GIQuIC and the MIPS 2021 QCDR Reporting Option – Part 2 of 2

May 18, 2021
Questions?

Your Participation

Grab Tab – Click orange arrow to open/close Control Panel.

Please continue to submit your text questions and comments using the Questions Panel.

**Note:** Today’s presentation is being recorded and will be available on the GIQuIC website in approximately two weeks.

If you have questions, please contact info@giquic.org.
This presentation provides information about the GIQuIC 2021 Qualified Clinical Data Registry (QCDR) as a reporting mechanism for the Merit-Based Incentive Payment System (MIPS) for the 2021 performance year. This is a two-part presentation.

Part 1 addressed assembling the basic information and resources you need to support your gastroenterologists in successful reporting, if done via the GIQuIC 2021 QCDR.

Part 2 will address MIPS reporting requirements and how they can be fulfilled by reporting via the GIQuIC 2021 QCDR.

**Important Note:** To report via the GIQuIC 2021 QCDR a site must be registered and actively participating in GIQuIC (submitting data, generating reports) *no later than June 30, 2021.*
I. Define Quality Improvement (QI) Registry and Qualified Clinical Data Registry (QCDR)

II. Describe broadly the Merit-based Incentive Payment System (MIPS)

III. Understand a physician’s eligibility status relative to reporting to the Merit-based Incentive Payment System - the need (or lack there of) to submit data to CMS

IV. Assemble your reporting team
Part 2 Agenda

I. Describe the Merit-based Incentive Payment System (MIPS)

II. Discuss MIPS performance categories requirements and scoring

III. Discuss how the GIQuIC 2021 QCDR meets reporting requirements

IV. Review upcoming activities in the GIQuIC 2021 QCDR reporting timeline

Download the slides from the Handouts box
Part 2 Simple Agenda

**Who:** MIPS-eligible clinicians

*covered in detail during the Part 1 webinar*

**What:** Quality Payment Program, MIPS, MIPS performance categories

**Why:** To avoid a negative payment adjustment in 2023

To potentially earn a positive payment adjustment

**How:** There are multiple mechanisms through which data submission can be made, including GIQuIC.

**When/Where:** We will focus on reporting via the GIQuIC 2021 QCDR.
Merit-Based Incentive Payment System

Quality Payment Program
What is the Quality Payment Program?

What is the Quality Payment Program?
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

MIPS
Merit-based Incentive Payment System
If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

Advanced APMs
Advanced Alternative Payment Models
If you participate in an Advanced APM and achieve Qualifying APM Participant (QPP) status, you may be eligible for a 5% incentive payment and you will be exited from MIPS.*

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

#### 2021 Final Rule Changes - MIPS

**Performance Threshold and Payment Adjustments**

<table>
<thead>
<tr>
<th>Final Score 2020</th>
<th>Payment Adjustment 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥85 points</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>Eligible for additional payment for exceptional performance—minimum of additional 0.5%</td>
</tr>
<tr>
<td>45.01-84.99 points</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>Not eligible for additional payment for exceptional performance</td>
</tr>
<tr>
<td>45 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>11.26-44.99 points</td>
<td>Negative payment adjustment greater than -9% and less than 0%</td>
</tr>
<tr>
<td>0-11.25 points</td>
<td>Negative payment adjustment of -9%</td>
</tr>
</tbody>
</table>

<table>
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<th>Final Score 2021</th>
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<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>Not eligible for additional payment for exceptional performance</td>
</tr>
<tr>
<td>60 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>15.01-59.99 points</td>
<td>Negative payment adjustment greater than -9% and less than 0%</td>
</tr>
<tr>
<td>0-15 points</td>
<td>Negative payment adjustment of -9%</td>
</tr>
</tbody>
</table>
Merit-Based Incentive Payment System

The MIPS is one way to participate in the QPP.

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

- **Quality**: Assesses the quality of care you deliver based on measures of performance.
- **Improvement Activities**: Assesses your participation in activities that improve clinical practice and support patient engagement.
- **Promoting Interoperability**: Assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT).
- **Cost**: Assesses the cost of the care you provide based on your Medicare Part B claims.

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight of MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>40%</td>
</tr>
<tr>
<td>Cost</td>
<td>20%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>25%</td>
</tr>
</tbody>
</table>
Quality Improvement Registry

Quality assessment/improvement registries (QI registries) seek to use systematic data collection and other tools to improve quality of care.


Qualified Clinical Data Registry

A QCDR is an entity that collects medical or clinical data for the purposes of patient and disease tracking to foster improvement in the quality of care provided and that has self-nominated, successfully completed a qualification process, and been approved by CMS as a reporting mechanism.

Centers for Medicare & Medicaid Services
## Quality Performance Category

<table>
<thead>
<tr>
<th>CMS Requirement</th>
<th>GIQuIC 2021 QCDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report data from January 1 – December 31, 2021</td>
<td>Only GIQuIC participants registered and <strong>actively</strong> submitting data to the registry by June 30, 2021, may consider reporting via the GIQuIC 2021 QCDR. For units that registered and started submitting data after January 1, 2021, data from January 1 onward must be entered (and in some cases manually) into the registry. The data in the registry must be for the entire reporting period regardless of the unit’s start date with GIQuIC.</td>
</tr>
<tr>
<td>CMS Requirement</td>
<td>GIQuIC 2021 QCDR</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Data Completeness Requirement</strong></td>
<td>To participate in GIQuIC a provider must upload 100% of colonoscopy cases done</td>
</tr>
<tr>
<td>Report on 70% of cases to which measure applies across</td>
<td>at the participating site(s) - all payers, not just Medicare.</td>
</tr>
<tr>
<td>all places of service regardless of payer; submission</td>
<td></td>
</tr>
<tr>
<td>must include at least one Medicare patient</td>
<td></td>
</tr>
<tr>
<td><strong>Variable depending upon provider</strong></td>
<td>Are at least 70% of the provider’s procedures captured in GIQuIC?</td>
</tr>
<tr>
<td>Are at least 70% of the provider’s procedures captured</td>
<td>• Look at the cases that qualify each measure denominator.</td>
</tr>
<tr>
<td>in GIQuIC?</td>
<td>• Consider the volume the provider does at each place of service.</td>
</tr>
</tbody>
</table>
### Quality Performance Category

<table>
<thead>
<tr>
<th>CMS Requirement</th>
<th>GIQuIC 2021 QCDR</th>
</tr>
</thead>
</table>
| Report at least 6 individual measures. Measures can be reported to CMS via multiple mechanisms. CMS will pick the six measures with the highest scores for the purposes of determining points earned and payment adjustment. | The GIQuIC QCDR includes 7 measures  
• 6 colonoscopy  
• 1 EGD                                                                 |
| One outcome measure required (or one high-priority measure if outcome measure is not available) | The GIQuIC QCDR includes 1 outcome and 5 high-priority measures |
| Readmission measure for groups with 16+ eligible clinicians                      | No reporting is required                                                        |
| Bonus points for end-to-end electronic reporting                                | Not available                                                                  |
GI Quality Improvement Consortium, Ltd. (GIQuIC)

2021 QCDR Measures

Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Quality performance category of the Merit-Based Incentive Payment System (MIPS) via the GIQuIC Qualified Clinical Data Registry (QCDR) for the 2021 program year. Additional detail on GIQuIC’s QCDR measures available for public reporting follows on the subsequent pages.

The GIQuIC 2021 QCDR has been approved to support individual eligible clinician, group, and virtual group reporting to the Quality, Improvement Activities, and Promoting Interoperability performance categories.

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Title</th>
<th>Outcome/High-Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIQIC22</td>
<td>Screening Colonoscopy Adenoma Detection Rate</td>
<td>Outcome</td>
</tr>
<tr>
<td>GIQIC23</td>
<td>Appropriate follow-up interval based on pathology findings in screening colonoscopy</td>
<td>High-Priority</td>
</tr>
<tr>
<td>NHCR4</td>
<td>Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation</td>
<td>High-Priority</td>
</tr>
<tr>
<td>QPP320</td>
<td>Appropriate follow-up interval for normal colonoscopy in average risk patients</td>
<td>High-Priority</td>
</tr>
<tr>
<td>QPP425</td>
<td>Photodocumentation of Cecal Intubation</td>
<td>N/A</td>
</tr>
<tr>
<td>QPP439</td>
<td>Age Appropriate Screening Colonoscopy</td>
<td>High-Priority</td>
</tr>
<tr>
<td>GIQIC10</td>
<td>Appropriate management of anticoagulation in the peri-procedural period rate – EGD</td>
<td>High-Priority</td>
</tr>
</tbody>
</table>
Quality Performance Category Scoring

Merit-based Incentive Payment System
Quality Performance Category - Scoring Basics in 2021

- Quality measures submitted for the 2021 performance period will receive between 0 and 10 measure achievement points.
- Quality measures fall into one of three categories for scoring:
  1. The measure meets the data completeness criteria, has a benchmark, and the volume of cases is sufficient (>20 cases for most measures)
     - These measures continue to receive between 3 to 10 points based on performance compared to the benchmark
  2. The measure meets the data completeness criteria but either (1) doesn’t have a benchmark and/or (2) the volume of cases you’ve submitted is insufficient (<20 cases for most measures)
     - These measures continue to receive 3 measure achievement points*
  3. The measure doesn’t meet the data completeness criteria, which varies by collection type
     - These measures receive 0 point, except for small practices, which would continue to receive 3 measure achievement points*

* These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims based measures.
**GIQuIC 2021 QCDR Measure Set - Scoring**

- Assuming data completeness + case minimum requirements met
- Benchmarks available as of May 18, 2021.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Points Available as of May 18, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIQIC22 Screening Colonoscopy ADR</td>
<td>3 points, possible benchmarks August 2021</td>
</tr>
<tr>
<td>GIQIC23 Appropriate Follow-Up Screens</td>
<td>3 points, possible benchmark post reporting</td>
</tr>
<tr>
<td>NHCR4 Repeat Screen Inadequate Prep</td>
<td>From 3 to 10 points can be earned</td>
</tr>
<tr>
<td>QPP320 Appropriate F/U Negative Screen</td>
<td>From 3 to 10 points can be earned</td>
</tr>
<tr>
<td>QPP425 Photodoc Cecal Intubation</td>
<td>From 3 to 10 points can be earned</td>
</tr>
<tr>
<td>QPP439 Age Appropriate Screens</td>
<td>3 points, possible benchmark post reporting</td>
</tr>
<tr>
<td>GIQIC10 Manage Anticoag - EGD</td>
<td>From 3 to 10 points can be earned</td>
</tr>
</tbody>
</table>
## Improvement Activities Category

### Full Resource Library

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>QPP Reporting Track</th>
<th>Performance Category</th>
<th>Resource Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>MIPS</td>
<td>Improvement Activities</td>
<td>All</td>
</tr>
</tbody>
</table>

5 Resources

### 2021 MIPS Improvement Activities

PDF 726KB | PY 2021 | MIPS | Improvement Activities | Technical Guides and User Guides

Created 04/14/2021
Improvement Activities Inventory

5 Resources

2021 MIPS Improvement Activities User Guide
PDF 726KB | PY 2021 | MIPS | Improvement Activities | Technical Guides and User Guides

A guide to help clinicians participating in the improvement activities performance category of the Merit-based Incentive Payment System (MIPS) during the 2021 performance period.

2021 MIPS Data Validation Criteria
ZIP 1MB | PY 2021 | MIPS | Quality, Promoting Interoperability, Improvement Activities, Overview | Technical Guides and User Guides

Lists the 2021 criteria used to audit and validate data submitted for the Merit-based Incentive Payment System (MIPS) performance categories.
Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75

### 2021 IA Criteria

<table>
<thead>
<tr>
<th>ID</th>
<th>Subcategory Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Objective &amp; Validation Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_IAA_1</td>
<td>Expanded Practice Access</td>
<td>Provide 24/7 access to MIPS eligible clinicians or groups for advice about urgent and emergent care (for example, eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record that could include one or more of the following:</td>
<td>Increase patient access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care.</td>
<td></td>
</tr>
<tr>
<td>IA_IAA_2</td>
<td>Expanded Practice Access</td>
<td>Use of telehealth services that extend practice access</td>
<td>Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.</td>
<td></td>
</tr>
<tr>
<td>IA_IAA_3</td>
<td>Expanded Practice Access</td>
<td>Collection and use of patient experience and satisfaction data on access</td>
<td>Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as auditing steps for improving communications with patients to help understanding of urgent access needs.</td>
<td></td>
</tr>
</tbody>
</table>

**Validation Documentation:** Evidence of documented use of telehealth services. For purposes of this activity, the clinician and patient, include the following element:

- **Telehealth services:** Demonstration of a standardized and routine approach to the use of telehealth. This includes, but is not limited to, the Medicare reimbursed telehealth service criteria. Examples of documentation include health record (EHR) or other medical record/document showing specific telehealth services, contacts, or referrals.
### Improvement Activities Category - Scoring

<table>
<thead>
<tr>
<th>High-weighted activity = 20 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium-weighted activity = 10 points</td>
</tr>
</tbody>
</table>

For maximum score, complete:
- 4 medium-weight or
- 2 high-weight activities or
- 1 high-weighted and 2 medium-weighted activities

Small practices and practices in rural areas complete 2 medium-weight activities or 1 high-weight activity for maximum score

Group or virtual group can attest to an improvement activity when **at least 50% of the clinicians (in the group or virtual group) perform the same activity** during any continuous 90-day period within the same performance period.
Improvement Activities Inventory

2021 MIPS Data Validation Criteria - Read-Only - Excel

MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. Eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent for the CY 2020 Quality Payment Program performance period, eligible clinicians would have engaged in the integrated prevention and treatment interventions.
| 2021 Promoting Interoperability Measure ID | 2021 Promoting Interoperability Measure | 2021 Promoting Interoperability Measure Description | 2021 Promoting Interoperability Measure: Required/Bonus | 2021 Promoting Interoperability Reporting Requirement (Yes/No Statement of Numerator/Denominator) | 2021 Promoting Interoperability Validation (During performance period) | 2021 Promoting Interoperability Suggested Documentation needs to be from certified eCARET inclusive of:

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| PI_09H1_1 | Security Risk Analysis | Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(vi) and 45 CFR 164.306(e)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process. | Required | Yes/No Statement | Security risk analysis of the CEHRT was performed or reviewed prior to the date of attestation on an annual basis and for the CEHRT used during the reporting period. If you choose to submit for a 90-day MIPS performance period, it is acceptable for the security risk analysis to be conducted outside the performance period; however, it must be conducted within the calendar year of the MIPS performance period (January 1st – December 31st). An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each MIPS performance period.

A dated report or screenshot that document the results. The report should be dated with the period and should include evidence to support (e.g., identified by National Provider Identifier name, practice name, etc.).

Notes:
- The measure requires clinicians to address minimum, clinicians should be able to show steps that are being taken to implement the
- Any documentation of an analysis will suffer from CEHRT.

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2021 PI Criteria
MIPS eligible clinicians must use EHR technology certified to the existing 2015 edition or the 2015 Edition Cures Update or a combination of both.

<table>
<thead>
<tr>
<th>90-day performance period</th>
</tr>
</thead>
</table>

Hardship exemptions include:
- Small practices that demonstrate “overwhelming barriers”
- Insufficient internet connectivity
- Insufficient internet access through an application process
- Extreme and uncontrollable circumstances
- Lack of control over availability of certified EHR technology
- Lack of face-to-face patient interaction

Hospital-Based clinicians who do not have sufficient PI measures applicable will have PI category weighted to zero.
(75% + of covered professional services in POS 21, POS 22, POS 23 or POS 19)

ASC-Based Eligible Clinicians are exempt from the PI requirements. ASC-based eligible clinicians have 75%+ services in POS 24.

For group reporting, 100% of the MIPS eligible clinicians in the group must qualify for exemption for the PI category to be reweighted.
2021 Final Rule Changes - MIPS

Promoting Interoperability Category

Objectives and Measures:

<table>
<thead>
<tr>
<th>Basics:</th>
<th>2020 Final</th>
<th>2021 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure</td>
<td><strong>Beginning with the 2020 performance period:</strong></td>
<td>Retained the Query of PDMP measure as an optional measure and increased its worth from 5 to 10 bonus points</td>
</tr>
<tr>
<td>Changed measure name and added an optional Health Information Exchange Bi-Directional Exchange measure</td>
<td>• Removed the Verify Opioid Treatment Agreement measure</td>
<td>• Changed the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling”</td>
</tr>
<tr>
<td>CEHRT flexibility</td>
<td>• Included the Query of PDMP measure as optional with yes/no response</td>
<td>• Added a new, optional Health Information Exchange (HIE) Bi-Directional Exchange measure</td>
</tr>
<tr>
<td><em>No changes to current automatic reweighting policies</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Promoting Interoperability Category**

### 2021 Final Rule Changes - MIPS

Promoting Interoperability Performance Category

#### CEHRT Flexibility

<table>
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<th>Basics:</th>
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<th>2021 Final</th>
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<td></td>
</tr>
<tr>
<td>No changes to current automatic reweighting policies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MIPS eligible clinicians must use technology certified to the 2015 Edition to collect and report their Promoting Interoperability data and eCQMs for the quality performance category:**

**MIPS eligible clinicians can use the following to collect and report their Promoting Interoperability data and eCQMs for the quality performance category:**

- Technology certified to the existing 2015 Edition, or
- Technology certified to the 2015 Edition Cures Update criteria, or
- A combination of both
CMS Webinars

Upcoming Webinars and Programs
No upcoming webinars. Check back periodically for updates.

Full Webinar Library

2021 Quality Payment Program Overview Webinar
Provides an overview of ways to participate in the Quality Payment Program for the 2021 performance year, including requirements for MIPS, APMs, and Advanced APMs.

Recording of Quality and Cost webinar posting soon!
Registration for IA and PI webinar opening soon!
Merit-Based Incentive Payment System

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

The MIPS is one way to participate in the QPP.

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

Quality
Assesses the quality of care you deliver based on measures of performance.

Promoting Interoperability
Assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (EHR). Be sure to use only one reporting mechanism.

Improvement Activities
Assesses your participation in activities that improve clinical practice and support patient engagement.

Cost
Assesses the cost of the care you provide based on your Medicare Part B claims. CMS uses administrative claims to calculate Cost.

Can report via multiple reporting mechanisms.
Small Practice Flexibilities

- 3 points for Quality measures that do not meet data completeness requirements
- Reduced Improvement Activity requirements
- PI hardship exception
- 6 bonus points added to Quality Category performance

Small Practice Defined:
15 or fewer eligible clinicians
- physician
- PA, NP, CNS
- CRNA
- certified nurse-midwife
- clinical social worker
- clinical psychologist
- registered dietitian/nutritional professional
- physical or occupational therapist
- qualified speech-language pathologist
- qualified audiologist
There are two exception applications available to clinicians in PY2021:

- The [Extreme and Uncontrollable Circumstances Exception](https://qpp.cms.gov/mips/exception-applications) application allows you to request reweighting for any or all performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.

- The [MIPS Promoting Interoperability Performance Category Hardship Exception](https://qpp.cms.gov/mips/exception-applications) application allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of the reasons identified below.
Find & compare nursing homes, hospitals & other providers near you.

Learn more about the types of providers listed here
2021 Performance Period Timeline

Merit-based Incentive Payment System

Timeline

- **Performance year**
  - Performance year opens January 1, 2021.
  - Closes December 31, 2021.
  - Clinicians care for patients and record data during the year.

- **submit**
  - Data submission opens January 4, 2022.
  - Deadline for submitting data is March 31, 2022.
  - Clinicians are encouraged to submit data early.

- **Feedback available**
  - CMS provides performance feedback after the data is submitted.
  - Clinicians will receive feedback before the start of the payment year.

- **adjustment**
  - MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2023.
• January 1, 2021 - December 31, 2021, is the performance period for 2023 payment.

• Data must be submitted by the vendor by March 31, 2022.
  – Keep in mind vendors such as GIQuIC typically have deadlines in advance of this final submission deadline to CMS.
  – If reporting via the GIQuIC 2021 QCDR, you must adhere to GIQuIC deadlines.
2021 Performance Period Timeline

- **June 11, 2021:** Data Release Consent Form (DRCF) and CMS Form 1500 Upload processes along with the 2021 MIPS Dashboard open
- **July 14, 2021:** Deadline to submit DRCF and upload CMS Form 1500

**Reminder:** To report via the GIQuIC 2021 QCDR a site must be registered and **actively** participating in GIQuIC (submitting data, generating reports) **no later than June 30, 2021.**

*Subsequent steps and associated deadlines to be published soon.*
Questions?

Your Participation

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Please continue to submit your text questions and comments using the Questions Panel.

Note: Today’s presentation is being recorded and will be available on the GIQuIC website in approximately two weeks.

If you have questions, please contact info@giquic.org.
Additional Questions

- Quality Payment Program
  [https://qpp.cms.gov/](https://qpp.cms.gov/)
  qpp@cms.hhs.gov

- GIQuIC
  Becca Adesanya, GIQuIC Registration only
  badesanya@gi.org or info@giquic.org

Any Questions

Open a new ticket in Service Desk by logging into the registry at [giquicregistry.org](http://giquicregistry.org) and select one of the MIPS-related options in Ticket Category. If you are unable to log in to the registry, please email giquiccams@figmd.com for assistance.