Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2021 Cost Performance Category Quick Start Guide: Traditional MIPS

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

Already know what MIPS is?
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Purpose: *This resource focuses on the cost performance category under traditional MIPS, providing high level information about the cost measures, including calculation and attribution for the 2021 performance period. For comprehensive information about these measures, please refer to the Measure Information Forms (linked in the Help, Resources, and Version History section). This resource does not address requirements under the Alternative Payment Model Performance Pathway (APP).*

How to Use This Guide

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not 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 QPP website are included throughout the guide to direct the reader to more information and resources.

Overview

Overview

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What is the Merit-based Incentive Payment System?

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

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

If you're eligible for MIPS in 2021:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS Final Score of 0 to 100 points.
- Your MIPS Final Score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2021 performance year and applied to payments for covered professional services beginning on January 1, 2023.

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

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

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

In addition to traditional MIPS, two other MIPS reporting frameworks will be available to MIPS eligible clinicians.

- The **Alternative Payment Model (APM) Performance Pathway, or APP**, is a streamlined reporting framework beginning with the 2021 performance period for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways, or MVPs**, are a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority. We anticipate the first MVP candidates to be proposed in the CY 2022 Quality Payment Program Proposed Rule NPRM.

To learn more about MIPS eligibility and participation options:

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

To learn more about the APP:

- *Visit the APM Performance Pathway (APP) webpage on the Quality Payment Program website*
- *View the 2021 APM Performance Pathway (APP) for MIPS APM Participants and 2021 APM Performance Pathway (APP) Infographic resources.*

To learn more about the MVPs:

- *Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website*

Overview

What is the MIPS Cost Performance Category?

The cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare patients, they can affect the amount and types of services provided. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high-quality care at a reasonable cost.

Traditional MIPS Performance Category Weights for Individuals, Groups, and Virtual Groups in 2021:

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

MIPS Performance Category Weights for MIPS APM Entities Reporting Traditional MIPS in 2021:

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

This resource examines the cost performance category under traditional MIPS. For information about the performance categories under the APP, please refer to the 2021 APM Performance Pathway for MIPS APM Participants Fact Sheet.

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What's New with Cost in 2021?

- Inclusion of services provided via telehealth into existing cost measures:
  - Most services included on the Medicare telehealth service list are billed as telehealth services through the use of a modifier appended to the same code that is used when the service is furnished in person. Many of these codes (without appended modifiers) are already included in the cost measures.
  - Additional codes directly relevant to the intent of cost measures are also included. Codes were added from the Medicare telehealth services list through the March 31st COVID-19 IFC (85 FR 19230) and subsequent sub-regulatory processes as established in the May 8th COVID-19 IFC (85 FR 27550), as well as in response to recent changes in practice patterns.
- MIPS eligible clinicians in MIPS APMs who report to traditional MIPS as individuals, groups, or virtual groups will be scored on cost. However, eligible clinicians in a MIPS APM that reports to traditional MIPS as a MIPS APM Entity will not be scored on cost. Instead, the cost performance category will be reweighted to 0% under traditional MIPS if the APM Entity reports quality and improvement activity data.

Get Started with Traditional MIPS Cost Measures in 4 Steps

Get Started with Cost Measures in 4 Steps

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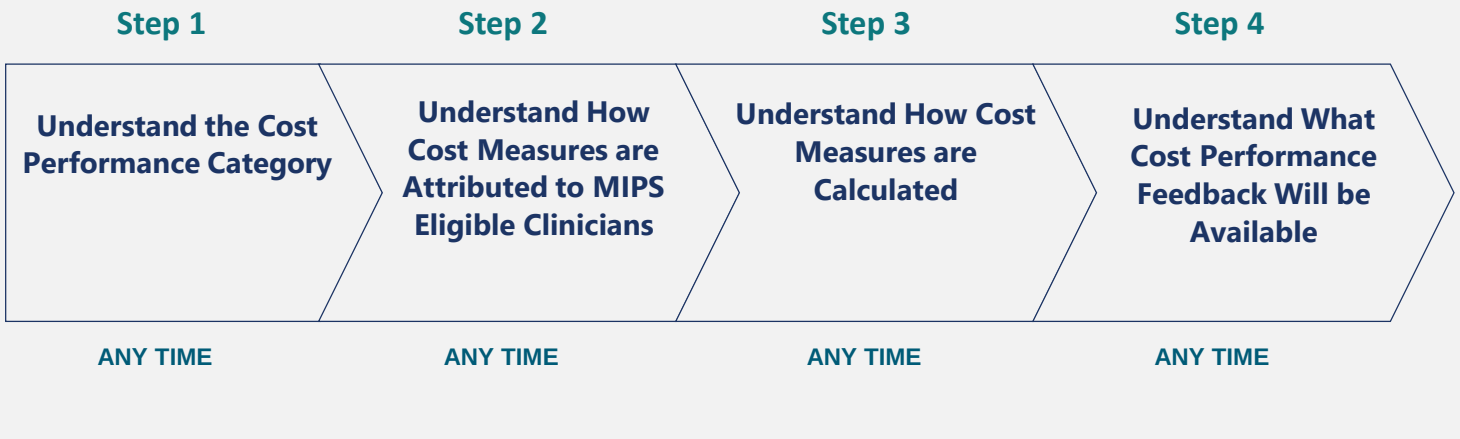

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures

There are 20 total cost measures for the 2021 performance period.

Measure Name	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	Assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	• Medicare Parts A and B claims data
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient	35 episodes	• Medicare Parts A and B claims data
13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (18 measures)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures, 10 episodes for procedural episode-based measures	• Medicare Parts A and B claims data

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures *(continued)*

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.	Ambulatory/office-based care centers, hospital outpatient departments (HOPDs), Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Patients who receive an elective knee arthroplasty during the performance period.	Acute inpatient (IP) hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period.	ASCs, HOPDs and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	Pre-Trigger Period = 60 days Post-Trigger Period = 90 days	Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.	ASCs, ambulatory/office-based care, and HOPDs
Screening/Surveillance Colonoscopy	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 14 days	Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.	ASCs, ambulatory/office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Patients who receive their first inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures *(continued)*

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Primary Hip Arthroplasty	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Patients who receive an elective primary hip arthroplasty during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Femoral or Inguinal Hernia Repair	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Hemodialysis Access Creation	Procedural	Pre-Trigger Period = 60 days Post-Trigger Period = 90 days	Patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period.	Ambulatory/office-based care centers, OP hospitals, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Pre-Trigger Period = 30 days Post- Trigger Period = 90 days	Patients who undergo surgery for lumbar spine fusion during the performance period.	ASCs, HOPDs, and acute IP hospitals
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Patients who undergo partial or total mastectomy for breast cancer during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, and ASCs
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Beneficiaries who undergo a CABG procedure during the performance period.	Acute inpatient hospitals
Renal or Ureteral Stone Surgical Treatment	Procedural	Pre-Trigger Period = 90 days Post-Trigger Period = 30 days	Patients who receive surgical treatment for renal or ureteral stones during the performance period.	Acute inpatient hospitals, HOPDs, ambulatory/office-based care centers, and ASCs

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures *(continued)*

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 90 days	Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.	Acute inpatient hospitals
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Patients who receive inpatient treatment for simple pneumonia during the performance period.	Acute inpatient hospitals
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Patients who present with ST-Elevation Myocardial Infarction indicating complete blockage of a coronary artery who emergently receive Percutaneous Coronary Intervention as treatment during the performance period.	Acute inpatient hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 60 days	Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.	Acute inpatient hospitals
Lower Gastrointestinal Hemorrhage (**applies to groups only**)	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Tigger period = 35 days	Patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period.	Acute inpatient hospitals

*To learn more about the 2021 MIPS cost measures, please refer to the 2021 Cost Measure Information Forms (MIFs).

Get Started with Cost Measures in 4 Steps

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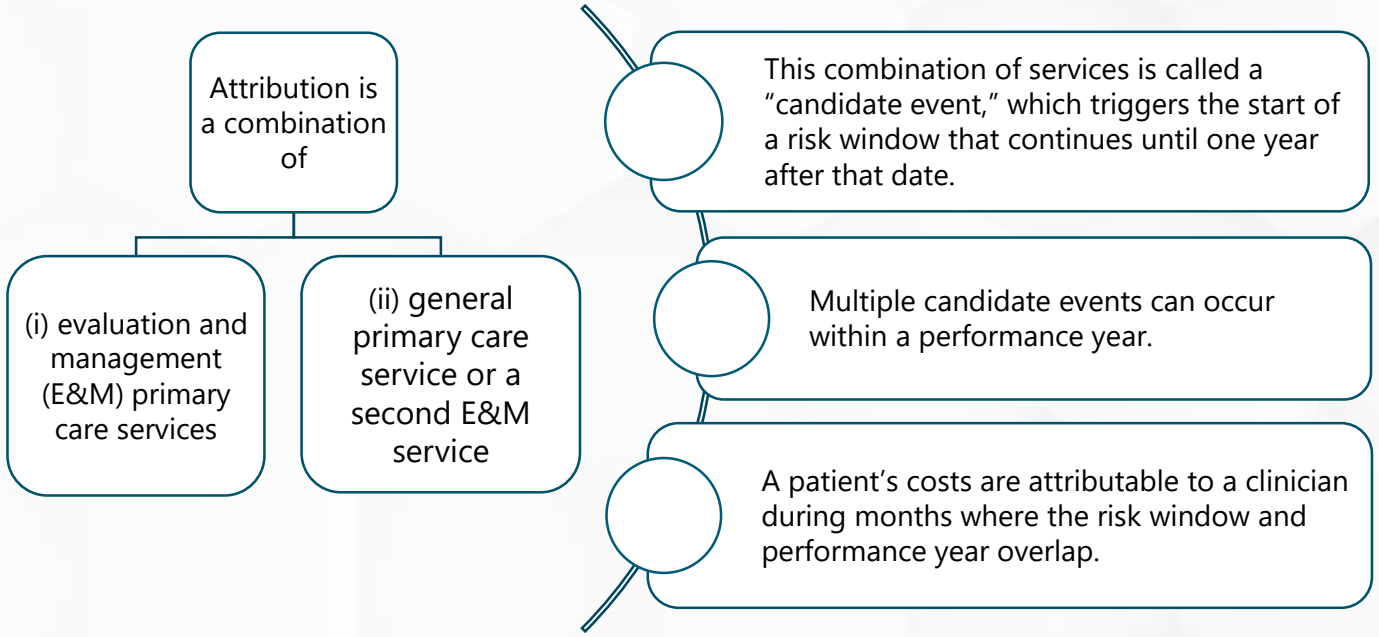
Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians

This section provides a brief overview of the steps used to attribute costs measures to individual clinicians. For more information about how costs measures are attributed to groups, identified by TIN, please refer to the measure specifications.

Total Per Capita Cost (TPCC) Measure Attribution[1]



We exclude eligible clinicians who:
Primarily deliver non-primary care services (e.g., general surgery) **OR** practice in specialties unlikely to be responsible for primary care services (e.g., dermatology)

[1] Please review the revised Total Per Capita Cost Measure Information Form for information about TIN (group) attribution.

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Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

TPCC attribution begins with a "candidate event," or services triggering the start of the primary care relationship.

Candidate Event

Clinician bills an initial E&M primary care service

AND

Any clinician bills another primary care service **within 3 days**

OR

A clinician from the same TIN bills a second E&M primary care service or another primary care service **within 90 days.**

Get Started with Cost Measures in 4 Steps

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Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

TPCC Measure Attribution (continued)

TIN-NPI Attribution When TIN Has 11 Candidate Events

Clinician: HCFA Specialty	Candidate Events	Exclusions	TIN-NPI Attribution
A: Cardiology Over 15% of clinician's candidate events had 10- or 90-day global surgery with same patient	Candidate Event 1 Candidate Event 2	Excluded from attribution based on **global surgery service exclusion**	Clinicians A and B **will not be attributed** Beneficiary months for candidate events 1-6 will not be attributed at either the TIN or TIN-NPI level
B: Optometry	Candidate Event 3 Candidate Event 4 Candidate Event 5 Candidate Event 6	Excluded from attribution based on **optometry specialty exclusion**	
C: Family Practice	Candidate Event 7 Candidate Event 8 Candidate Event 9 Candidate Event 10	**No exclusions apply**	Clinician C who is responsible for the plurality of the patient's attributable candidate events **will be attributed** beneficiary months for candidate events 7 – 10
D: Geriatric Medicine	Candidate Event 11	**No exclusions apply**	Clinician D **will not be attributed** any beneficiary months because they do not bill the plurality of candidate events for this patient Beneficiary months for candidate event 11 will not be attributed at the TIN-NPI level

Get Started with Cost Measures in 4 Steps

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Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

MSPB Clinician: Episode Attribution

MSPB Clinician attribution begins by identifying the "episode," triggered by an inpatient hospital admission

Episodes are classified as either medical or surgical, based on the Medicare Severity- Diagnosis Related Group (MS-DRG).

- A **medical episode** is
    - First attributed to the TIN billing at least 30% of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
    - Then attributed to any clinician in the TIN who billed at least one inpatient E/M service that was used to determine the episode's attribution to the TIN.
- A **surgical episode** is attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

Get Started with Cost Measures in 4 Steps

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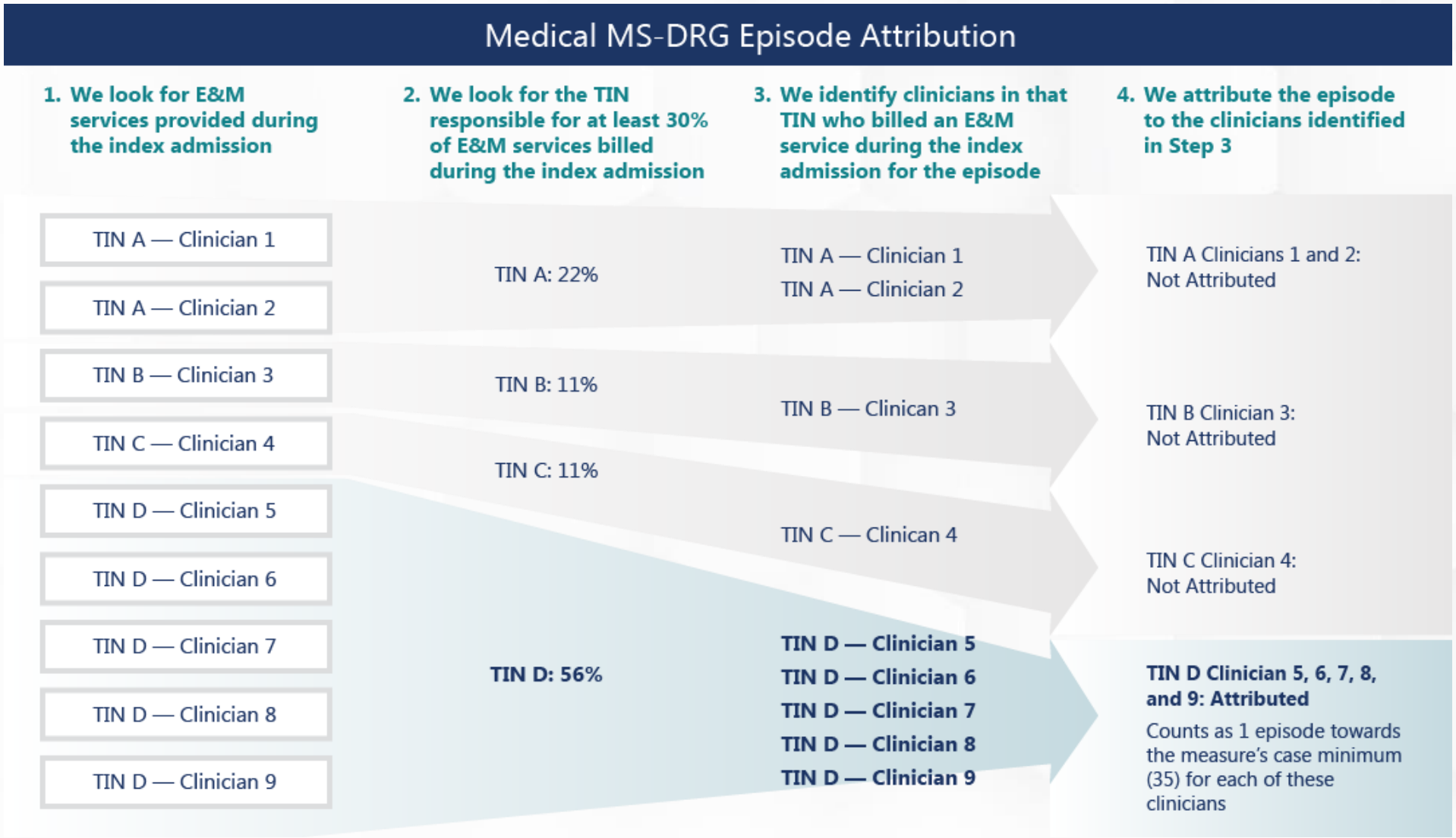
Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

MSPB Clinician: Medical Episode Attribution Example



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Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

MSPB Clinician: Surgical Episode Attribution Example

Surgical Episode Attribution Example

1. We identify TINs and Clinicians who billed CPT/HCPCS codes during Index Admission for a surgical episode	2. We identify TINs and Clinicians that billed relevant CPT/HCPCS codes for the surgical episode	3. We attribute the episode to the TIN(s) and clinician(s) identified in step 2
TIN A — Clinician 1 TIN A — Clinician 2	**TIN A: Yes** **Clinician 1: Yes** Clinician 2: No	**TIN A: Attributed** **Clinician 1: Attributed** Clinician 2: Not Attributed
TIN B — Clinician 3 TIN C — Clinician 4	TIN B: No Clinician 3: No	TIN B: Not Attributed Clinician 3: Not Attributed
TIN C — Clinician 5 TIN C — Clinician 6	TIN C: No Clinician 4: No Clinician 5: No Clinician 6: No	TIN C: Not Attributed Clinician 4: Not Attributed Clinician 5: Not Attributed Clinician 6: Not Attributed

Get Started with Cost Measures in 4 Steps

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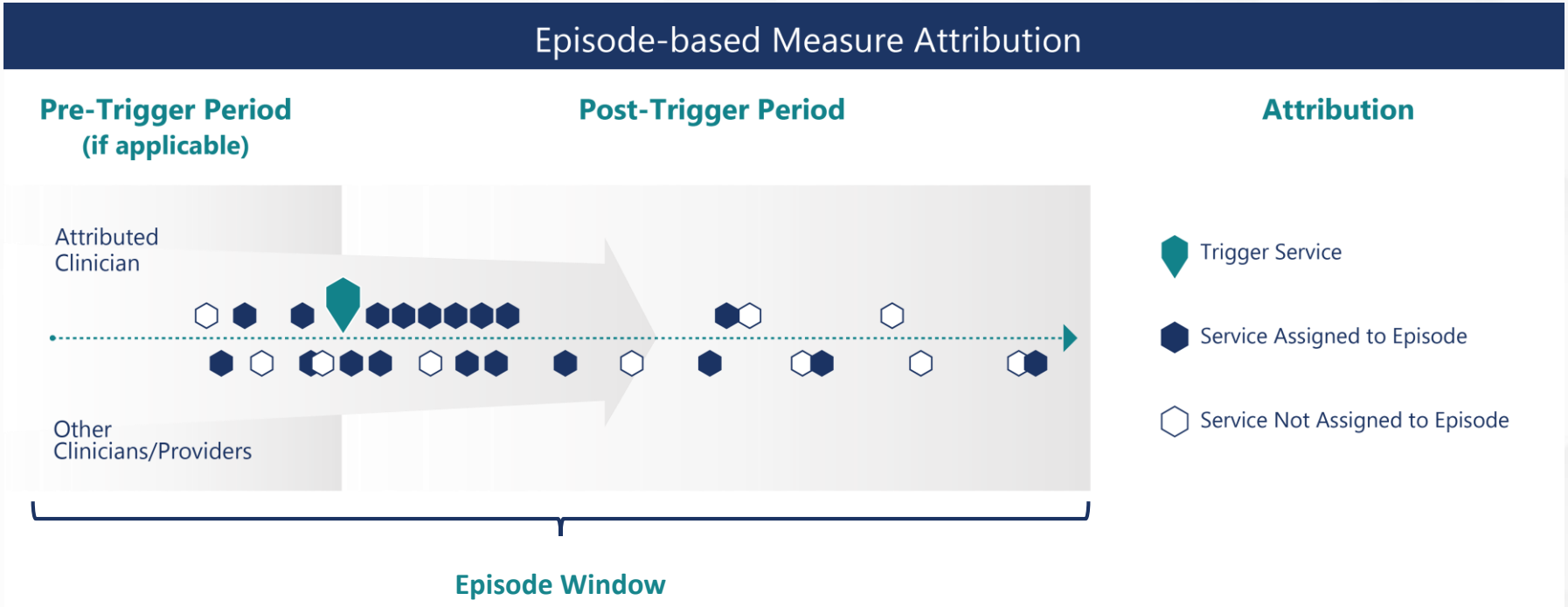
Step 2. Understand How Cost Measures are Attributed to MIPS Eligible Clinicians *(continued)*

MSPB Clinician: Episode-based Measure Attribution

For **acute inpatient episodes**, an episode is:

- First attributed to the TIN billing at least 30% of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

For **procedural episodes**, we attribute the episode to any clinician who bills the code that triggers the episode.



Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated

TPCC Measure Calculation

Step	Description/ Additional Information
1. Identify candidate events	This is the start of a primary care relationship between a clinician and Medicare patient.
2. Apply service category and specialty exclusions	This excludes candidate events for certain clinicians. For example, clinicians whose candidate events meet thresholds for certain service categories (e.g., global surgery) or practice under certain specialties (e.g., dermatology).
3. Construct risk windows	For remaining candidate events, this opens a year-long risk window beginning with the initial E&M primary care service of the candidate event.
4. Attribute months to TINs and TIN-NPIs	Months in the risk window that occur during the performance period are attributed to the remaining eligible TIN-NPIs within the TIN responsible for the majority share, or plurality, of candidate events for a patient.
5. Calculate monthly standardized observed cost	This sums the cost of all services billed for the Medicare patient during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
6. Risk-adjust monthly costs	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
7. Apply specialty adjustment	This accounts for the fact that costs vary across specialties and across TINs with varying specialty compositions.
8. Calculate the measure score	This is done by dividing each TIN and TIN-NPI's risk-adjusted monthly cost by the specialty-adjustment factor and multiplying by the observed cost across the total population of beneficiary-months where the risk window overlaps with the performance year.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated *(continued)*

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Measure Calculation

Step	Description/ Additional Information
1. Define the population of index admissions	An episode is opened by an inpatient hospital admission ("index admission"). Medicare Part A and Part B claims billed 3 days prior to and during the index admission and 30 days after hospital discharge are considered for inclusion.
2. Attribute MSPB Clinician episodes	The MSPB Clinician attribution methodology distinguishes between medical episodes and surgical episodes. Episodes with medical MS-DRGs are attributed to: 1) the TIN that billed at least 30% of inpatient E&M services during the index admission, and 2) any TIN-NPI who billed at least one E&M service that was used to meet the 30% threshold for the TIN. Episodes with surgical MS-DRGs are attributed to the TIN and TIN-NPI that provided the main procedure for the index admission.
3. Exclude unrelated services and calculate episode standardized observed cost	We exclude unrelated services specific to groups of MS-DRGs aggregated by Major Diagnostic Categories (MDCs), such as orthopedic procedures. This removes services clinically unrelated to the index admission and sums the cost of the remaining services. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Risk-adjust MSPB Clinician episode costs to calculate expected cost	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
5. Exclude outliers and winsorize costs	This mitigates the effect of outlier high- and low-cost episodes on each TIN-NPI or TIN's MSPB Clinician measure score.
6. Calculate MSPB Clinician Measure score	This is done by calculating the ratio of standardized observed episode costs to winsorized expected episode costs and multiplying the average of this cost ratio across episodes for each TIN-NPI or TIN by the national average observed episode cost.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated *(continued)*

Episode-based Measure Calculation

Step	Description/ Additional Information
1. Trigger and define an episode	This relies on billing codes that open, or "trigger," an episode. The pre- and post-trigger period length of the episode varies by measure.
2. Attribute the episode to a clinician	For acute inpatient condition episodes, this is a clinician billing E&M services under a TIN that bills 30% of inpatient E&M services during the inpatient stay. For procedural episodes, this can be any clinician who bills the trigger procedure code.
3. Assign costs to the episode and calculate the standardized episode observed cost	The cost of the assigned services is summed to determine each episode's standardized observed cost. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Exclude episodes	This removes unique groups of patients in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
5. Risk-adjust cost to calculate expected episode costs	This step accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
6. Calculate the measure score	This is done by calculating the ratio of standardized observed episode costs to expected episode costs and multiplying the average cost ratio across episodes for each TIN-NPI or TIN by the national average episode cost.

Get Started with Cost Measures in 4 Steps

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Step 4. Understand What Cost Performance Feedback Will Be Available

MIPS eligible clinicians, groups, and virtual groups who meet the case minimum for any of the cost measures will receive category- and measure-level scoring information in their performance feedback. Each measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

To see what performance feedback looked like in previous years, review the 2019 MIPS Performance Feedback Resources.

We have also provided patient-level reports for viewing and downloading by clinicians and groups who were scored on a MIPS cost measure and/or the 2019 30-Day All-Cause Readmission (ACR) measure. Visit the "2019 MIPS Performance Feedback Patient-Level Data Reports FAQs" document in the 2019 MIPS Performance Feedback Resources zip file for more information. (Note, this is the most current resource at the time of publication.)

Final performance feedback will be available by July 2022 when you sign in to qpp.cms.gov.

Help, Resources, and Version History

Help, Resources, and Version History

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Where Can You Go for Help?

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

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

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

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

Help, Resources, and Version History

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Additional Resources

The QPP Resource Library houses fact sheets, measure specifications, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
2021 Improvement Activities Inventory	A complete list and descriptions of the 2021 MIPS improvement activities.
2021 MIPS Quick Start Guide	A high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2020 performance period.
2021 MIPS Eligibility and Participation Quick Start Guide	A high-level overview and actionable steps to understand your 2020 MIPS eligibility and participation requirements.
2021 Quality Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about quality measure selection, data collection, and submission for the 2021 MIPS quality performance category.
2021 Part B Claims Quick Start Guide: Traditional MIPS	A high-level overview and practical information about reporting quality measures through Medicare Part B claims.
2021 Promoting Interoperability Performance Category Quick start Guide: Traditional MIPS	A high-level overview and practical information about data collection and submission for the 2021 MIPS Promoting Interoperability performance category.
2021 Improvement Activities Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about selecting and implementing activities and submitting data for the 2021 MIPS Improvement Activities performance category.
2021 Quality Payment Final Rule Resources	A zip file containing 2021 QPP final rule resources, including the 2021 QPP Final Rule Fact Sheet, FAQs, and Proposed and Final Rule Comparison Table.

Help, Resources, and Version History

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Version History

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

Resource	Description
1/14/21	Original Posting