Upload Fai | field 'value' in Submission.measurementSets[0].measurements[0] is invali | | | | | | |
| .Quali | 1.3 KB | 2024-12-0 | Upload Fai | strata for measureId 052 must be an array | | | | | | |

# Reporting Overview Page (Continued)

Once data has been submitted, the Reporting Summary will reflect this. If you need to contact the Service Center about your submission, you'll need to provide your **Submission ID**.




Click **View & Edit** to access details about the data that's already been submitted for a performance category.

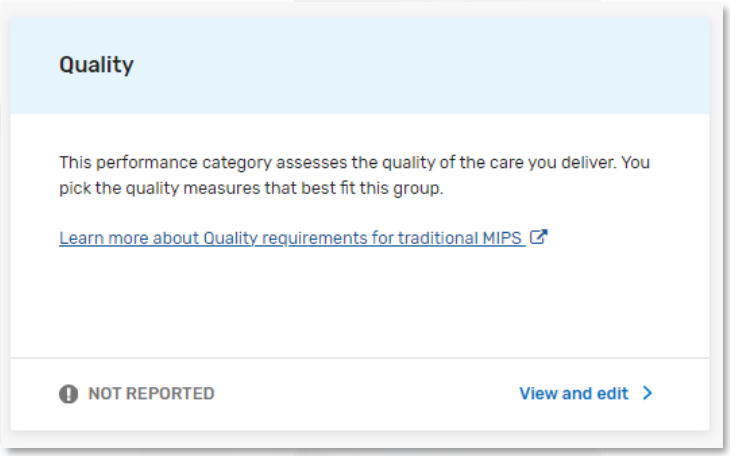


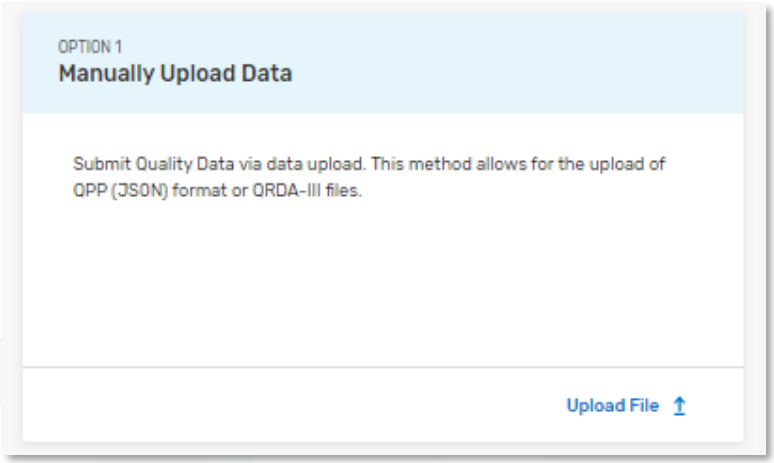

**Note:** If applicable, you'll also see performance category reweighting indicators (from auto EUC, exception applications, or special status) on the reporting overview page.

# Submitting and Reviewing Quality Data

# Upload Your Quality Measures

You can upload files for any or all performance categories from the Reporting Overview page. Alternately, if no quality data has been reported, you can upload your own QRDA III or QPP JSON file with your eCQMs or MIPS CQMs by clicking **View & Edit** in the Quality section of the Reporting Overview and then **Upload File**:



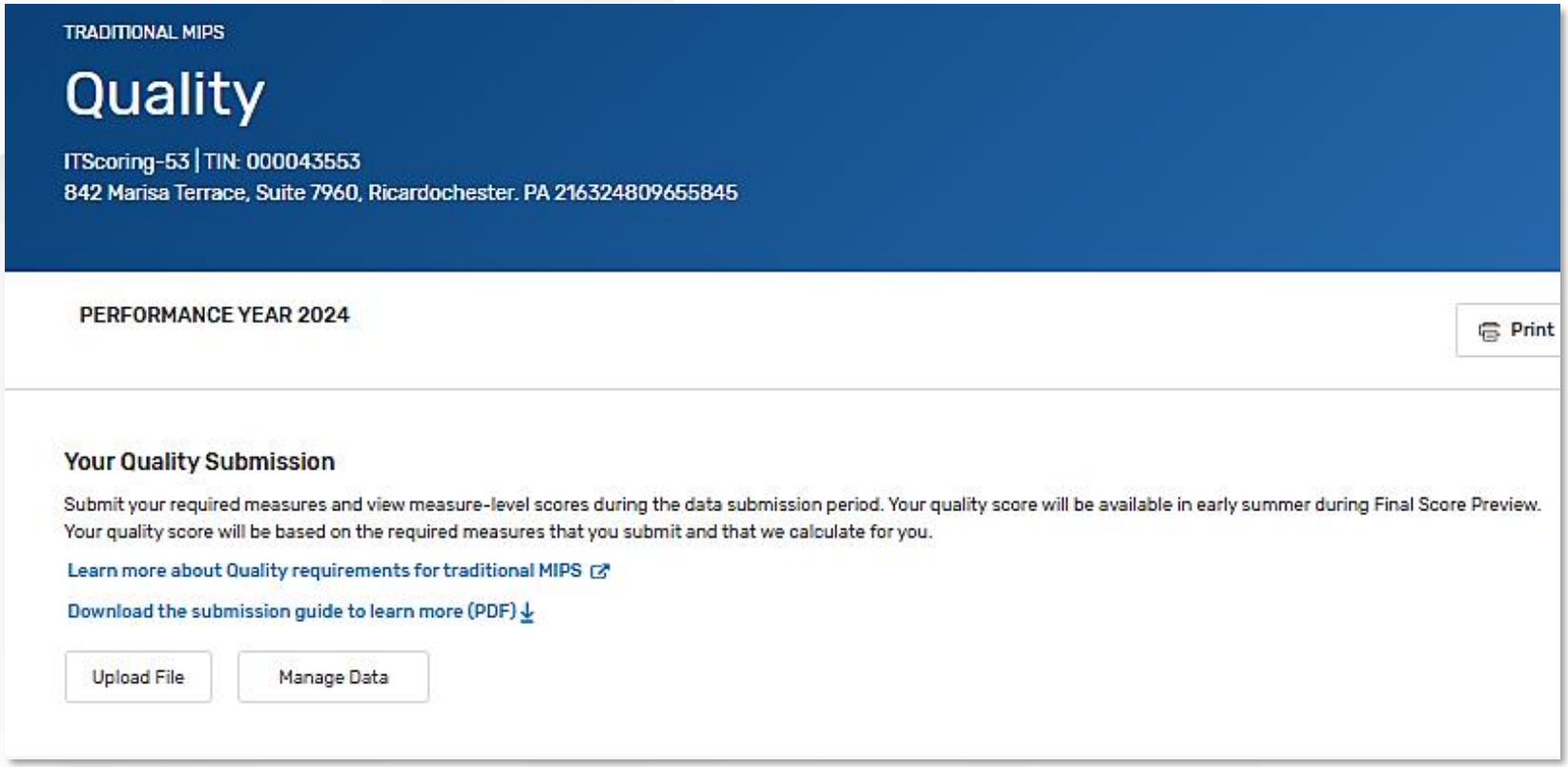

Once quality measures have been submitted, you will need to upload new files from the Reporting Overview page.

**Having trouble uploading your QRDAIII file?**

Skip ahead to the troubleshooting section of this guide.

# Review Previously Submitted Data

From the Reporting Overview, click **View & Edit** in the Quality section to access the Quality details page.



# Review Previously Submitted Data (Continued)

**During the submission period, this page will reflect:**

- ✓ Medicare Part B claims measures reported by clinicians in a small practice throughout the performance period (available by late January 2025), and
- ✓ eCQMs or MIPS CQMs that you have uploaded directly or were submitted by a third party (such as a Qualified Registry or QCDR), and
- ✓ QCDR measures submitted on your behalf by a QCDR

**Medicare Part B Claims Measures**

Only clinicians in small practices (fewer than 16 clinicians) can report Medicare Part B claims measures. If you don't see your preliminary scores for Part B claims measures, check the QPP Participation Status lookup tool to see if you have the small practice special status.

**We'll only automatically calculate a quality score at the group level if the practice also submits data at the group level for another performance category.**

We intend to update preliminary Part B claims measure scores on a monthly basis during the submission period (to account for the 60-day run out period for claims measure processing).

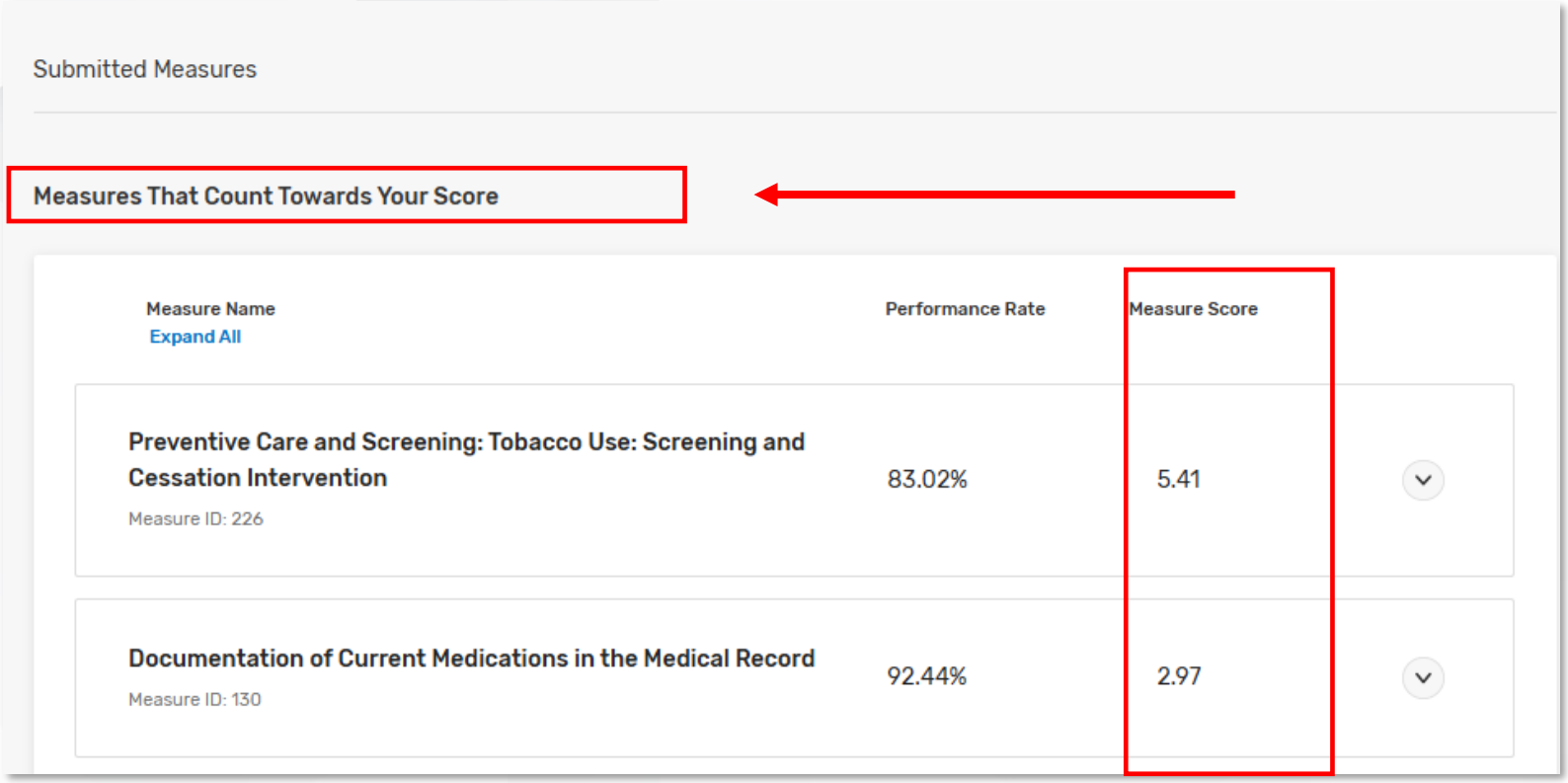
**During the submission period, this page WON'T reflect:**

- × Scoring for the CAHPS for MIPS Survey measure.
- × Scoring on any administrative claims quality measures.
- × A preliminary score for the quality performance category.

# Measure Information

Measures may be divided into 2 groups:

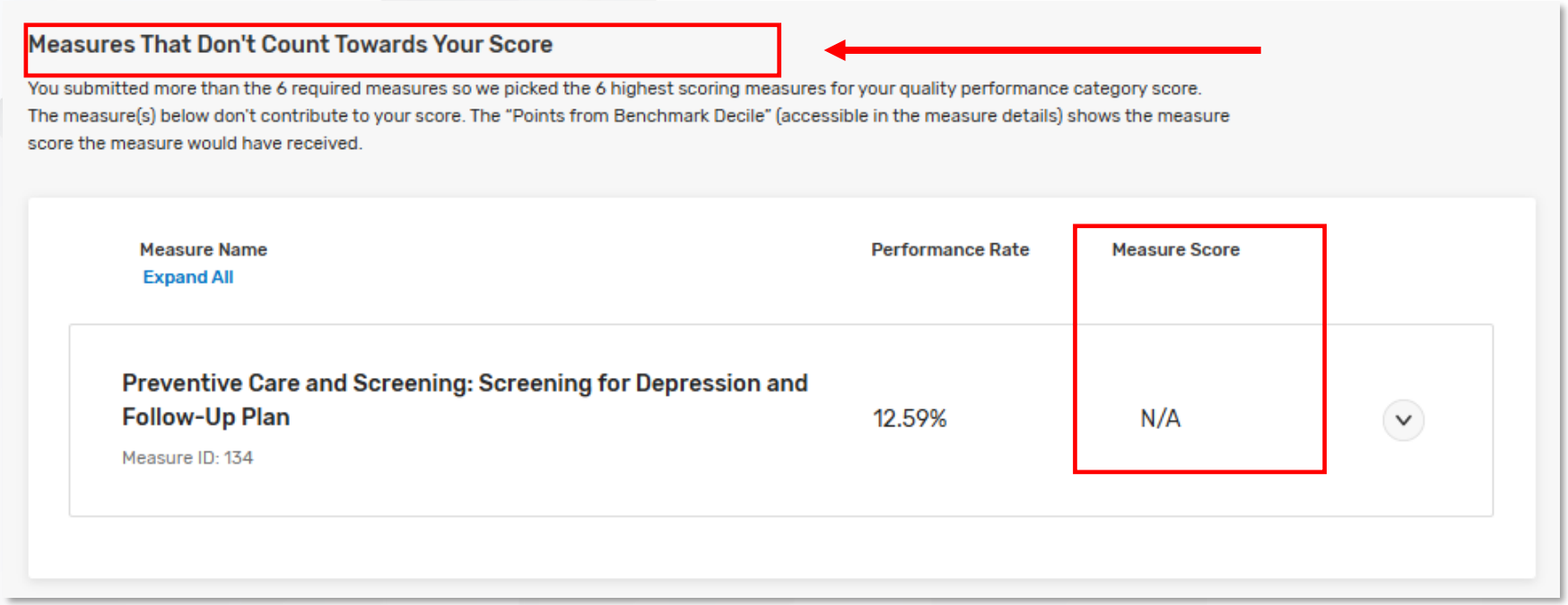
1. Measures whose performance points count toward your quality performance category score. The measure score will display your performance points (those achieved based on performance in comparison to the measure's benchmark).



# Measure Information (Continued)

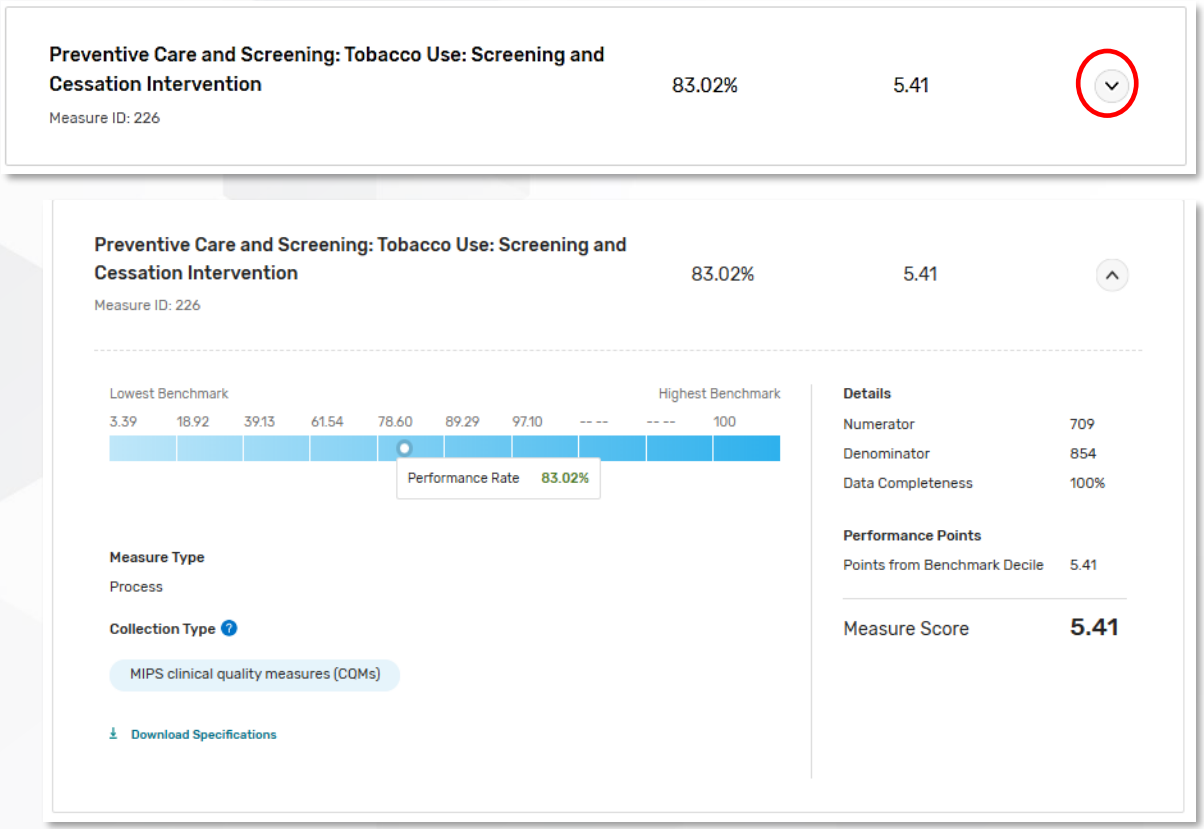
**Measures may be divided into 2 groups** (Continued):

2. Measures that contribute no points to your quality performance category score. You will see an "N/A" in the measure score.



# Measure Information (Continued)

To view measure details, click the down arrow on the right side of the measure information:




From here, you will see performance points (those earned by comparing your performance to a historical benchmark), and other scoring details about the measure.

# Measure Information (Continued)

**In addition to the required outcome measure (or high priority measure if no outcome measure is available), we'll use your 5 highest scoring measures to determine your quality performance category score.**

If you submit the same measure through multiple collection types*, we'll use the collection type that earned the most performance points.

***What's a collection type?**

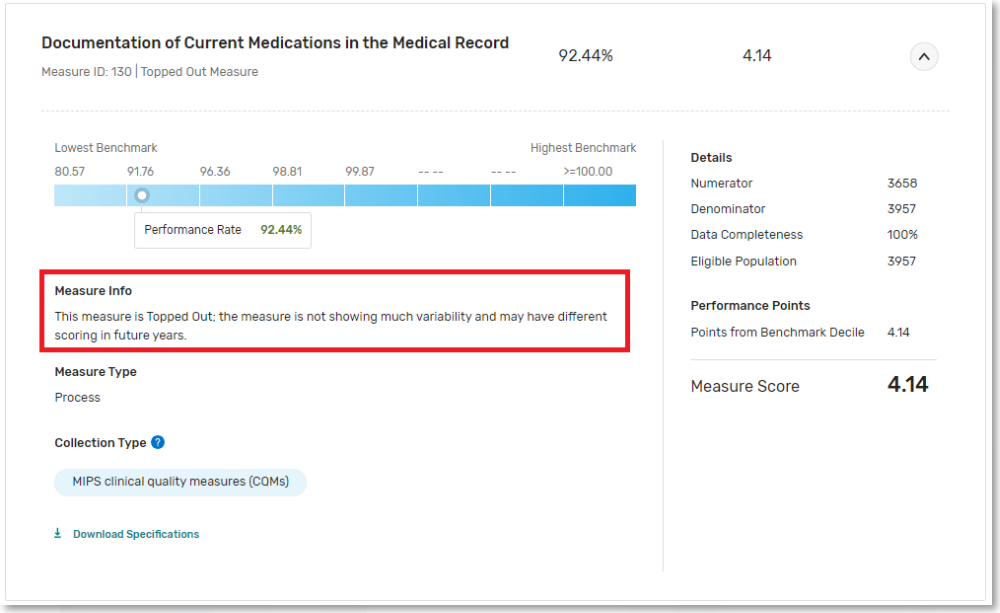
A collection type refers to a set of quality measures with comparable specifications and data completeness requirements. The same measure may be reported through multiple collection types, where each collection type has a distinct measure specification for collecting the data and calculating the measure.

For example, Measure 130 (Documentation of Current Medication in the Medical Record) may be reported as:

- A MIPS Clinical Quality Measure (MIPS CQM)
- An Electronic Clinical Quality Measure (eCQM)

# Topped-Out Measures

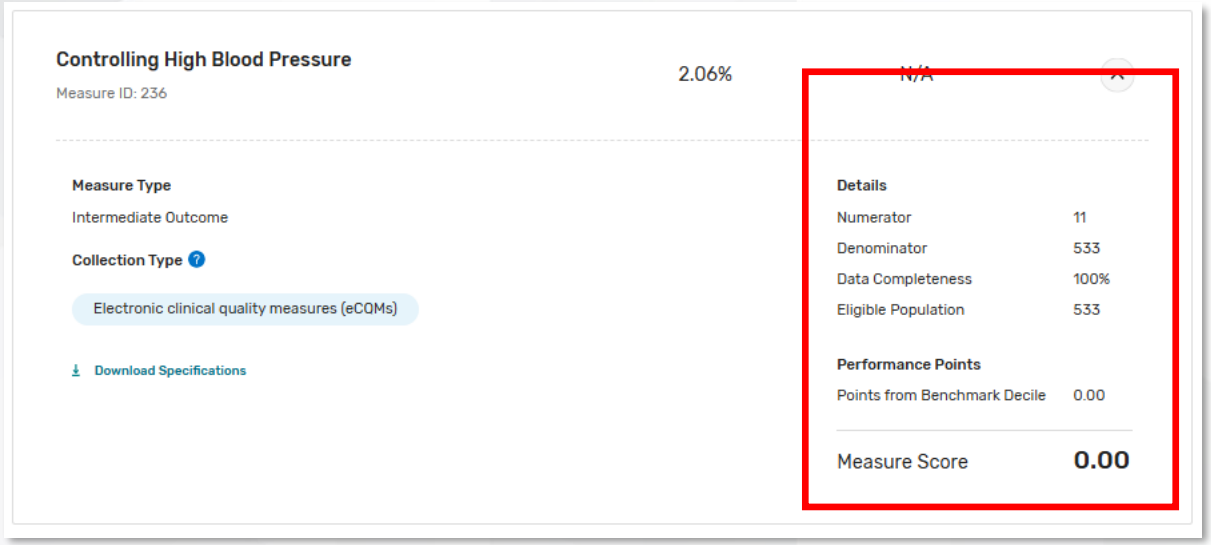
A topped-out measure is one where performance is high with little variation among those reporting the measure – a topped out **process** measure is defined as a measure with a **median** performance rate of 95% or greater (or 5% or less, for inverse measures).




**Did you know?**

Not all topped out measures are capped at 7 points. To be capped at 7 points, a measure must be in its 2nd (or 3rd or 4th) consecutive year of being topped out through the same collection type. Refer to "Seven Point Cap" column in the 2024 Quality Benchmarks file.

# Measures Without a Historical Benchmark




If you report a measure without a historical benchmark, you will receive 0 performance points. Small practices will continue to earn 3 points, provided the measure meets data completeness requirements.

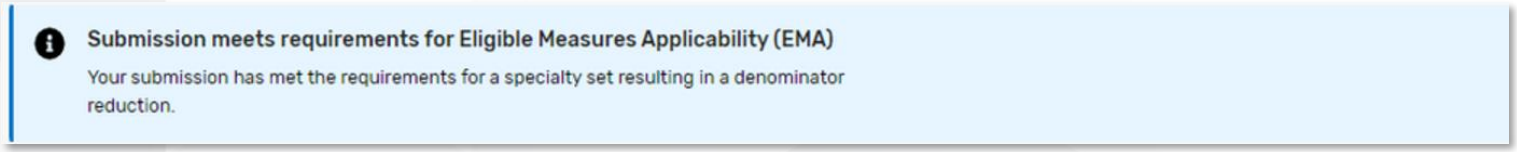
If we can calculate a performance period benchmark, we will update the measure's performance points in your final performance feedback (available summer 2025).

# Submitting Fewer than 6 Measures

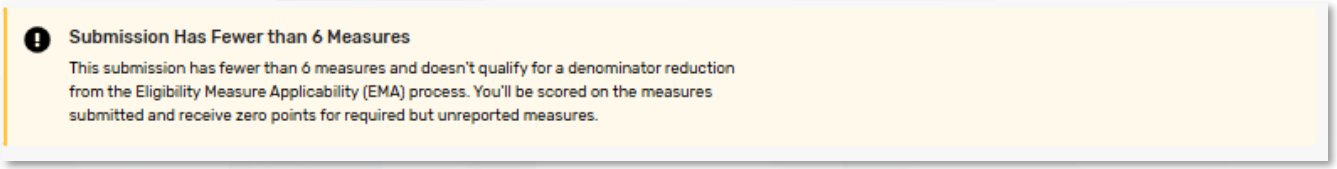
Clinicians who don't have 6 available quality measures and who report Medicare Part B claims measures or MIPS CQMs may qualify for the Eligible Measure Applicability, or EMA, process. We check for unreported, clinically related measures – or whether you reported all measures in a specialty measure set with fewer than 6 measures – which can result in a denominator reduction in the Quality performance category.

If you submit fewer than 6 MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA.

Submission (MIPS CQMs) qualifies for denominator reduction




Submission (MIPS CQMs) doesn't qualify for denominator reduction




**Did you know?**

If you reported Medicare Part B Claims measures, the EMA process is generally applied **after the submission period** to account for the 60-day claims run out period (during which time, CMS may still receive Medicare Part B claims with dates of service in 2024).

For more information on EMA, review the 2024 EMA and Denominator Reductions User Guide (PDF, 872KB) on the QPP website.

# Multiple Quality Submissions from the Same Organization

Please review the QPP Submissions Application Program Interface (API) documentation for detailed information about API submissions.

We'll keep the most recent data submitted when the data is **submitted the same way** (e.g., via file upload) AND **by the same organization** (e.g., the practice) AND **for the same**:

- ✓ **Performance category** (e.g., quality)
- ✓ **Collection type**
- ✓ Participation option (e.g., group)
- ✓ Reporting option (e.g., traditional MIPS)

This approach allows practices to correct and resubmit previously submitted data.

# Multiple Quality Submissions from the Same Organization (Continued)

Example 1.

John and Kathy are practice staff at Mountain Medical and support the group's MIPS reporting. Mountain Medical is reporting traditional MIPS as a group.

| John uploaded a file with 3 measures (047, 130, and 134) on Tuesday | Kathy uploaded a file with 3 measures (134, 155, and 181) on Thursday |
|---|---|
| ✓ Quality performance category | ✓ Quality performance category |
| ✓ MIPS CQM collection type | ✓ MIPS CQM collection type |
| ✓ Group reporting | ✓ Group reporting |
| ✓ Traditional MIPS | ✓ Traditional MIPS |

The group will be scored on the 3 MIPS CQMs that Kathy submitted on Thursday.

Why? Kathy submitted the most recent data by their organization, through the same submission method, for the same performance category, collection type, participation option, and reporting option.

# Multiple Quality Submissions from the Same Organization (Continued)

**Example 2.**

Dr. Andrews is a solo practitioner reporting traditional MIPS.

- She reported 3 quality measures through Medicare Part B claims throughout the performance period.
- She uploaded a file with 3 eCQMs (a report she extracted from her EHR) during the submission period.

| Dr. Andrews reported 3 measures during the performance period: | Dr. Andrews submitted 3 measures during the submission period: |
|---|---|
| ✓ Quality performance category | ✓ Quality performance category |
| × Medicare Part B claims | × eCQM collection type |
| ✓ Individual reporting | ✓ Individual reporting |
| ✓ Traditional MIPS | ✓ Traditional MIPS |

**Dr. Andrews will be scored on all 6 measures.**

**Why?** The 3 measures submitted by file upload won't overwrite the 3 measures submitted through Medicare Part B claims because they were submitted through different methods and for different collection types.

# Multiple Quality Submissions from the Same Organization (Continued)

Example 3.

Steven and Elise are assistant practice managers at Keaton's Oncology Center, which is reporting both traditional MIPS and the Advancing Cancer Care MVP at the group level. Steven oversees their traditional MIPS reporting and Elise oversees their MVP reporting.

| Steven uploaded a file with 6 measures on Thursday: | Elise uploaded a file with 4 measures on Friday: |
|---|---|
| ✓ Quality performance category | ✓ Quality performance category |
| ✓ MIPS CQM collection type | ✓ MIPS CQM collection type |
| ✓ Group reporting | ✓ Group reporting |
| × Traditional MIPS | × Advancing Cancer Care MVP |

**The group will receive a quality score in traditional MIPS (based on the 6 measures Steven submitted) and a quality score for the Advancing Cancer Care MVP (based on the 4 measures submitted by Elise).**

- Note: When a group reports both traditional MIPS and an MVP, the group will ultimately receive the higher MIPS final score, either from traditional MIPS reporting (based on traditional MIPS submissions for all categories) or MVP reporting (based on MVP submissions for all categories).

**Why?** Elise's data didn't overwrite Steven's data because they submitted data for different reporting options.

# Submitting and Reviewing Promoting Interoperability Data

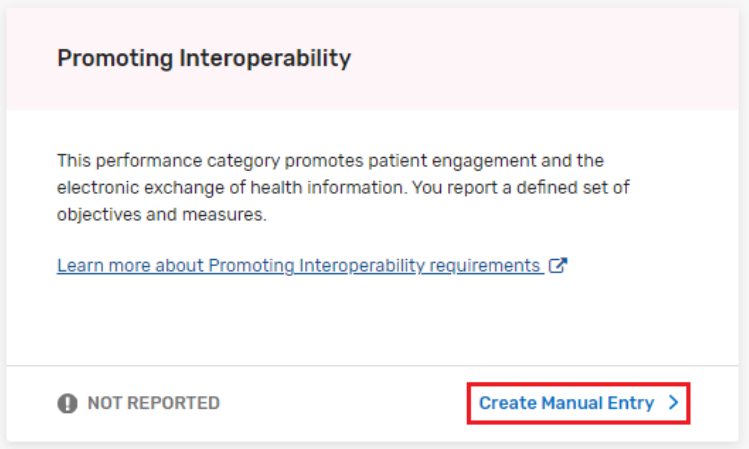
# File Upload

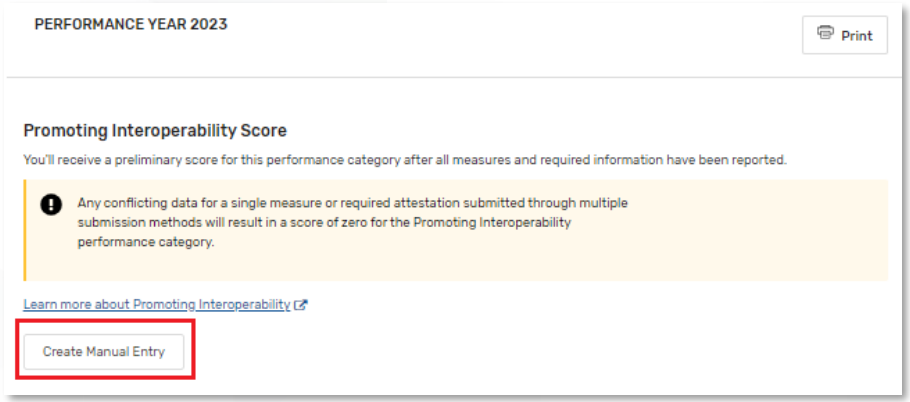
You can upload a QRDA III or QPP JSON file with your Promoting Interoperability data on the Reporting Overview page.

# Manual Entry (Attestation)

You can also attest to your Promoting Interoperability data by manually entering numerators, denominators, and yes/no values as appropriate to the measure.

Click Create Manual Entry on the **Reporting Overview**, and then again on the **Promoting Interoperability** page.

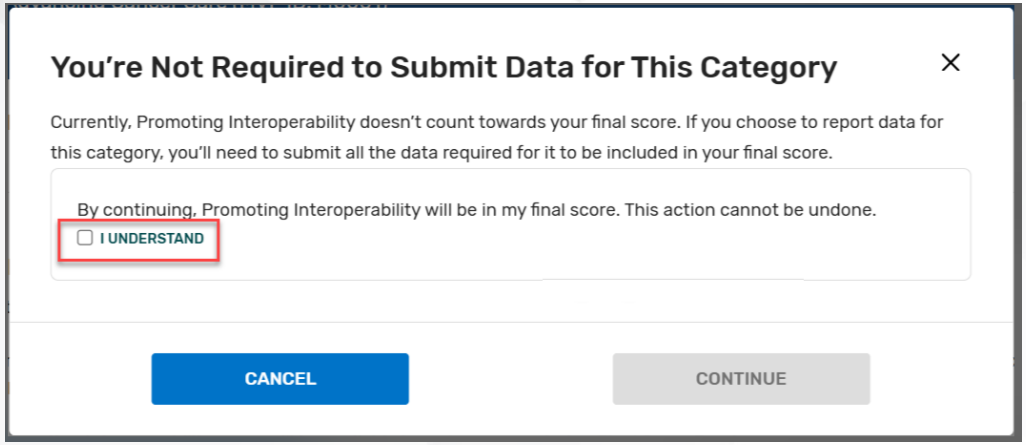


# Manual Entry (Attestation) (Continued)

If your Promoting Interoperability performance category is currently weighted at 0%, you will be prompted to confirm that you wish to proceed (click **I Understand** then **Continue**).

- If you click Continue and attest to all required data, you will receive a score in this performance category.
  - NEW: Beginning with the 2024 submission period, a non-qualifying submission - submitting some but not all required data - WON'T override reweighting.




**Did you know?**

Small practices have a different redistribution when **Promoting Interoperability** is reweighted to 0%

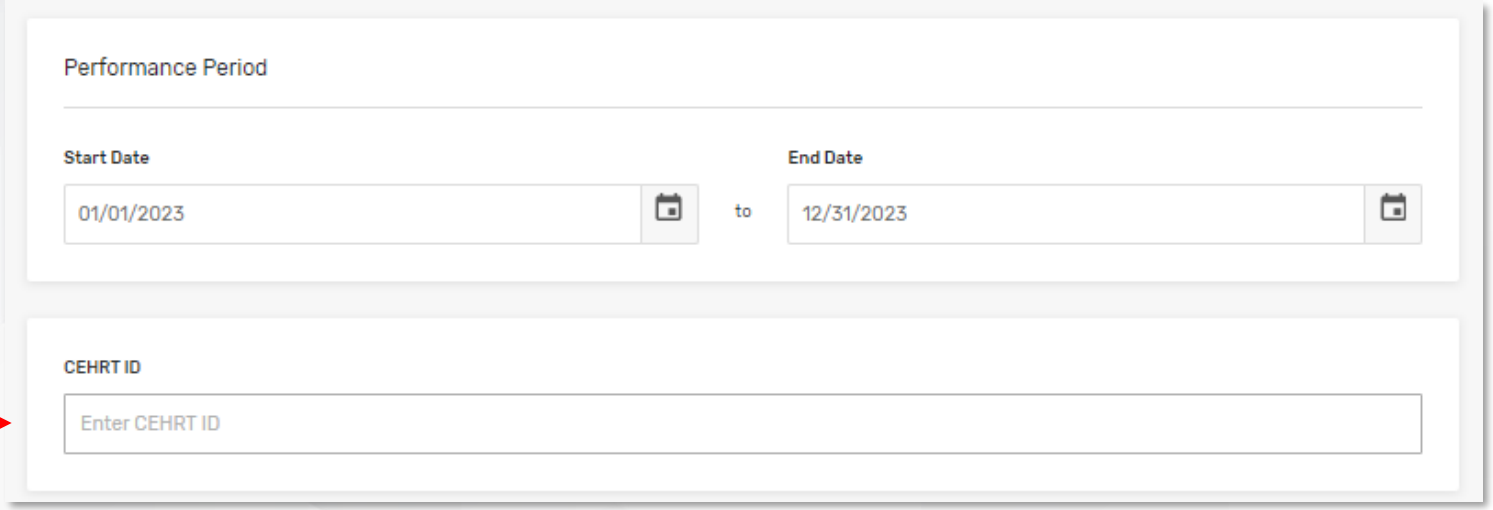
- **Quality:** 40%
- **Improvement Activities:** 30%
- **Cost:** 30%

As you provide required information on the Manual Entry page, more fields will appear. For example, once you enter your performance period, the CEHRT ID field will appear. You must provide all required information (including measure data) before you can receive a preliminary score for this performance category.

# Manual Entry (Attestation) (Continued)

Enter Your Performance Period and CMS EHR Certification ID ("CEHRT ID")

**Reminder: The Promoting Interoperability performance period increased to 180 days in the 2024 performance period.**



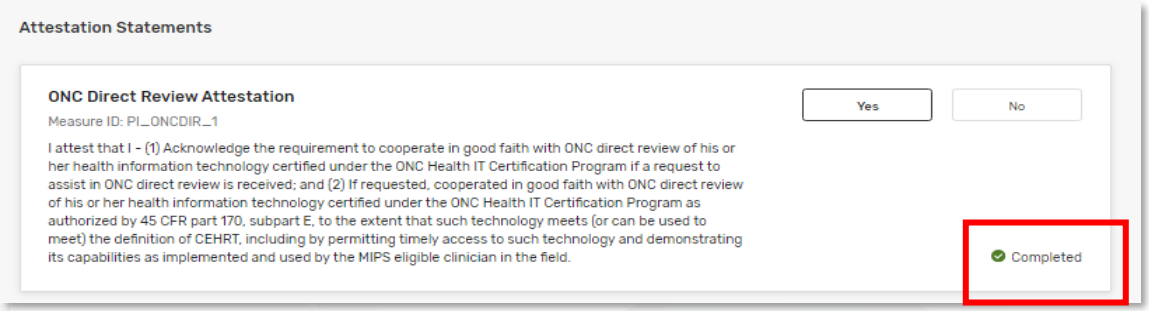

For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 23-25 of the CHPL Public User Guide (PDF, 763KB).

A **valid** CMS EHR Certification ID for the 2024 performance period will include **"15C"**.

# Manual Entry (Attestation) (Continued)

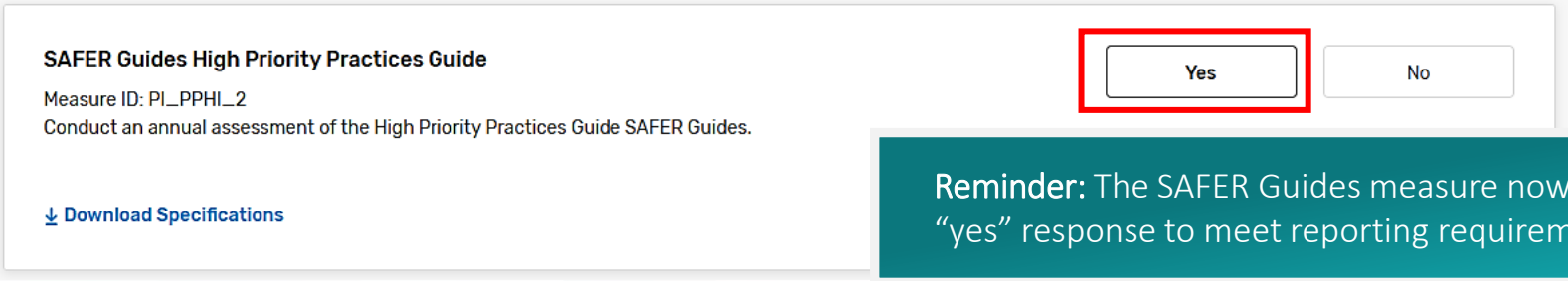
## Complete Required Attestation Statements and Measures

You must select **Yes** for the 3 required attestations before you can begin entering your measure data. As you move through the required information, you will see an indicator as each requirement is **completed.**




To manually report a measure, you will need to either select **Yes** or enter the **numerator/denominator** value, according to the measure. You can also claim an exclusion if you qualify.

**Yes Example.**

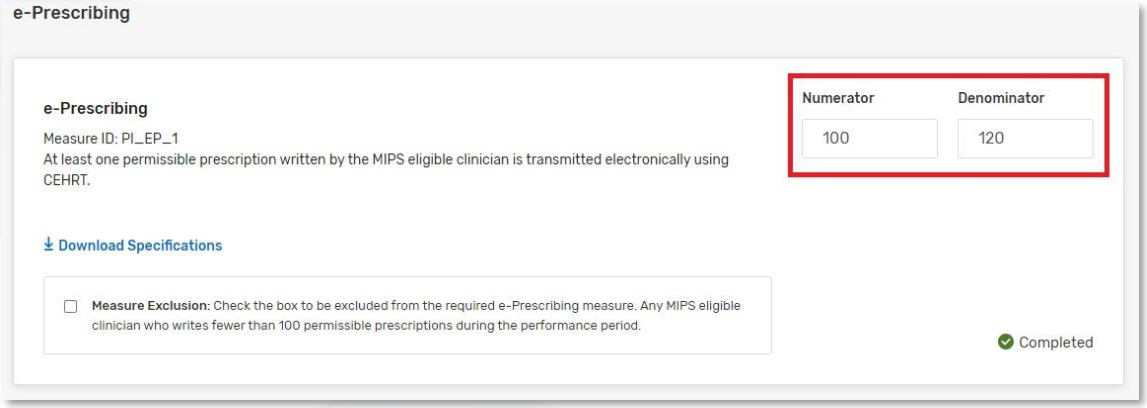



**Reminder:** The SAFER Guides measure now requires a "yes" response to meet reporting requirements.

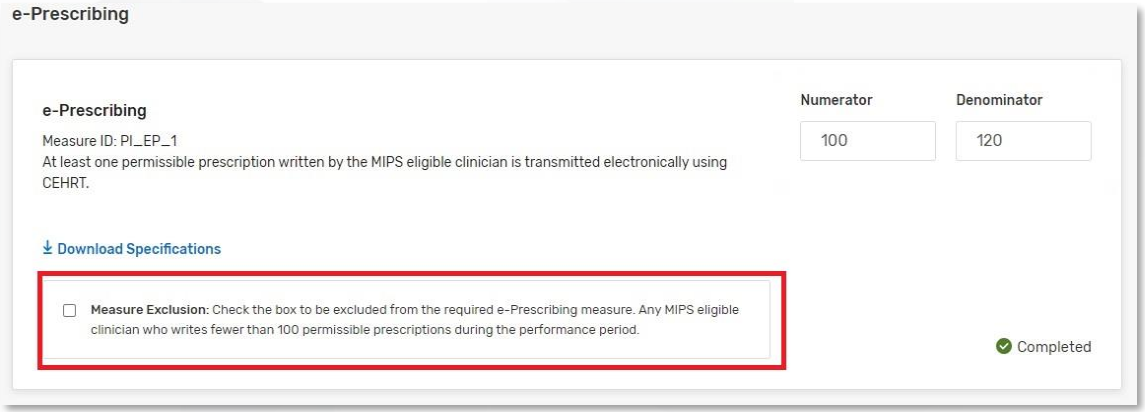
# Manual Entry (Attestation) (Continued)

## Complete Required Attestation Statements and Measures (Continued)

Numerator/Denominator Example




Exclusion Example



# Manual Entry (Attestation) (Continued)

## Health Information Exchange Objective

There are 3 options for meeting the Health Information Exchange (HIE) objective:

### Option 1:

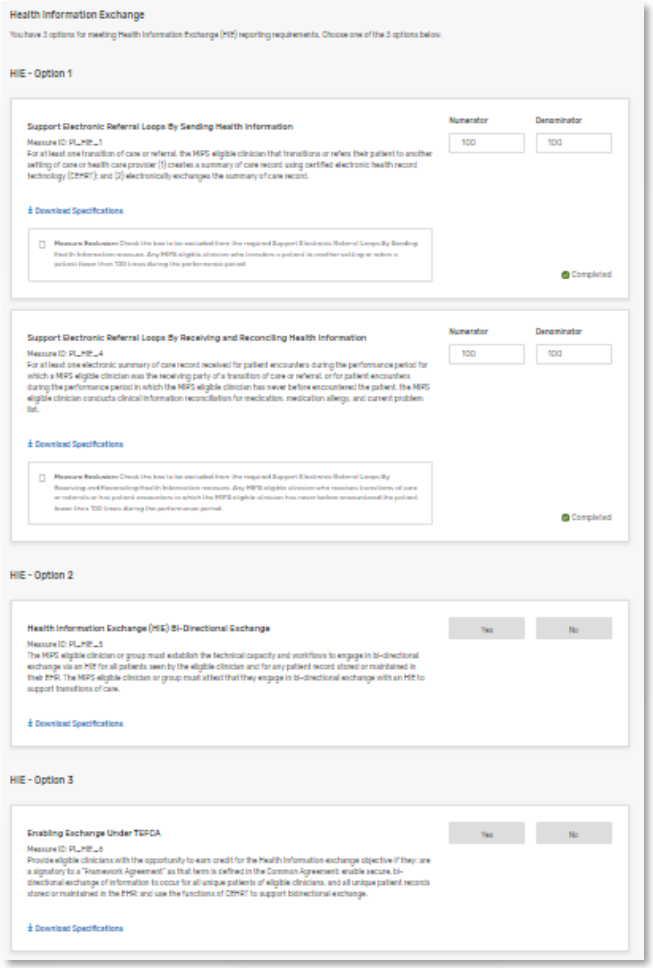
- Support Electronic Referral Loops by Sending Health Information
- Support Electronic Referral Loops by Receiving and Reconciling Health Information

### Option 2:

- Health Information Exchange: Bi-Directional Exchange

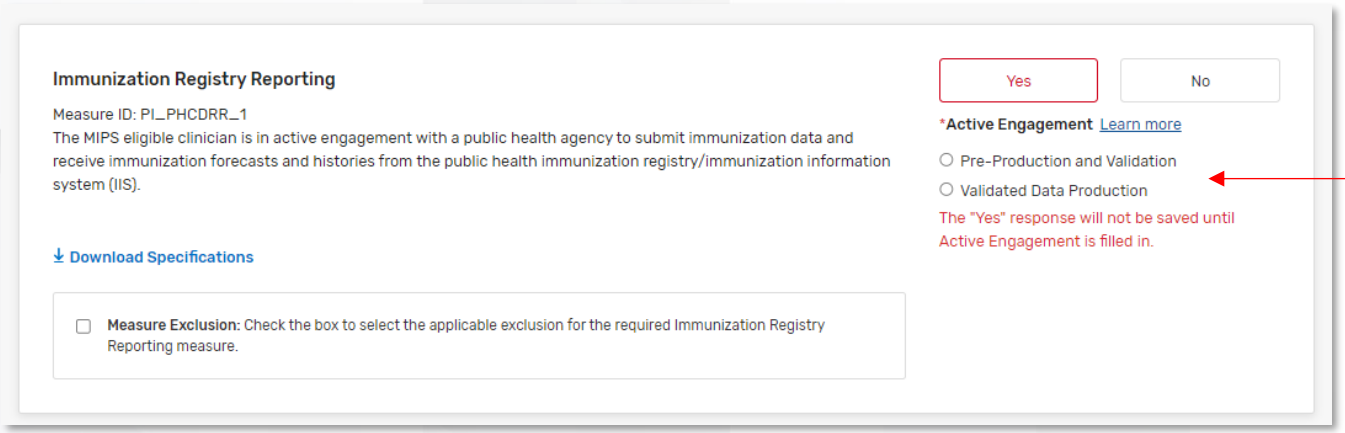
### Option 3:

- Enabling Exchange Under TEFCA



# Manual Entry (Attestation) (Continued)

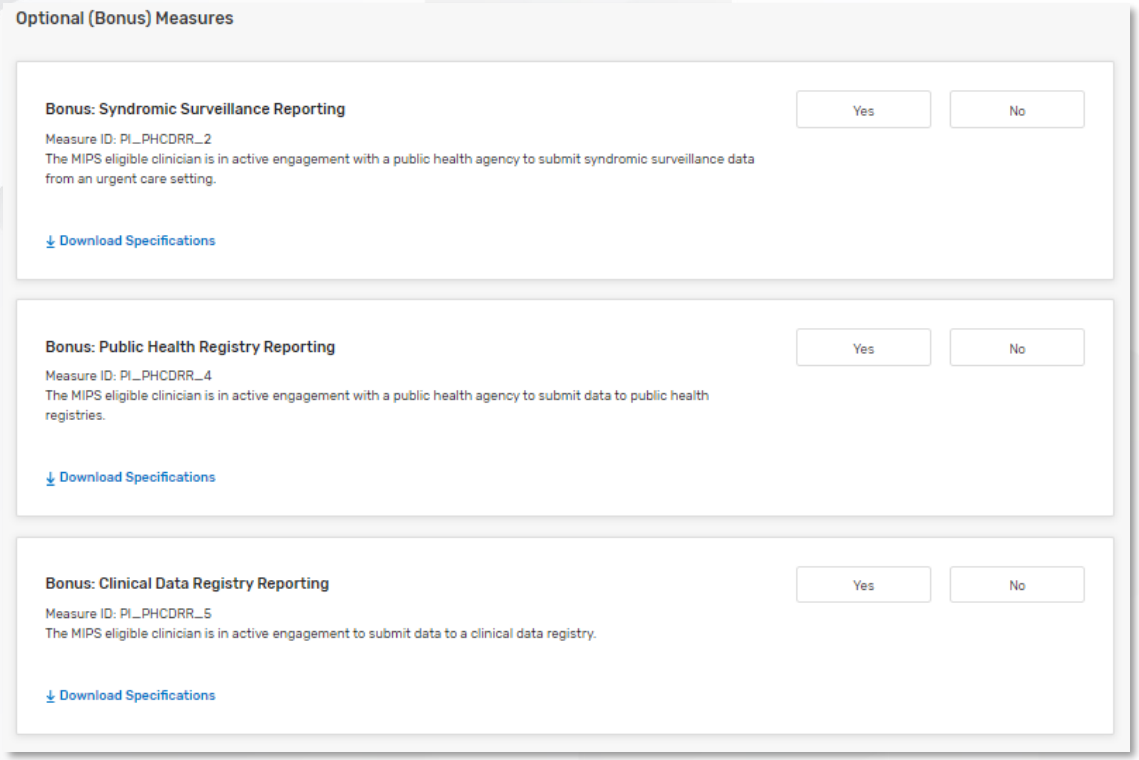
Complete Required Attestation Statements and Measures – Public Health and Clinical Data Exchange




Choose one of the options for Active Engagement. A “Yes” response won’t be saved until you make a selection.

# Manual Entry (Attestation) (Continued)

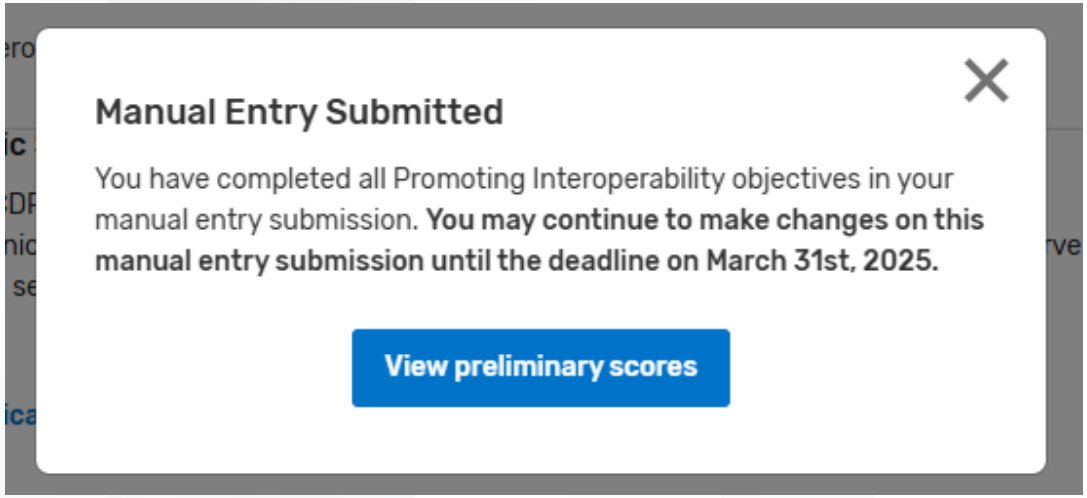
## Optional/Bonus Measures – Public Health and Clinical Data Exchange




To earn an additional 5 bonus points in this performance category, you can choose to report 1 or more of the remaining, optional measures. There are 5 bonus points available whether you report 1, 2 or all 3 of the optional measures.

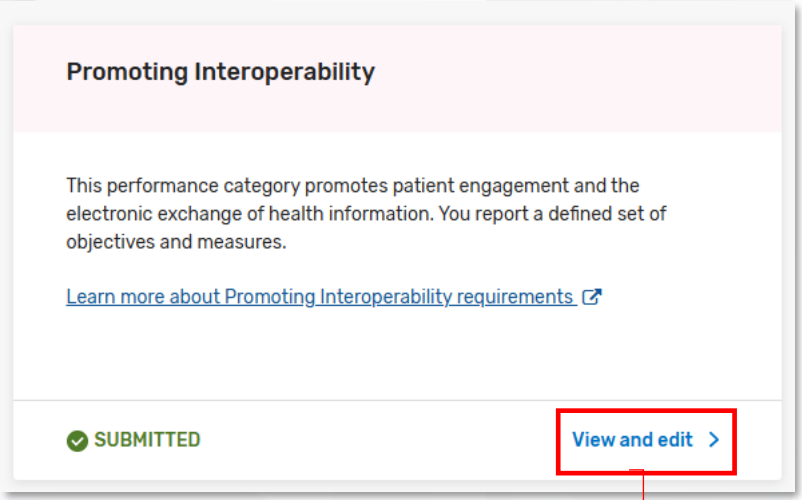
# Manual Entry (Attestation) (Continued)

Once all required data have been reported, the system will notify you and allow you to view your measure-level scores.



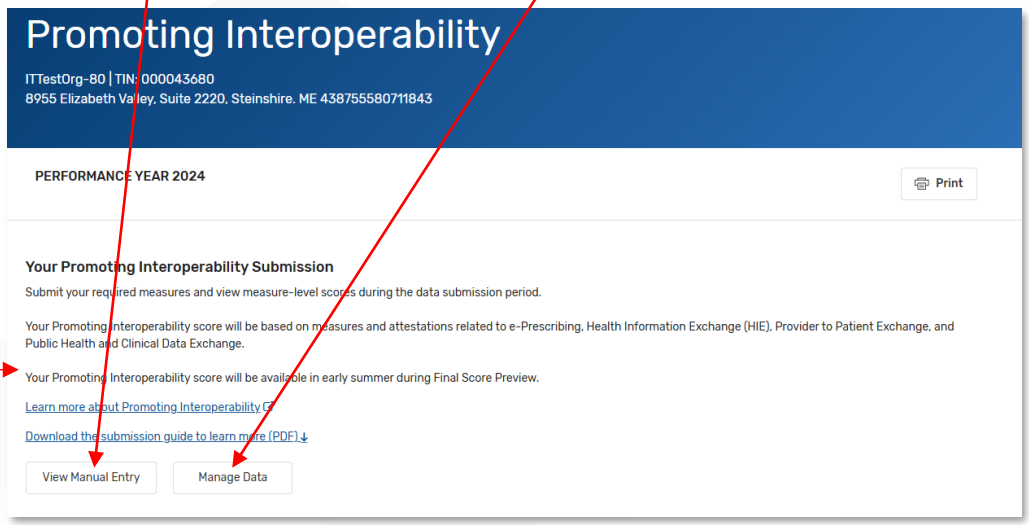
# Review Previously Submitted Data

Scroll down the Reporting Overview page to the Promoting Interoperability card. Click **View and edit**. You will land on a read-only page, letting you review the preliminary measure scoring details of your submission.




If you need to update your manually entered data, click **View Manual Entry.**

If you need to delete data your organization has submitted, click **Manage Data.**



# Multiple Submissions

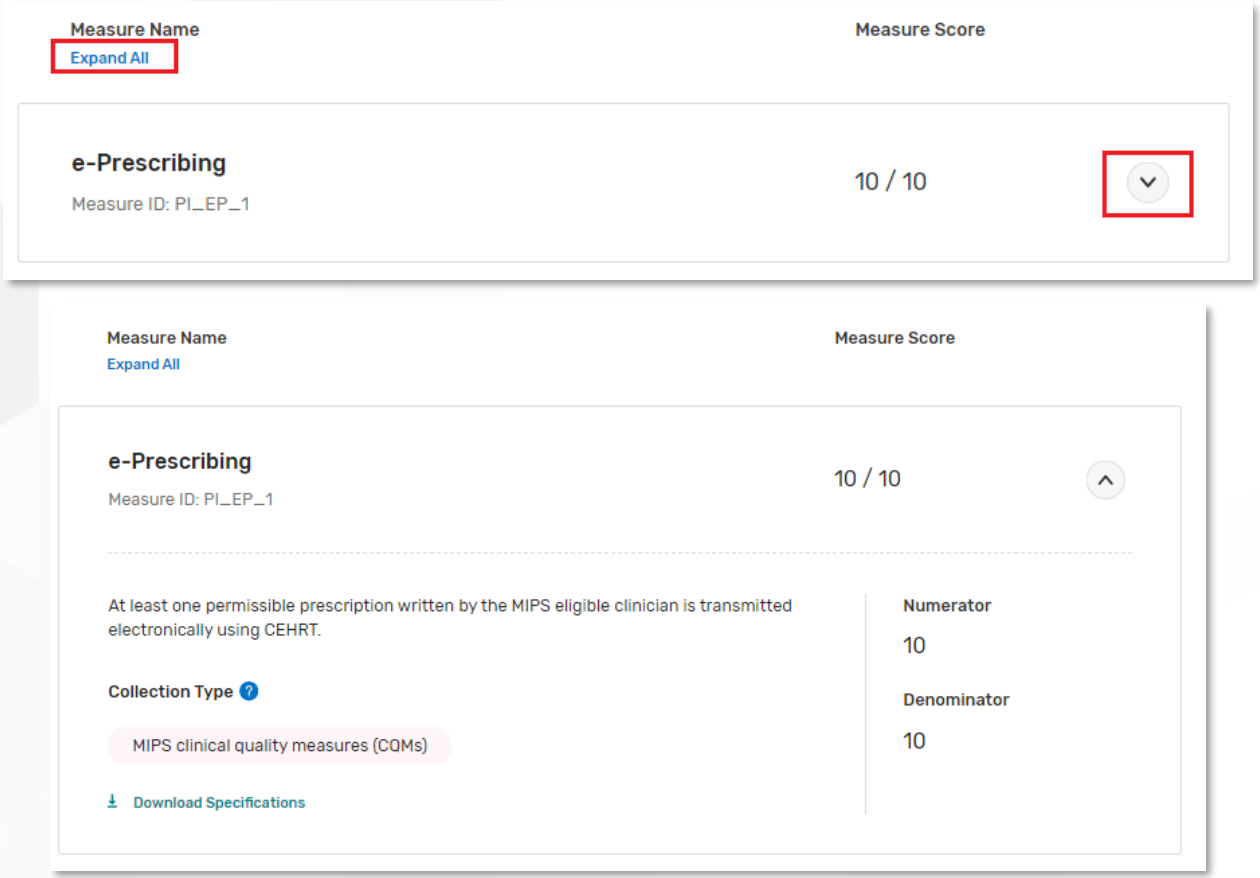
Please review the QPP Submissions Application Program Interface (API) documentation for detailed information about API submissions.

NEW for 2024: When there are multiple Promoting Interoperability submissions for an individual clinician, group, virtual group, or APM Entity, we'll score all submissions and assign the highest score to the clinician, group, virtual group, or APM Entity.

- We'll no longer assign a performance category score of zero when there are conflicting submissions.

# Access Previously Submitted Data

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



# Submitting and Reviewing Improvement Activities Data

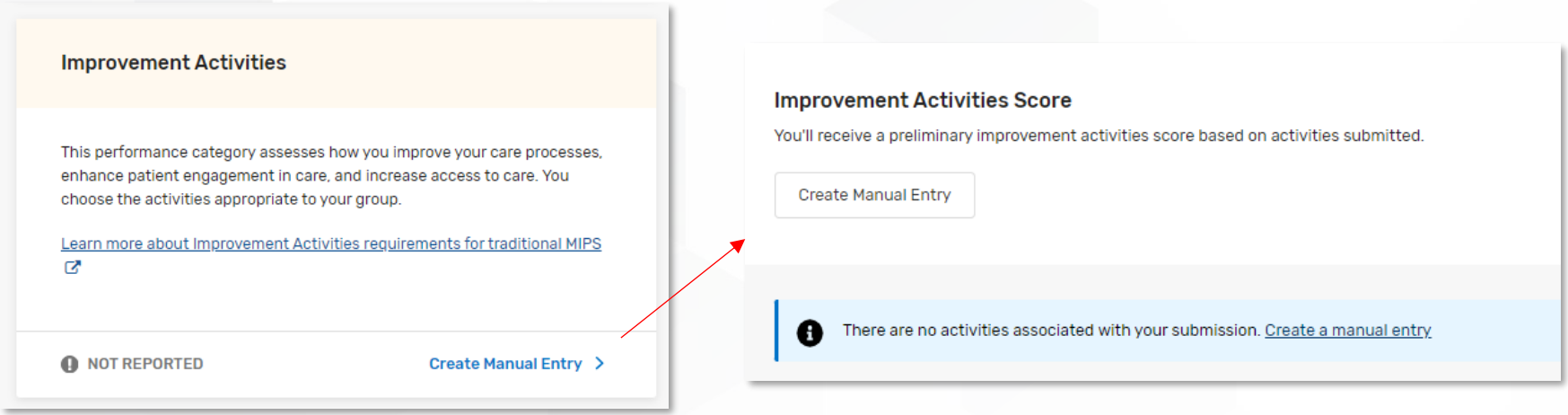
# File Upload

You can upload a QRDA III or QPP JSON file with your Improvement Activities data on the Reporting Overview page.

# Manual Entry (Attestation)

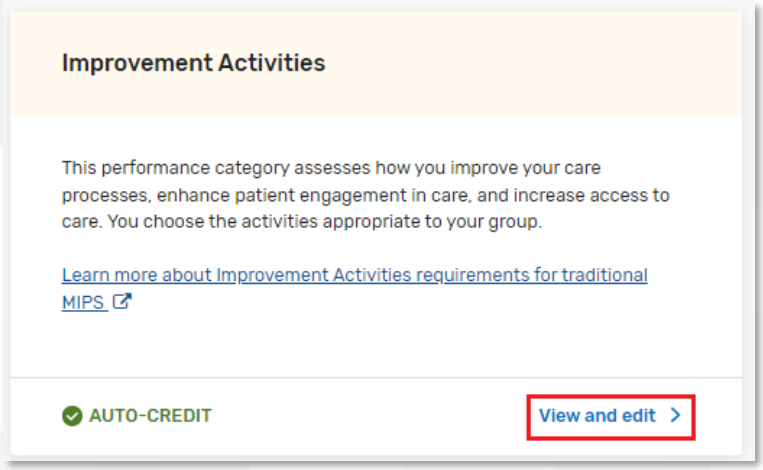
You can also attest to your Improvement Activities data by manually entering yes values to indicate you've completed the activity.

Click Create Manual Entry on the **Reporting Overview**, and then again on the **Improvement Activities** page.

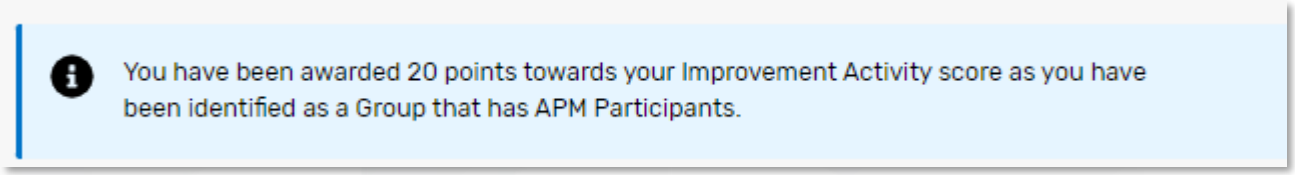


# Manual Entry (Attestation) (Continued)

Clinicians in an APM reporting traditional MIPS will automatically receive 50% credit in the Improvement Activities performance category as long as some MIPS data is submitted, regardless of performance category.

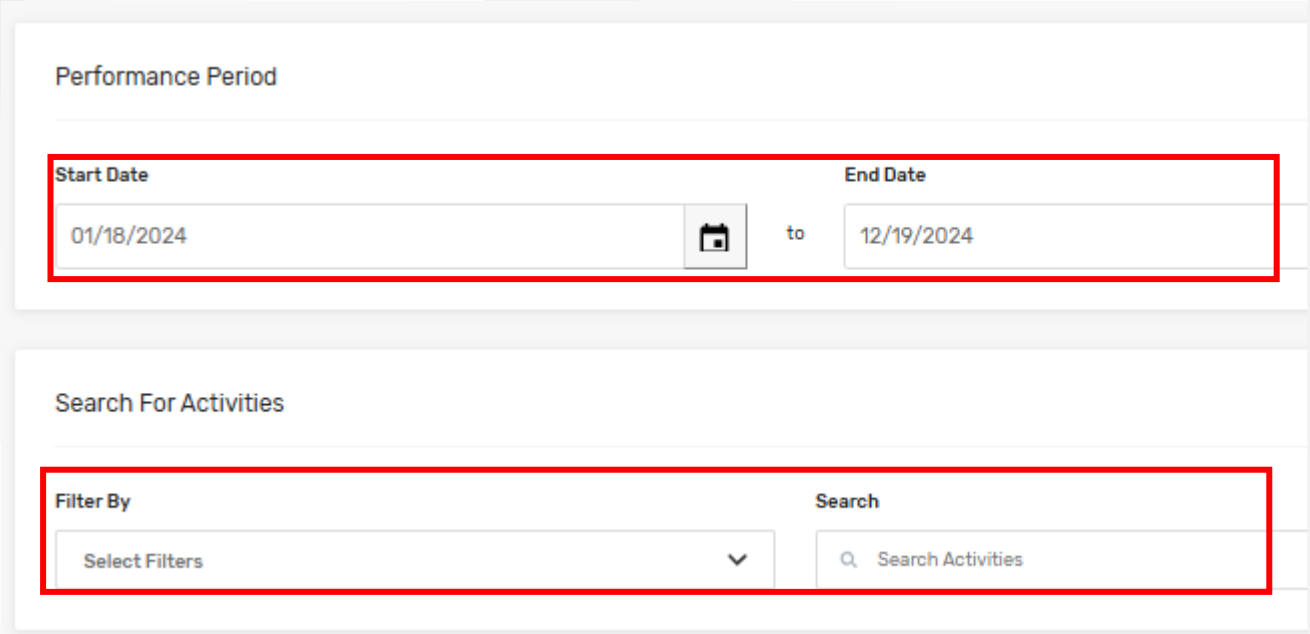



Once you select Create Manual Entry, you will see a message that 20 (out of 40 possible) points have been awarded based on your APM participation (or for Group reporting, based on having at least one clinician who participates in an APM).



# Manual Entry (Attestation) (Continued)

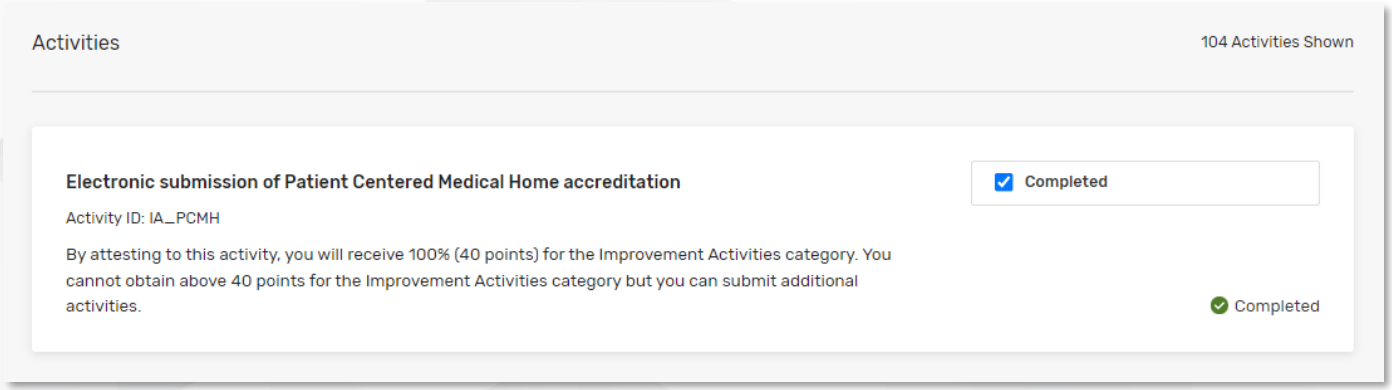
Once you enter your performance period, you can **search** for your activities by key term or **filter** by weight or subcategory. Check the box next to **Completed** to attest that the activity was performed.




Each activity has a continuous 90-day performance period (or as specified in the activity description), but multiple activities don't have to be performed during the same 90-day period. If your improvement activities are performed at different times during the year, your performance period at the category level:

- **Starts** on the first day in the year that any improvement activity was performed, and
- **Ends** on the last day in the year that any improvement activity was performed.

# Manual Entry (Attestation) (Continued)

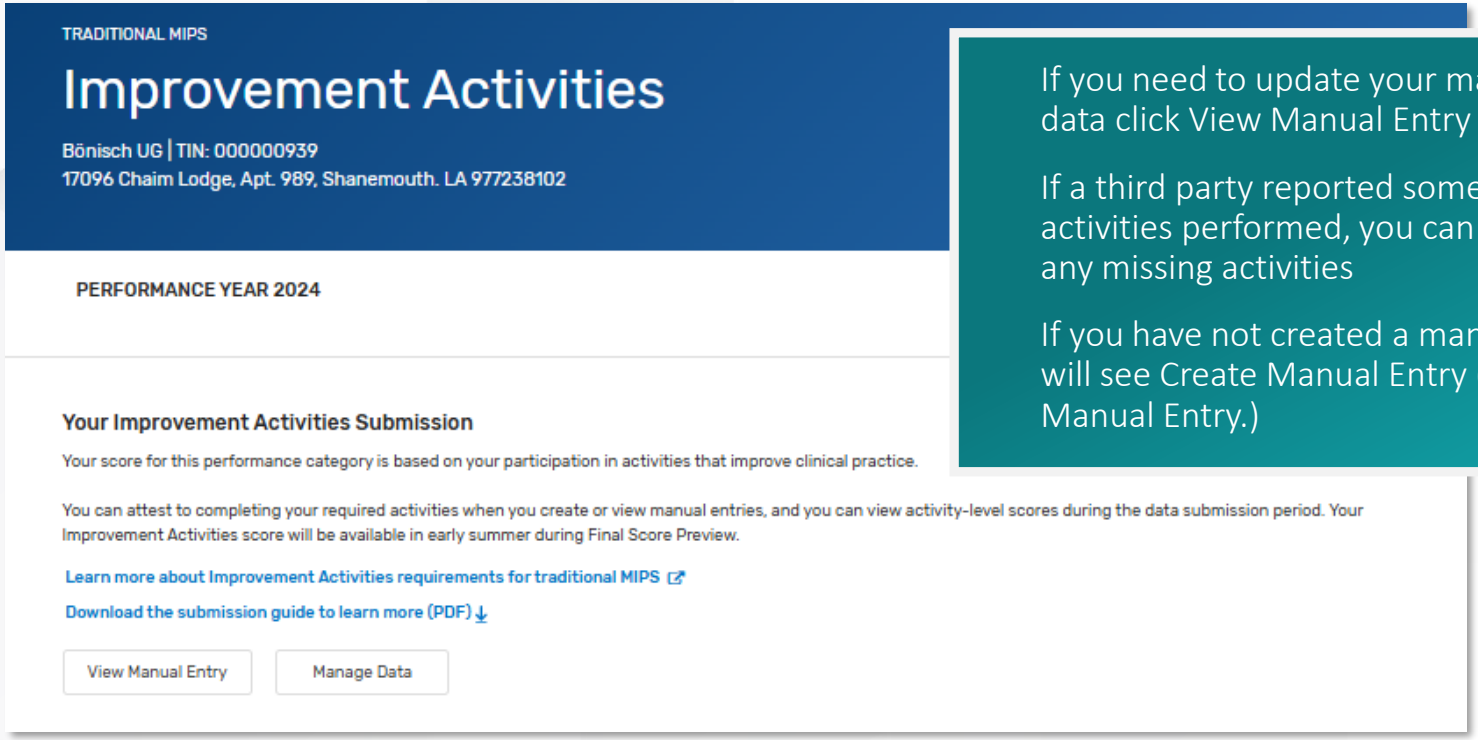



**Helpful Hint:**

The Patient Centered Medical Home attestation is the first activity listed.

# Review Previously Submitted Data

Click **View & Edit** from the Reporting Overview.




If you need to update your manually entered data click View Manual Entry

If a third party reported some but not all of the activities performed, you can manually enter any missing activities

If you have not created a manual entry, you will see Create Manual Entry (instead of View Manual Entry.)

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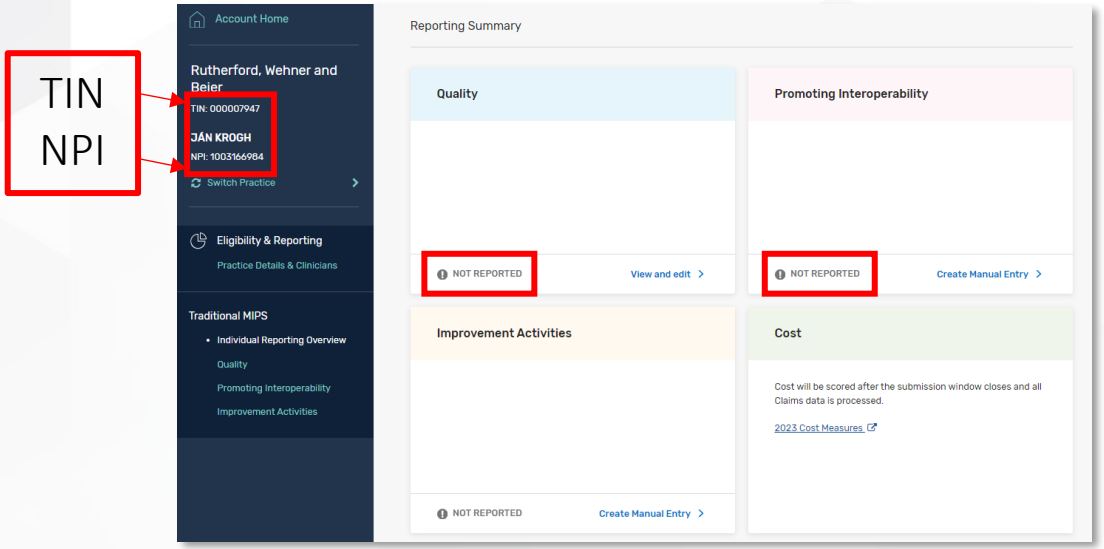
# File Uploads: Troubleshooting

# QPP JSON or QRDA III

## Don't See Successfully Uploaded Data

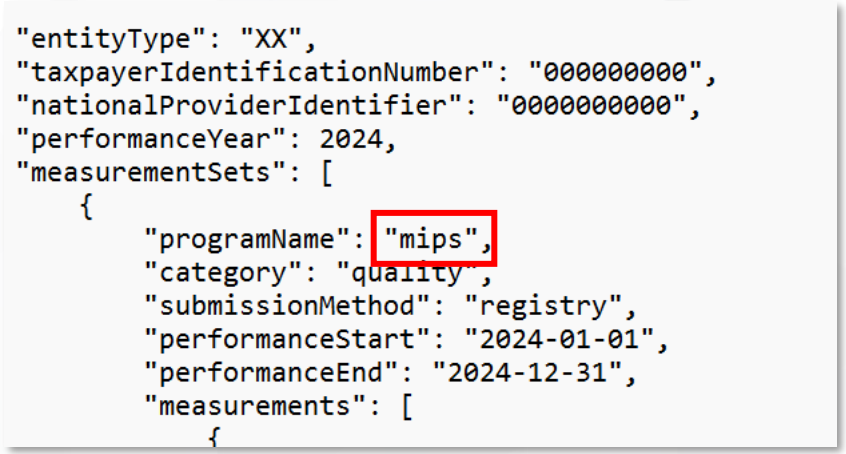
- Scenario: I successfully uploaded a file with quality and Promoting Interoperability data. Why can't I see the data after I hit "View Submission"?
- Possibility 1: You uploaded a file for a different TIN or NPI.
- Action: Double check that NPI and TIN in your file match the information on the clinician profile you are in. Once you determine which NPI was included in that file, find that clinician in Practice Details & Clinicians and select Report as Individuals. You should see the successfully uploaded data results in the clinician's Reporting Overview.



# QPP JSON or QRDA III

## Don't See Successfully Uploaded Data

- Scenario: I successfully uploaded a file with quality and Promoting Interoperability data. Why can't I see the data after I hit "View Submission"?
- Possibility 2: You uploaded a file with the wrong program name.
- Action: Double check that the "programName" in the file says "mips", and correct and resubmit the file if need be. You should now see the successfully uploaded data in the Reporting Overview.



# QRDA III (Continued)

Common Error Message

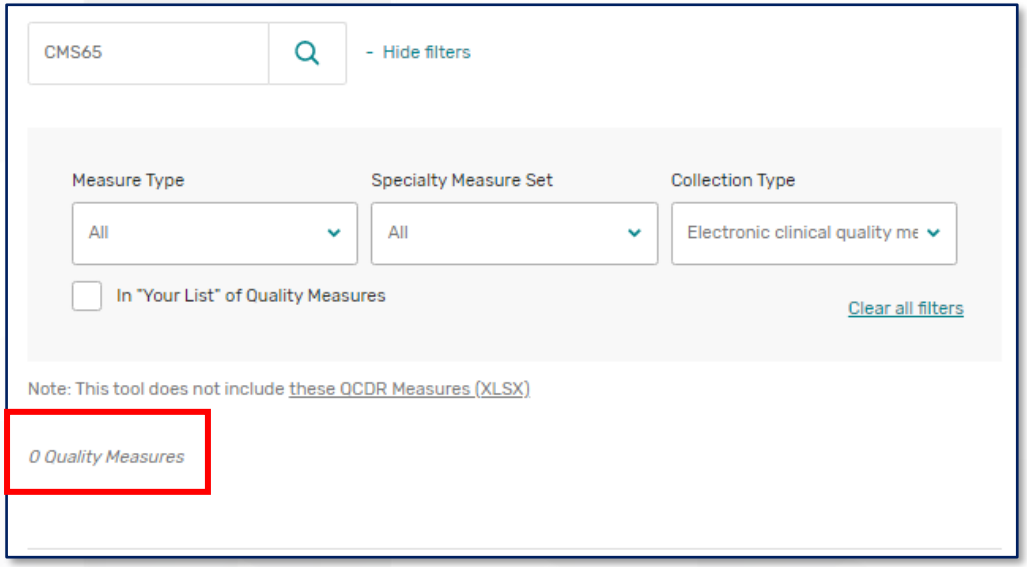
"The measure GUID supplied 40280382-6963-bf5e-0169- e8dc81613f8b is invalid"

- Action: Go to the QRDA page of the eCQI Resource Center, open the 2024 CMS QRDA III Implementation Guide for Eligible Clinicians, and search (beginning on p. 43) for the GUID (also referred to as a UUID) listed in your error message.
  - If you can't find it, it is not a valid measure for the 2024 performance year

| NQF/ Quality # | eCQM CMS # | Version Specific Measure ID | Population ID | |
|---|---|---|---|---|
| N/A/ 134 | CMS2v13 | 2c928083-8651-08a3-0186-c82995a91d28 | IPOP:<br>DENOM:<br>DENEX:<br>NUMER:<br>DENEXCEP: | AD83208C-1313-401E-BB62-ABCCE0982B49<br>696066C7-C558-4849-A325-A3CDDB58CF8F<br>E52F7FAE-96D9-417A-8538-6E3DB4A31D7A<br>E2557B71-1B97-413F-BE26-2B037E4D590B<br>FBA7B9D9-8588-4CB2-AB72-642CBD980334 |

# QRDA III (Continued)

Search the 2024 Explore Measures & Activities Tool (filter by the eCQM collection type) for the associated eCQM ID to confirm it isn't valid for the 2024 performance year.




You can also search the eCQI resource center

(2024 Performance Period Eligible Professional/Clinician eCQMs)

# QRDA III (Continued)

## Individual vs Group Reporting

### Are you submitting individually?

Make sure your file is coded as an **individual** submission and your individual NPI is in your file correctly.

Example:

```
<intendedRecipient>
<id root="2.16.840.1.113883.3.249.7"
extension="MIPS_INDIV" />
</intendedRecipient>
```

### Are you submitting as a group?

Make sure your file is coded as a **group** submission and your group's TIN is in your file correctly without any NPIs.

Example:

```
<intendedRecipient>
<id root="2.16.840.1.113883.3.249.7"
extension="MIPS_GROUP" />
</intendedRecipient>
```

**Helpful Hint:**

Search "2.16.840.1.113883.4.6" (the object identifier) in the file and then look for the next occurrence of "extension=". The value immediately after "extension=" should be the 10-digit NPI.

Example:

```
<assignedEntity>
<id root="2.16.840.1.113883.4.6"
extension="1234567890" />
</assignedEntity>
```

**Helpful Hint:**

Search for "2.16.840.1.113883.4.2" in the file and then look for the next occurrence of "extension=". The value immediately after "extension=" should be the 9-digit TIN.

Example:

```
<representedOrganization>
<id root="2.16.840.1.113883.4.2"
extension="123456789" />
<name>CT</name>
```

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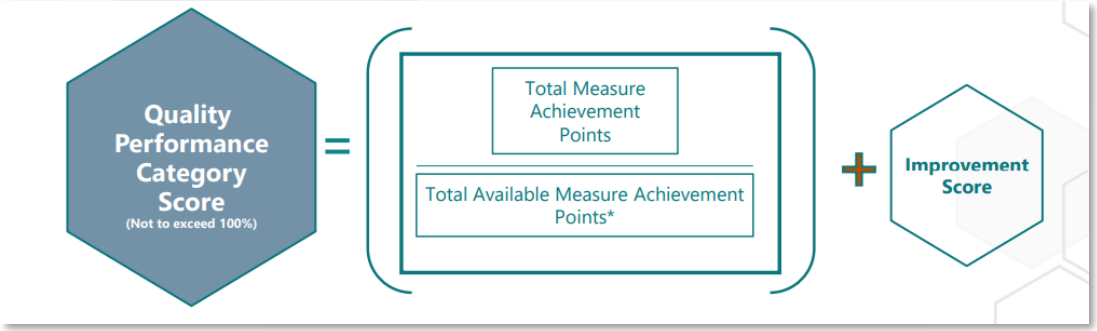
# Scoring Calculation

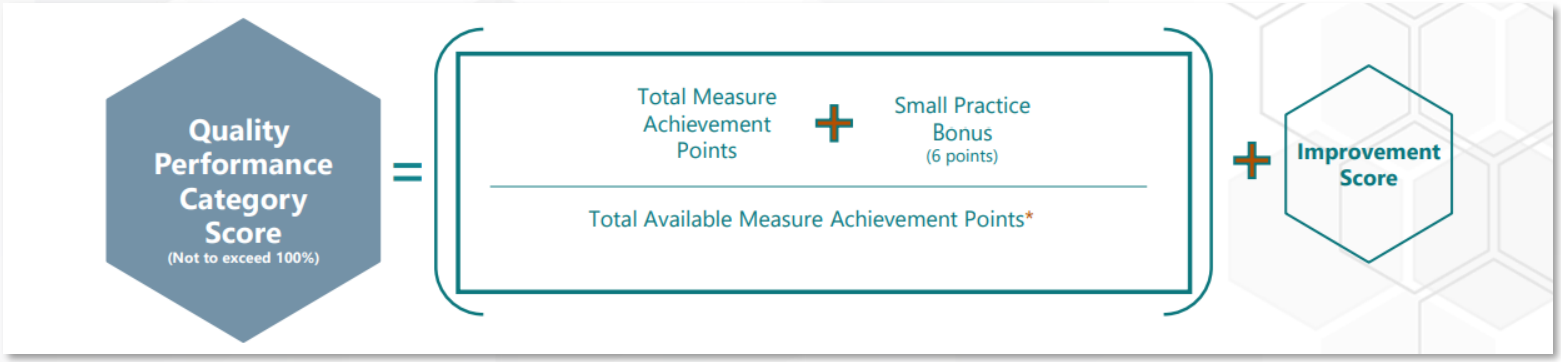
# Quality Score Calculation: How We'll Get There

We'll calculate your quality score after the data submission period, once we've received all required available data.




We don't display preliminary performance category scores.

(Small practices that submit 1 quality measure qualify for 6 bonus points)



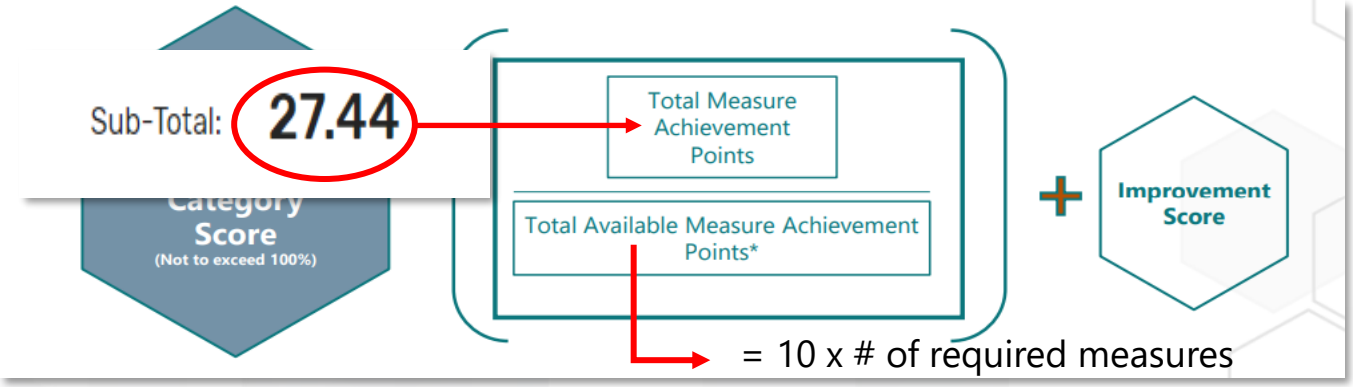

For more information about quality score calculations, refer to the 2024 Traditional MIPS Scoring Guide (PDF, 1MB).

# Quality Score Calculation

The **Sub-Total** displayed at the bottom of your submitted measures shows how many achievement points you've earned to date based on the measures you've submitted.

This number can change after the submission period.

- For example, this number would increase based on the achievement points earned for any administrative claims measures we can score you on.




In traditional MIPS, you're generally required to submit **6 measures**, which would mean **60 total points** available. This number can be lower if you meet the requirements for a denominator reduction, such as through the Eligible Measure Applicability process or by reporting a specialty set with fewer than 6 measures. Learn more about dominator reductions, view the 2024 EMA and Denominator Reduction Guide (PDF, 872KB).

**This number can change after the data submission period.**

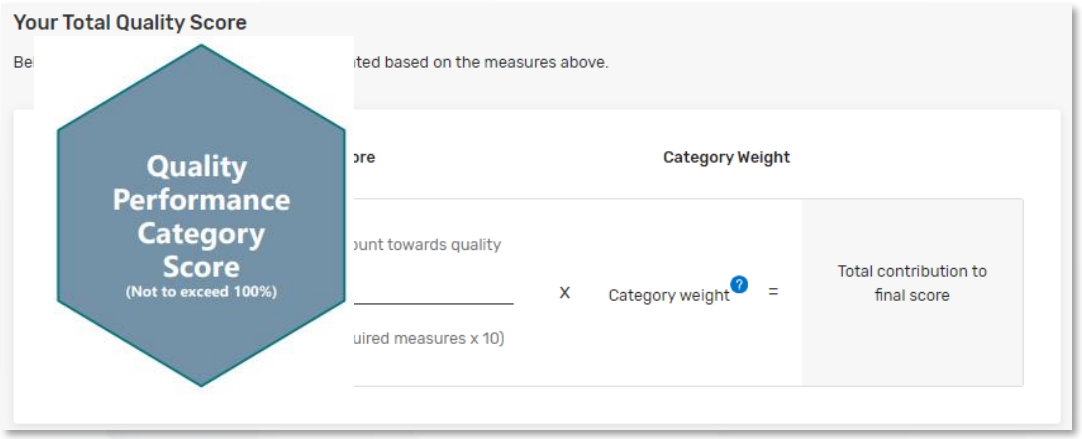
- For example, we'd increase this number by 10 points for each administrative claims measures you can be scored on.

# Quality Score Calculation

**Performance Category Weight.**

Once we calculate your quality score, we'll multiply it by the category weight.

- The weight tells you the maximum number of points the performance category can contribute to your final score.
- Your final score will be between 0 and 100 points.




**Example.**

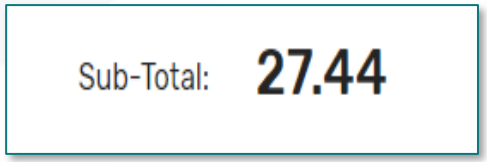
When quality is **weighted at 30%** of your final score, quality can contribute **up to 30 points to your final score**.

# Quality Score Calculation

**Scoring Calculation Example.**

You're required to report 6 measures, for possible total of 60 points for the measures you submit.

**During the submission period,** your group sees a Sub-Total of 27.44 points for the measures you submitted.




**After the submission period,** we calculate administrative claims measures and determine your group can be scored on 2 of these measures.

- This raises your group's total possible points from 60 points to 80 points.
- Your group earns 7.23 points on one administrative claims measure and 5.27 points on the other, for a total of 13 achievement points for the 2 administrative claims measures.
- Your group doesn't qualify for quality improvement scoring.

# Quality Score Calculation

Your group's quality performance category is calculated:

**Achievement points:**

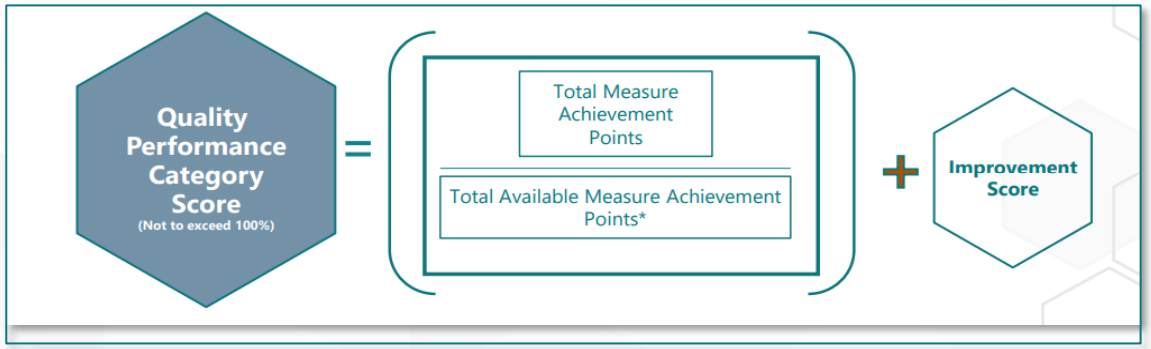
27.44 (measures submitted) + 13.00 (administrative claims measures )= 40.44

**Available achievement points:**

60 (required measures for submission) + 20 (2 administrative claims measures) = 80

**Quality Performance Category Score:**

[40.44 / 80 ] + 0 improvement = 50.55%



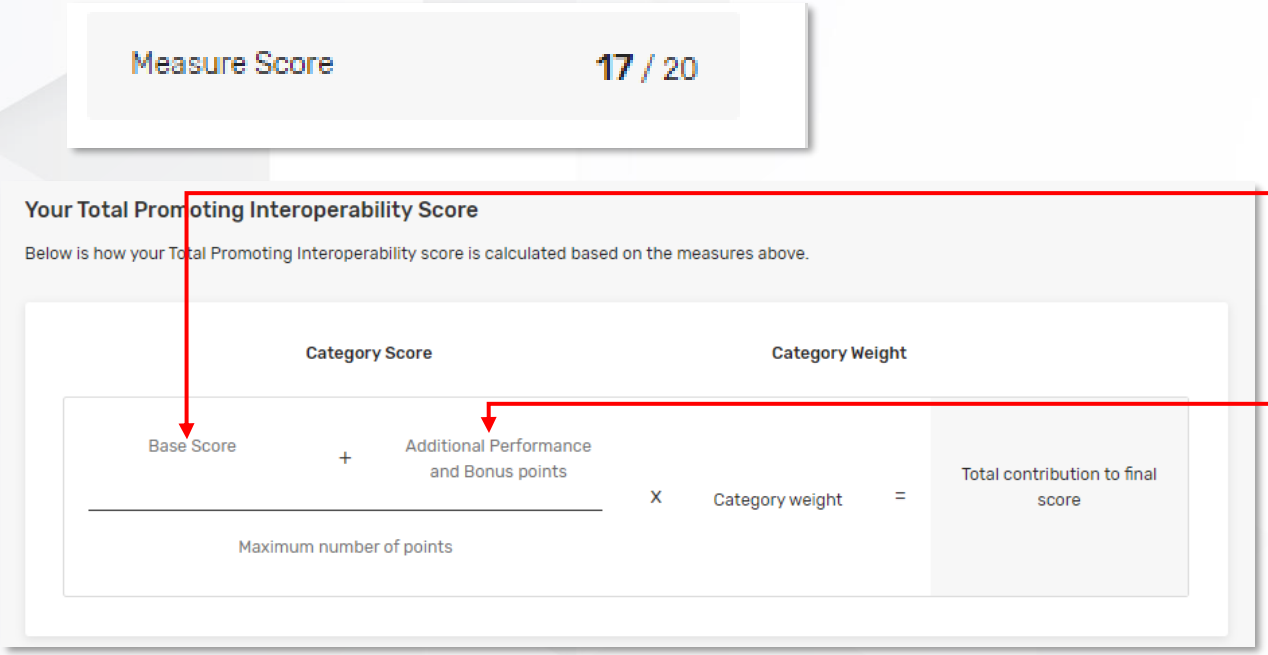

**This category score (50.55%) is multiplied by the category weight (30%)**

**→ 15.17 quality points contributing to the group's final score.**

For more information about quality score calculations, refer to the 2024 Traditional MIPS Scoring Guide (PDF, 1MB).

# Promoting Interoperability Score Calculation

We'll calculate your Promoting Interoperability score after the data submission period from the measure scores displayed during the submission period. Then we'll multiply that by the performance category weight to determine how many points the Promoting Interoperability performance category will contribute to your final score.




Sum of points earned for all required measures

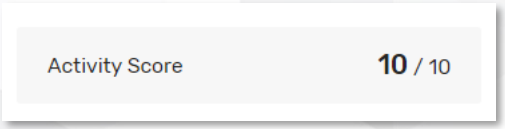
**Bonus points** earned for reporting optional measure(s)

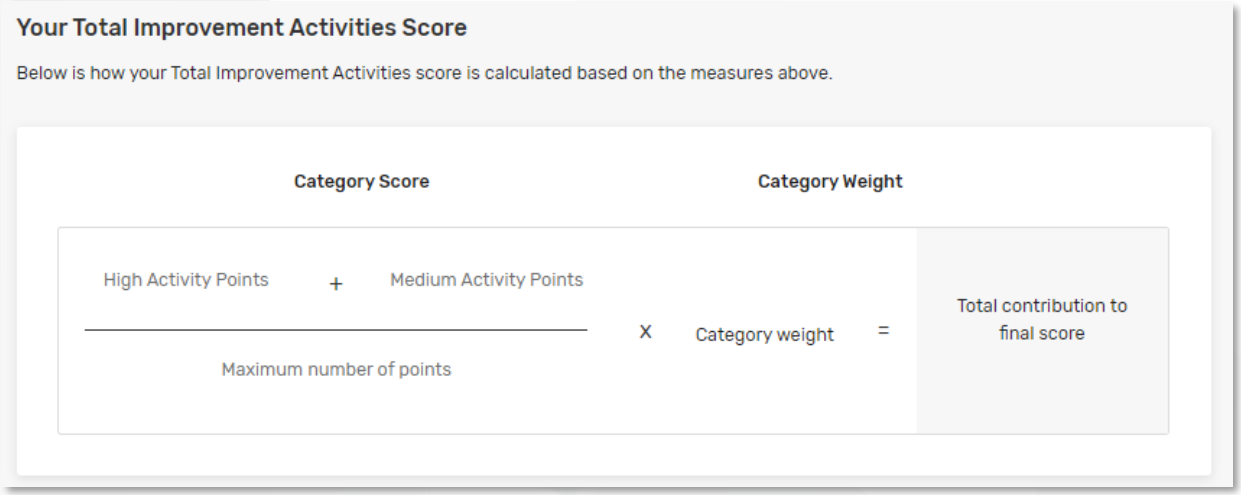
New: Beginning with performance year 2023 submissions, we will no longer display preliminary scores.

For more information about Promoting Interoperability score calculations, refer to the 2024 Traditional MIPS Scoring Guide (PDF, 1MB).

# Improvement Activities Score Calculation

We'll calculate your improvement activities score after the data submission period from the activity scores displayed during the submission period. Then we'll multiply that by the performance category weight to determine how many points the improvement activities performance category will contribute to your final score.



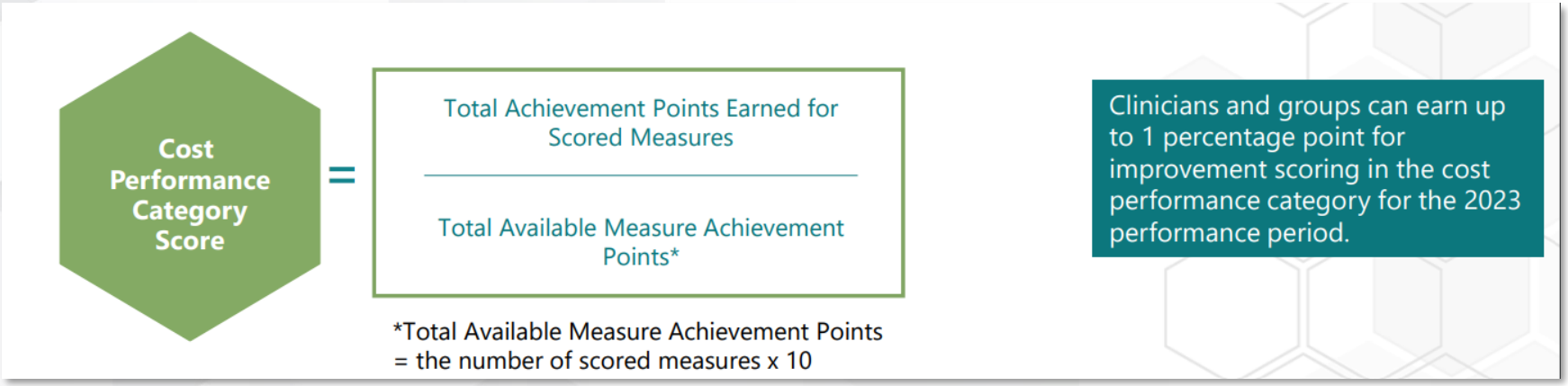




We no longer display preliminary performance category scores.

For more information about improvement activities score calculations, refer to the 2024 Traditional MIPS Scoring Guide (PDF, 1MB).

# Cost Score Calculation

Cost measures and cost performance category scores are calculated after the data submission period. You'll receive a cost score if you can be scored on at least one cost measure.




Then we'll multiply your score by the performance category weight to determine how many points the cost performance category will contribute to your final score.

It's generally weighted at 30% of your final score.

For more information about cost score calculations, refer to the 2024 Traditional MIPS Scoring Guide (PDF, 1MB).

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# Help 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.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

# Version History

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

| DATE | DESCRIPTION |
|---|---|
| 03/31/2025 | Updated to account for the data submission deadline extension (now closing 8 p.m. ET on April 14, 2025).<br><br>Added clarification to partial QP election slides that the deadline to make an election is still March 31.<br><br>Updated Appendix C to add the 2 suppressed measures, as announced via QPP listserv on 3/21/2025. (Measure 185 was identified as truncated in a QPP listserv sent 10/2/2024 and was included in Appendix C in the original posting of this guide.) |
| 12/23/2024 | Original Posting. |

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# Appendices

# Data Submission and the Automatic EUC Policy

The tables on the following slides illustrate the Performance Year 2024 MIPS performance category reweighting policies that CMS will apply under the MIPS automatic EUC policy to affected clinicians who submit MIPS data as individuals.

This policy was triggered by the following events for the 2024 performance year:

- Designated counties* in Texas for Hurricane Beryl
- Designated counties* in Florida for Hurricane Debby (Counties updated 10/15/2024)
- Designated parishes* in Louisiana for Hurricane Francine (Parishes updated 11/04/2024)
- Designated counties* in Florida, Georgia, North Carolina, South Carolina and Tennessee for Hurricane or Tropical Storm Helene
- Designated* counties in Florida for Hurricane Milton

Please refer to Appendix B (beginning on p. 10) of the 2024 MIPS Automatic Extreme and Uncontrollable Circumstances Policy Fact Sheet (PDF, 399KB) for a list of these designated counties and parishes.

**Note:** Participants in APMs are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category, which will override reweighting of this performance category.

# Data Submission and the Automatic EUC Policy (Continued)

Table 1: Reweighting for Clinicians Not in a Small Practice

| Data Submitted | Quality Category Weight | Promoting Interoperability Category Weight | Improvement Activities Category Weight | Cost Category Weight | Payment Adjustment |
|---|---|---|---|---|---|
| No data | 0% | 0% | 0% | 0% | Neutral |
| **Submit Data for 1 Performance Category** | | | | | |
| Quality Only[1] | 100% | 0% | 0% | 0% | Neutral |
| Promoting Interoperability Only[1] | 0% | 100% | 0% | 0% | Neutral |
| Improvement Activities Only | 0% | 0% | 100% | 0% | Neutral |
| **Submit Data for 2 Performance Categories** | | | | | |
| Quality **and** Promoting Interoperability[1] | 70% | 30% | 0% | 0% | Positive, Negative, or Neutral |
| Quality **and** Improvement Activities | 85% | 0% | 15% | 0% | Positive, Negative, or Neutral |
| Improvement Activities and Promoting Interoperability | 0% | 85% | 15% | 0% | Positive, Negative, or Neutral |
| **Submit Data for 3 Performance Categories** | | | | | |
| Quality and Improvement Activities and Promoting Interoperability | 55% | 30% | 15% | 0% | Positive, Negative, or Neutral |

[1] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

# Data Submission and the Automatic EUC Policy (Continued)

Table 2: Reweighting for Clinicians in a Small Practice

| Data Submitted | Quality Category Weight | Promoting Interoperability Category Weight | Improvement Activities Category Weight | Cost Category Weight | Payment Adjustment |
|---|---|---|---|---|---|
| No data | 0% | 0% | 0% | 0% | Neutral |
| **Submit Data for 1 Performance Category** | | | | | |
| Quality Only[2] | 100% | 0% | 0% | 0% | Neutral |
| Promoting Interoperability Only[2] | 0% | 100% | 0% | 0% | Neutral |
| Improvement Activities Only | 0% | 0% | 100% | 0% | Neutral |
| **Submit Data for 2 Performance Categories** | | | | | |
| Quality **and** Promoting Interoperability[2] | 70% | 30% | 0% | 0% | Positive, Negative, or Neutral |
| Quality **and** Improvement Activities | 50% | 0% | 50% | 0% | Positive, Negative, or Neutral |
| Improvement Activities and Promoting Interoperability | 0% | 85% | 15% | 0% | Positive, Negative, or Neutral |
| **Submit Data for 3 Performance Categories** | | | | | |
| Quality and Improvement Activities and Promoting Interoperability | 55% | 30% | 15% | 0% | Positive, Negative, or Neutral |

[2] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

# Submission Period: QPP Access and Permissions by Organization Type

This table provides a snapshot of what you can and can't do/view based on your access (role) and organization type during the submission period (January 2 – April 14, 2025).

| With this access | You CAN | You CAN'T |
|---|---|---|
| Staff User or Security Official for a **Practice**<br><br>(includes solo practitioners) | ✓ Access information about eligibility and special status at the individual clinician and group level<br>✓ View information about performance category reweighting (including from approved exception applications)<br>✓ Submit data on behalf of your practice (as a group and/or individuals)<br>• Includes Promoting Interoperability data for MIPS APM participants<br>✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals)<br>✓ View data submitted on behalf of your practice (group and/or individual)<br>✓ View measure-level scoring for Part B claims measures reported throughout the performance period<br>• This data will be updated during the submission period to account for claims received by CMS until March 1, 2025<br>✓ View measure and activity-level scores and a sub-total of points for the group and individual clinicians | ✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable)<br>✗ View your cost feedback (if applicable)<br>• Cost data won't be available during the submission period<br>✗ View facility-based scoring for quality / cost (if applicable)<br>✗ View data submitted by your APM Entity<br>**Example.** If you're a Participant TIN in a Shared Savings Program ACO, you will not be able to view the quality data reported by the ACO through the CMS Web Interface<br>✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group)<br>✗ View the overall preliminary score or preliminary performance category score |

# Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view based on your access (role) and organization type during the submission period (January 2 – April 14, 2025).

| With this access | You CAN | You CAN'T |
|---|---|---|
| Clinician Role | You can't do anything related to Performance Year 2023 submissions with this role<br>This is a view-only role to access final performance feedback | |
| Staff User or Security Official for a **Virtual Group** | ✓ Access information about the practices (TINs) and clinicians participating in the virtual group<br>✓ View information about performance category reweighting (including from approved exception applications)<br>✓ Submit data on behalf of your virtual group<br>✓ View data submitted on behalf of your virtual group<br>✓ View measure and activity-level scores and a sub-total of points for the virtual group | ✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable)<br>✗ View your cost feedback (if applicable)<br>• Cost data won't be available during the submission period<br>✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission)<br>✗ Overall preliminary score or preliminary performance category score |
| Staff User or Security Official for a **Registry** (QCDR or Qualified Registry) | ✓ Download your API token (security officials only)<br>✓ Upload a submission file on behalf of your clients (groups and/or individuals)<br>✓ Submit opt-in elections on behalf of your clients<br>✓ View measure and activity-level scores and a sub-total of points for your clients based on the data you submitted for them | ✗ View data submitted directly by your clients<br>✗ View data submitted by another third party on behalf of your clients<br>✗ View data collected and calculated by CMS on behalf of your clients<br>✗ Cost measures (if applicable)<br>✗ View preliminary category level scores |

# 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.

| 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. |