AASIM®

MIPS SUBMISSION

TOOLKIT

Table of Contents

Overview 3
Introduction & Background 3
How to create a HCQIS Access Roles and Profile (HARP) Account 4
MIPS Eligibility & Performance Categories 11
How to use the QPP Tool 15
How To Submit MIPS Data? 15
MIPS Value Pathways (MVPs) 23
Timeline and Important Dates: 25
Recommended Quality Measures 27
Recommended Improvement Activities 30
Frequently Asked Questions (FAQs) 32
Reference Page 34

Overview

This toolkit will provide information and guidance to AASM members and volunteers on the Centers for Medicare and Medicaid Service (CMS) Quality Payment Program (QPP) MIPS submission tool. The following content areas are included:

- Introduction and background of the QPP MIPS program
- Access to QPP HARP Account
- MIPS Eligibility and Performance Categories
- The QPP Tool
- Submitting MIPS Data
- MIPS Value Pathways (MVPs)
- Timeline and Important Dates
- Frequently Asked Questions (FAQs)

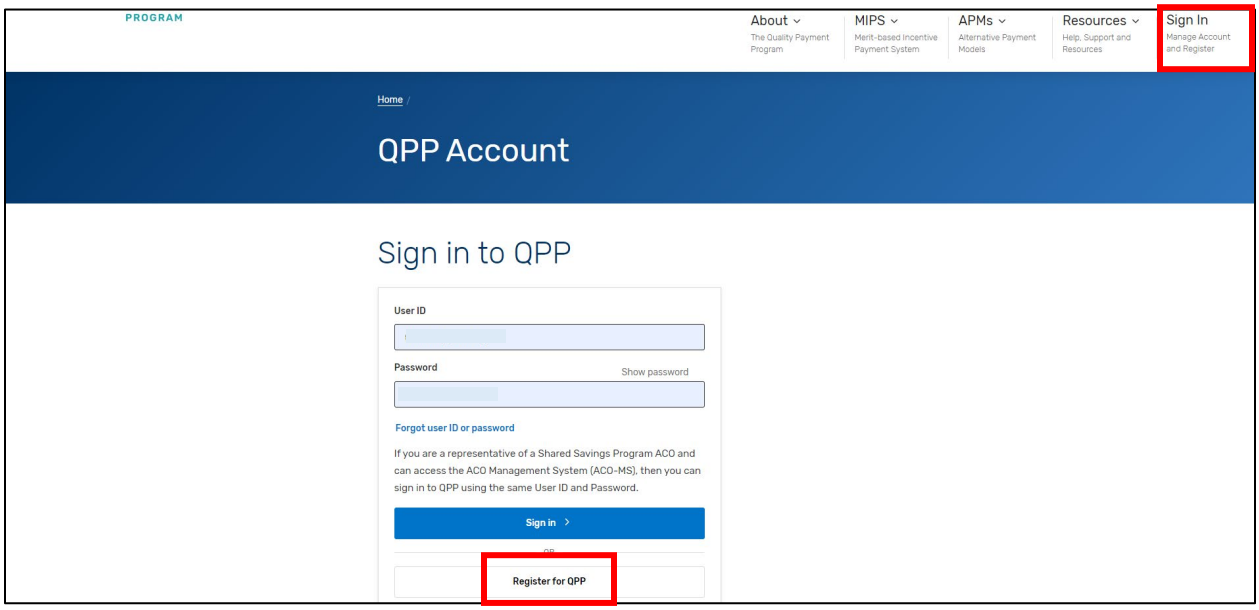
Introduction & Background

The MIPS performance year is defined as the period extending from January 1 to December 31 each year. Eligible participants in the MIPS program are mandated to submit data collected throughout the calendar year by March 31 of the following year. Payment adjustments, which are contingent upon the data submitted regarding services rendered, will be applied to Medicare Part B claims during the period from January 1 to December 31 of the year subsequent to the data submission. For example, if data is collected from January 1 to December 31, 2024 (designated as the performance year), it is imperative to report this data by March 31, 2025. Consequently, a MIPS payment adjustment will be implemented between January 1 and December 31, 2026 (referred to as the payment year).

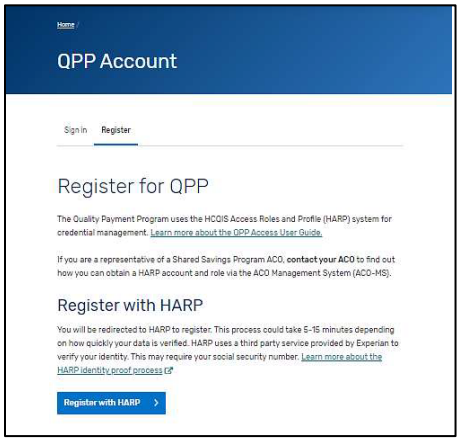
How to create a HCQIS Access Roles and Profile (HARP) Account

Step 1: Register for a HARP Account
***Follow the following steps, if you don't have a user ID and password for qpp.cms.gov**

- Click **Sign In** on the upper right-hand corner of qpp.cms.gov and **Register for QPP** tab.



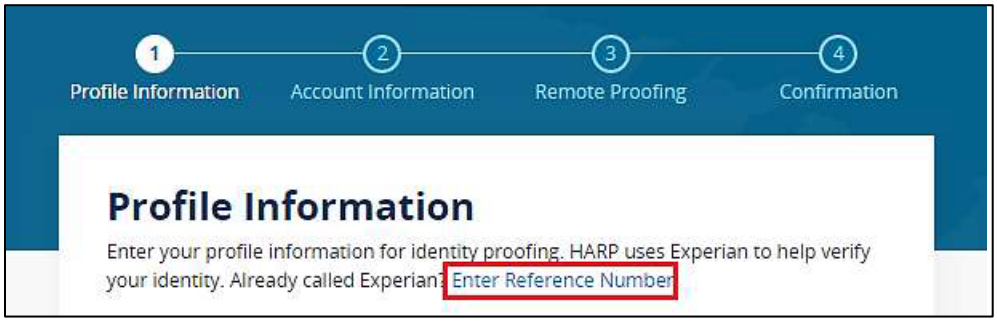
- Click **Register with HARP** (you will be redirected to the HARP site for registration).

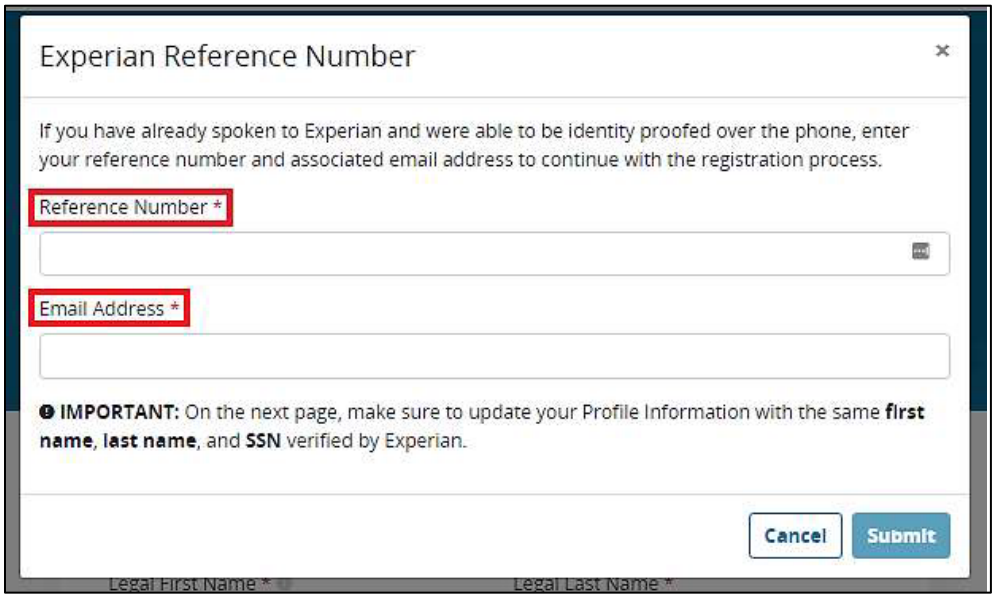


HARP Registration will take about 15 minutes. Please note that all fields with an asterisk (*) are required. For a video walking you through the HARP registration process visit the HARP YouTube Playlist.

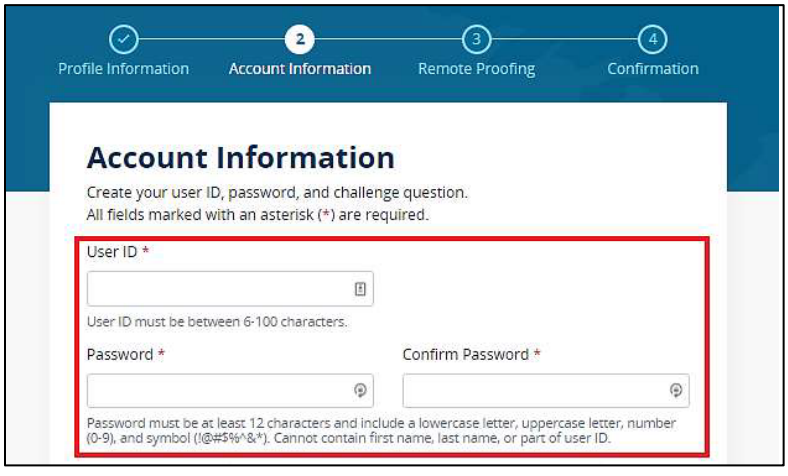
- Review **Terms and Conditions** and check the box to confirm that you have read

- Enter the **reference number** (provided by Experian) and your **email address** to continue the registration process.

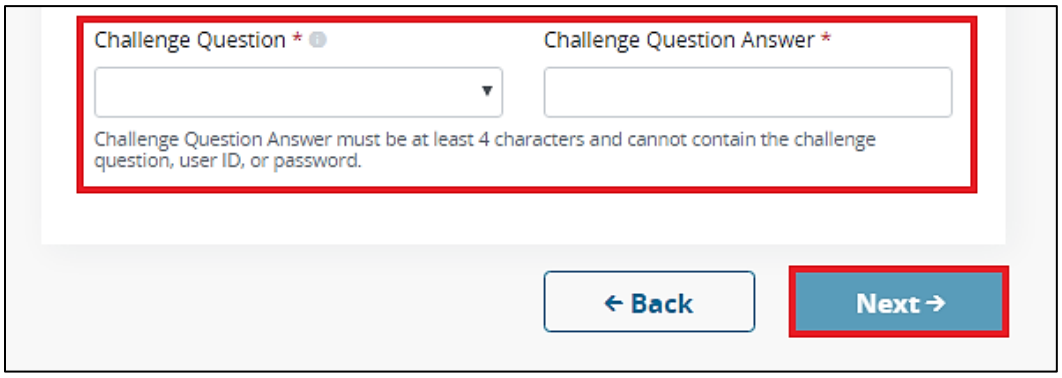




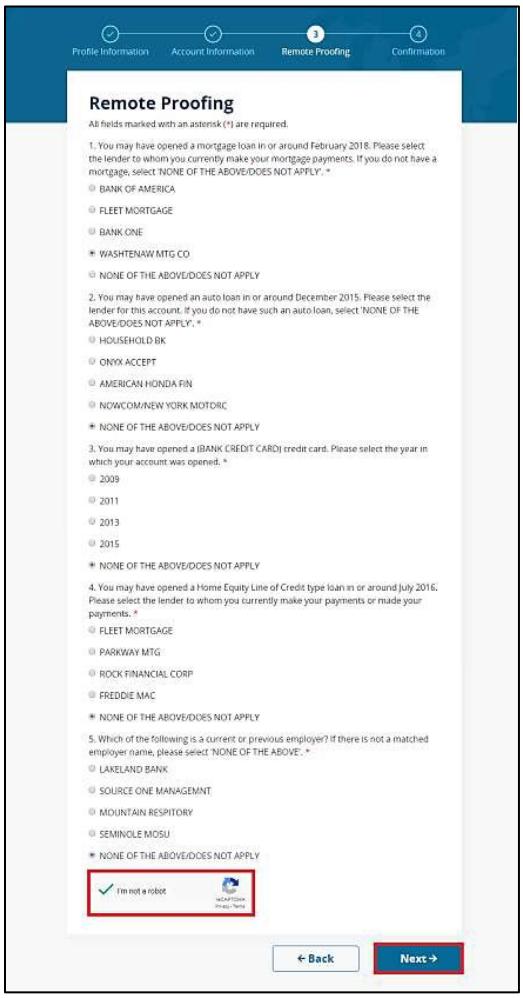
- Create a **User ID** and **Password**



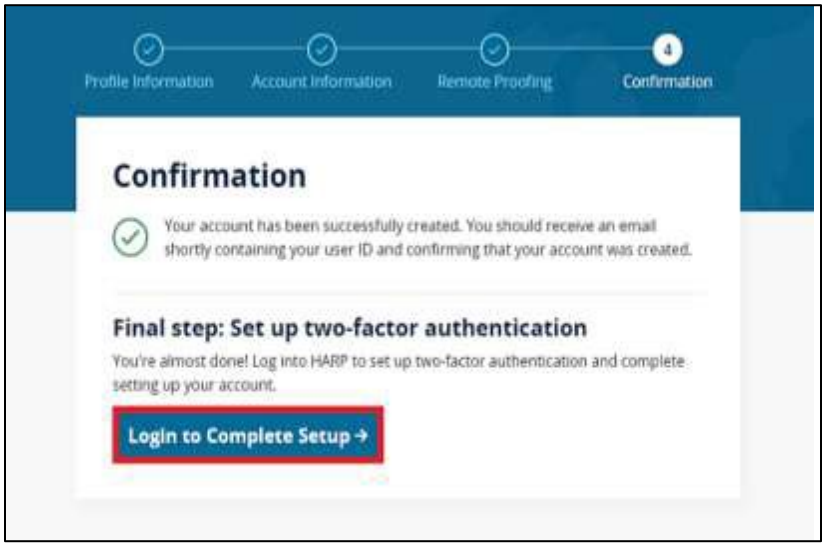
- Select a **challenge question** and document the **challenge question answer**



- Answer the **remote proofing questions** for Experian to confirm your identity, check **I'm not a robot**, then click **Next**



- Click **Login to Complete Setup** (You will also receive **an email** confirming your registration which contains your User ID.)

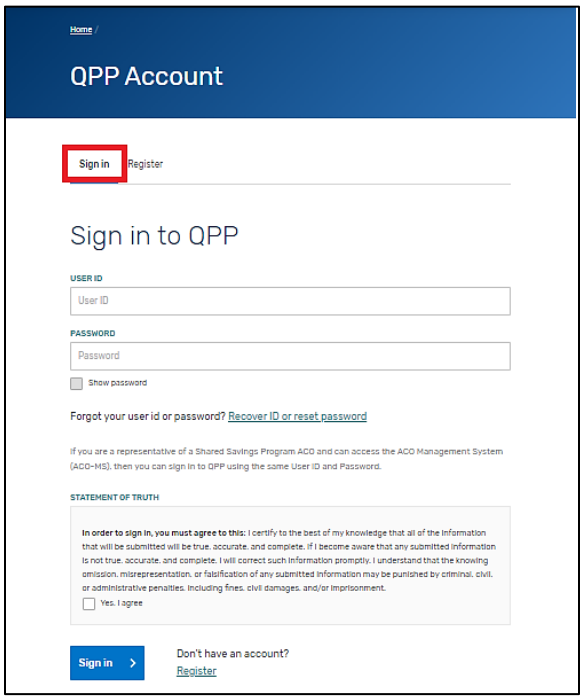


HARP Registration FAQs can be found on page 32

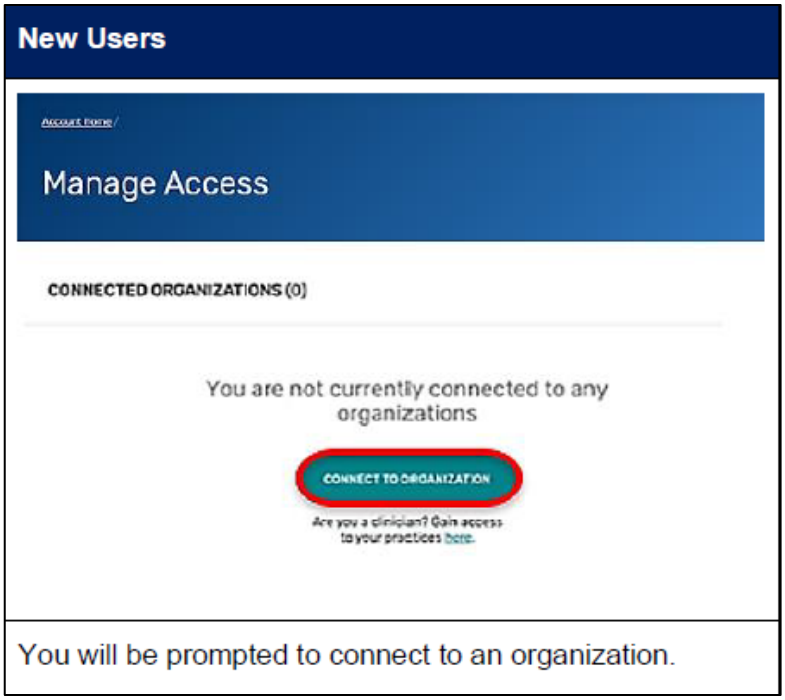
Step 2: Request the Appropriate Access

***This step is mandatory to view data, submit data, and manage access on behalf of the organization.**

- Click **Sign In** on the upper right-hand corner of qpp.cms.gov

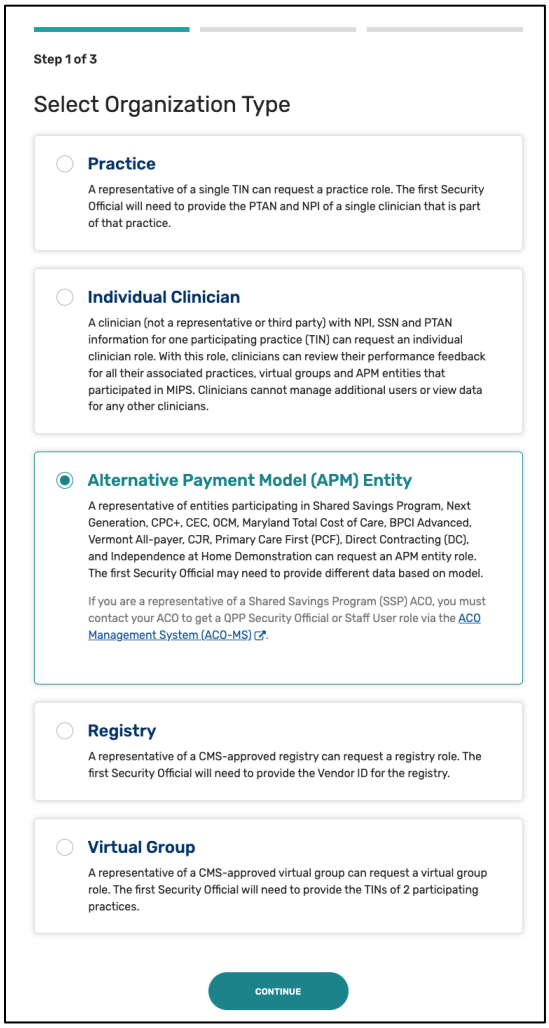


- Click **Manage Access** on the left-hand navigation pane



You will be prompted to connect to an organization.

Select **Connect to Organization**



Choose **Organization Type**

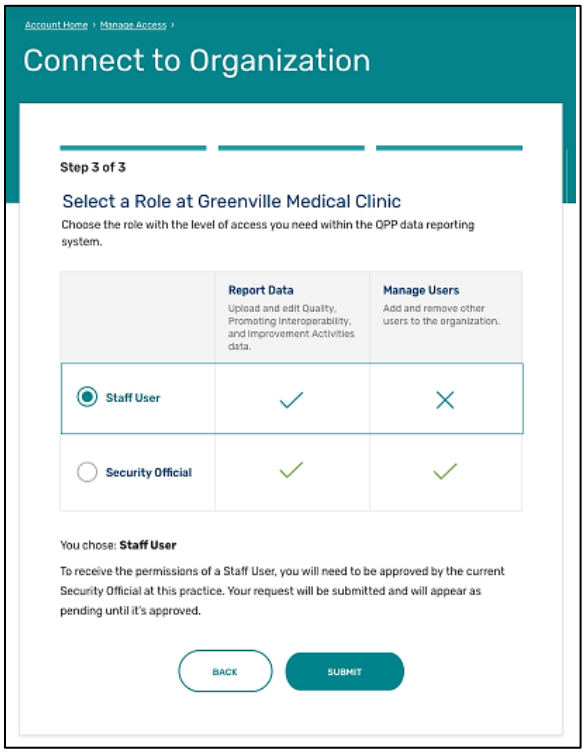
- Find your organization

Organization Type	Criteria you can use to search
Practice	• Legal Business Name; **OR** • Complete TIN **without dashes** ○ No search results will populate until you enter the complete TIN (9 digits)
APM Entity	**Step 1:** Identify your APM **Step 2:** Provide: • Legal Business Name (APM Entity Name) • APM Entity ID (e.g., ACO ID or Practice ID for some models like PCF and KCC)
Registry *(Qualified Registries and QCDRs)*	• Legal Business Name; **OR** • Vendor ID; **OR** • Complete TIN ○ No search results will populate until you enter the complete TIN (9 digits, **without dashes**)
Virtual Group	• Complete Virtual Group ID

- Select your role

For all organization types, you have two roles to select from: Staff User or Security Official

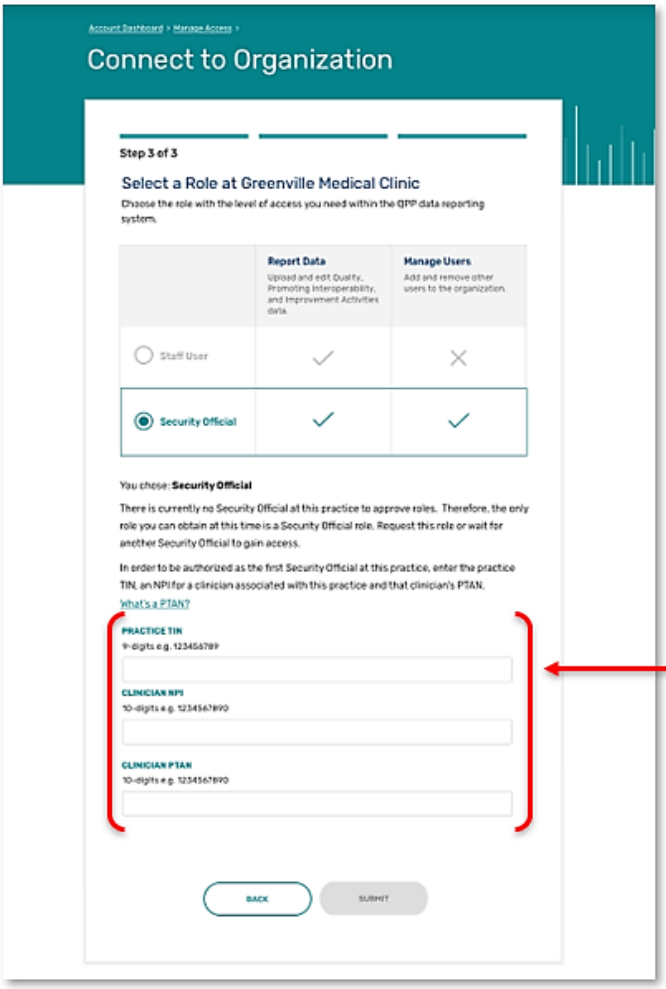
1. Staff User
    a. If you are a Staff User, select **Staff User** and click **Submit**. You will **not** be prompted to provide additional information.



What's Next

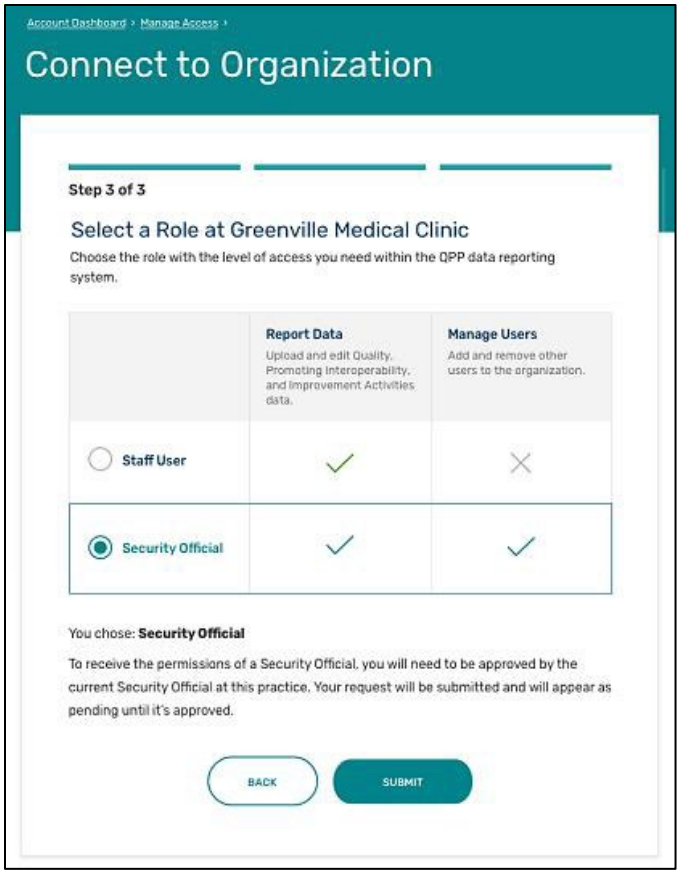
Your Staff User role request is currently pending approval.

2. Security Official (Each organization type must have **at least one individual with the Security Official role** before anyone can request a Staff User role or additional Security Official roles)
    a. First Security Official: If you are the **first** person to connect to your organization, select **Security Official**.



You will be prompted to enter additional information for validation and then select **Submit**. You will automatically be approved if your

    b. Additional Security Official
        i. If there is already a Security Official at your organization, select **Security Official** and click **Submit**. You will not be prompted to provide additional information.



What's Next

Your Security Official role request is currently pending

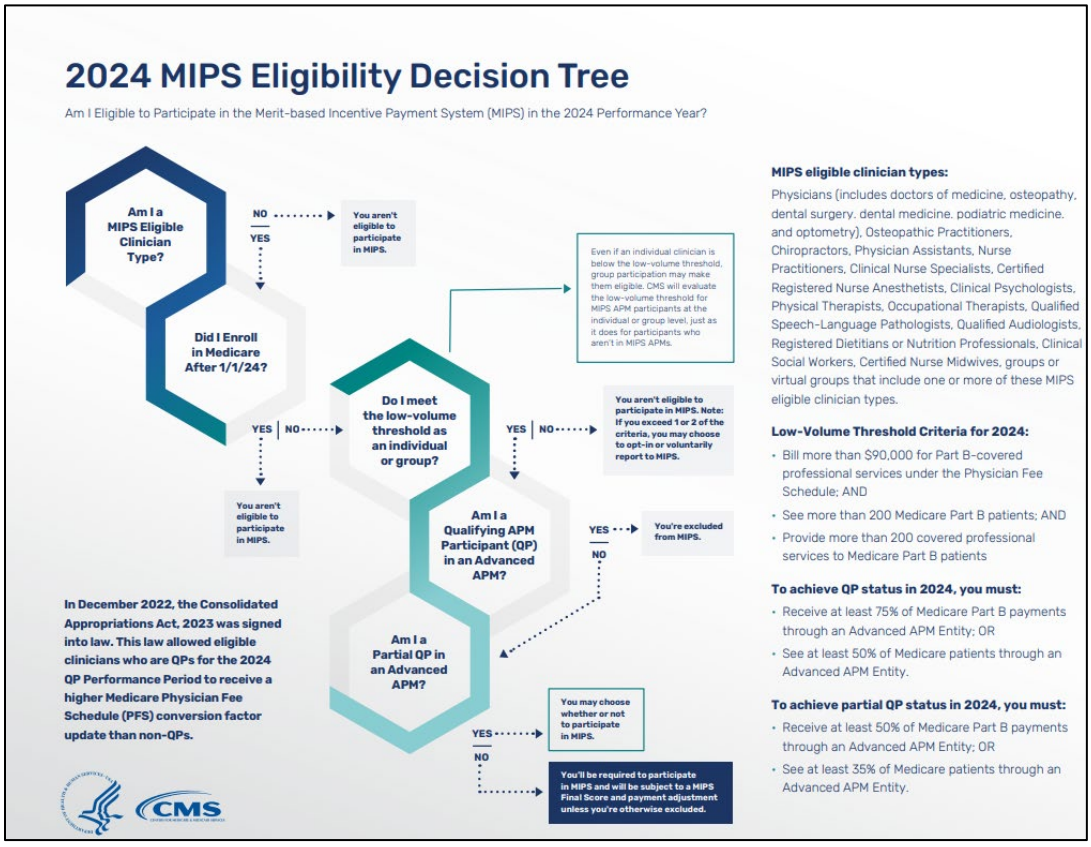
QPP Role Frequently Asked Questions can be found on page 32

MIPS Eligibility & Performance Categories

The Merit-based Incentive Payment System (MIPS) serves as a mechanism for participation in the Quality Payment Program (QPP). Under MIPS, healthcare providers may receive payment adjustments for professional services reimbursed by Medicare Part B, contingent upon an evaluation of their performance across several defined categories. These categories assess the quality and cost-effectiveness of the care provided, improvements in clinical processes, patient engagement, and the utilization of certified electronic health record technology (CEHRT) to promote and enhance the electronic exchange of health information.

MIPS Eligibility

It is important to determine your MIPS eligibility before participating in MIPS.



If you qualify for the Merit-based Incentive Payment System (MIPS) for a specified performance year:

- You are generally obligated to report data pertaining to measures and activities associated with the quality, improvement activities, and Promoting Interoperability performance categories, collected throughout that year.
- Your performance across the MIPS categories, each assigned a distinct weight, will culminate in a final MIPS score that ranges from 0 to 100 points.
- This final MIPS score will determine the nature of the payment adjustment for your Medicare Part B-covered professional services, which may be classified as negative, neutral, or positive.

CMS Quality Payment Program Image provided by the Quality Payment Program Library

MIPS Performance Categories

The MIPS performance framework comprises four distinct categories, each of which plays a significant role in determining the overall score. The following section provides a concise overview of each performance category, detailing its respective contribution percentage to the final score, the requisite data to be submitted or attested to, the general reporting requirements, and a link to the measures associated with each category.

Quality - 30% OF FINAL SCORE

This performance category evaluates the quality of care provided, utilizing performance metrics established by the Centers for Medicare & Medicaid Services (CMS), alongside contributions from medical professional organizations, specialty societies, and other stakeholders. You have the discretion to select the quality measures that are most applicable to your practice.

What Quality Data Should I Submit?

MIPS Quality Measure Data

- You must collect and submit measure data for the 12-month performance period (January 1 - December 31, 2024).

General reporting requirements are as follows:

- You'll need to submit collected data for at least 6 quality measures
- You'll need to report performance data for at least 75% of the denominator eligible cases for each quality measure (data completeness)
- You can submit measures from different collection types to fulfill the requirement to report data for at least 6 quality measures.

*Link to Quality Measures

**List of Recommended Quality Measures can be found on page 27

Promoting Interoperability - 25% OF FINAL SCORE

This performance category fosters patient engagement and facilitates the electronic exchange of health information through the utilization of certified electronic health record technology (CEHRT). You are required to report a specified set of objectives and measures related to Promoting Interoperability.

What Promoting Interoperability Data Should I Submit?

- You'll submit a single set of Promoting Interoperability objectives and measures organized under several objectives.

General reporting requirements are as follows:

- You're required to use an Electronic Health Record (EHR) that meets the certification
- In most cases, you must submit collected data for the required measures in each objective during the calendar year.
- In addition to submitting measures, you must provide your EHR's CMS identification code and submit a "yes" to:
    - The Actions to Limit or Restrict Compatibility or Interoperability of CEHRT (previously named the Prevention of Information Blocking) Attestation.
    - The ONC Direct Review Attestation (this is an optional attestation, you may attest "yes" or "no").
    - The Security Risk Analysis Measure.
    - The Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

*Link to Promoting Interoperability Measures

Improvement Activities - 15% OF FINAL SCORE

This performance category evaluates the extent to which you enhance your care processes, promote patient engagement in their healthcare, and expand access to care. You have the autonomy to select the activities that are most suitable for your practice.

What Improvement Activities Data Should I Submit?

To earn full credit in this performance category, you must generally submit one of the following combinations of activities:

- 2 high-weighted activities,
- 1 high-weighted activity and 2 medium-weighted activities, or
- 4 medium-weighted activities.

Improvement activities have a minimum of a continuous 90-day performance period (during calendar year (CY) 2024) unless otherwise stated in the activity description.

*Link to Improvement Activities Measures

**List of Recommended Quality Measures can be found on page 27

Cost - 30% OF FINAL SCORE

This performance category assesses relative cost efficiency, as demonstrated by outcomes on established cost measures.

What Cost Data Should I Submit?

- None, CMS will collect and calculate data for this cost performance category.

*Link to Cost Measures

How to use the QPP Tool

This tool was designed to assist you in understanding the measures and activities available for each performance category under traditional MIPS. It is intended solely for planning purposes and will not submit any information to CMS. To get the most out of the tool, follow the steps below:

Search available measures

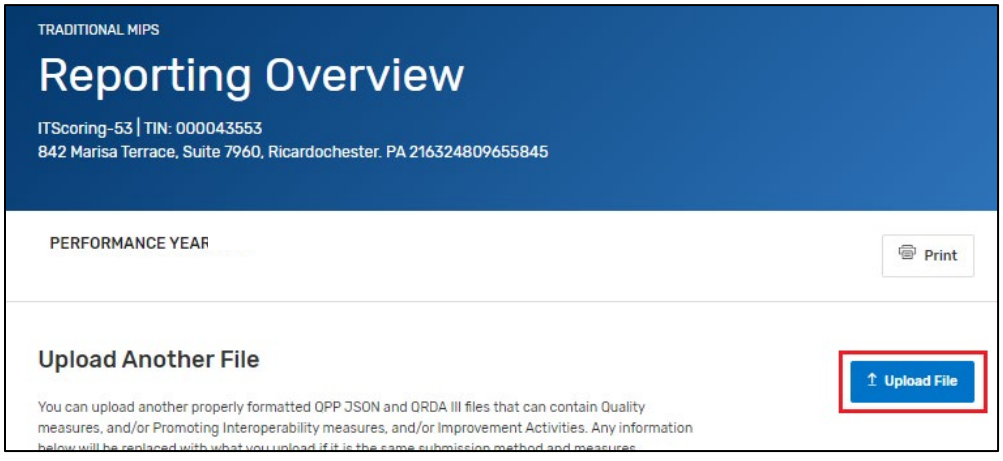
Add measures to list

Download list of measures for reference

How To Submit MIPS Data?

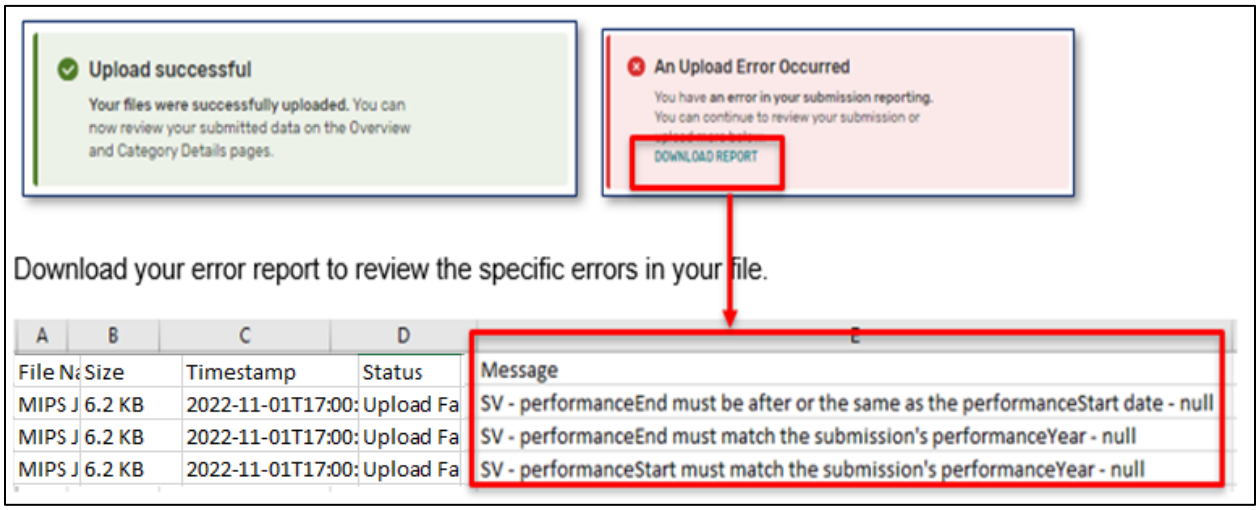
- Sign In to the QPP Website – If you have not created a HARP account, please go to page 4 and follow instructions to access the QPP site

From the Reporting Page, 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



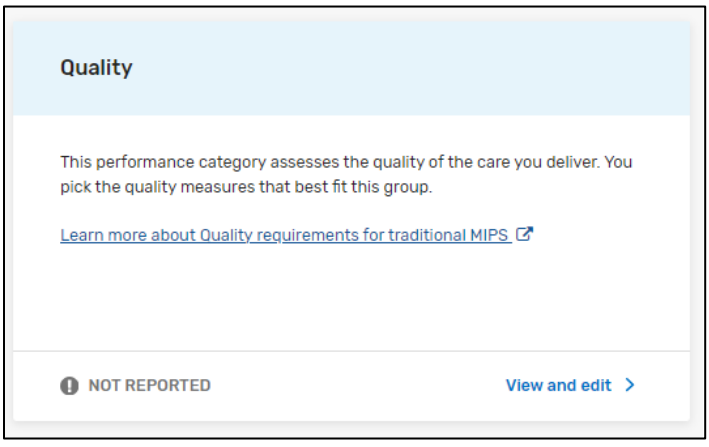
CMS Quality Payment Program Image provided by the Quality Payment Program Library

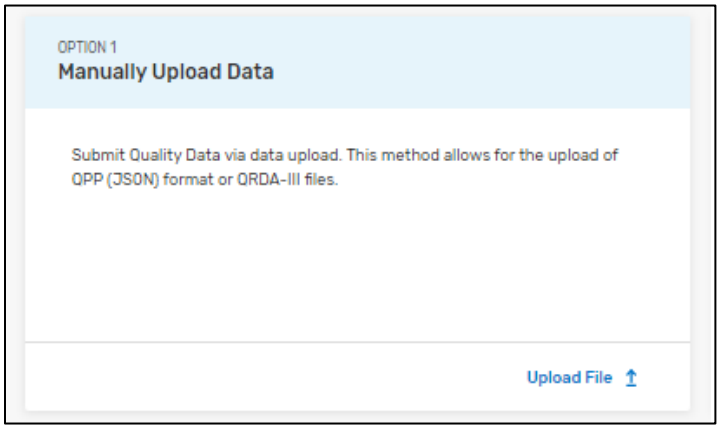
Once you've uploaded your file, you will see an indicator of success or error.



Submitting and Reviewing Quality Measure Data

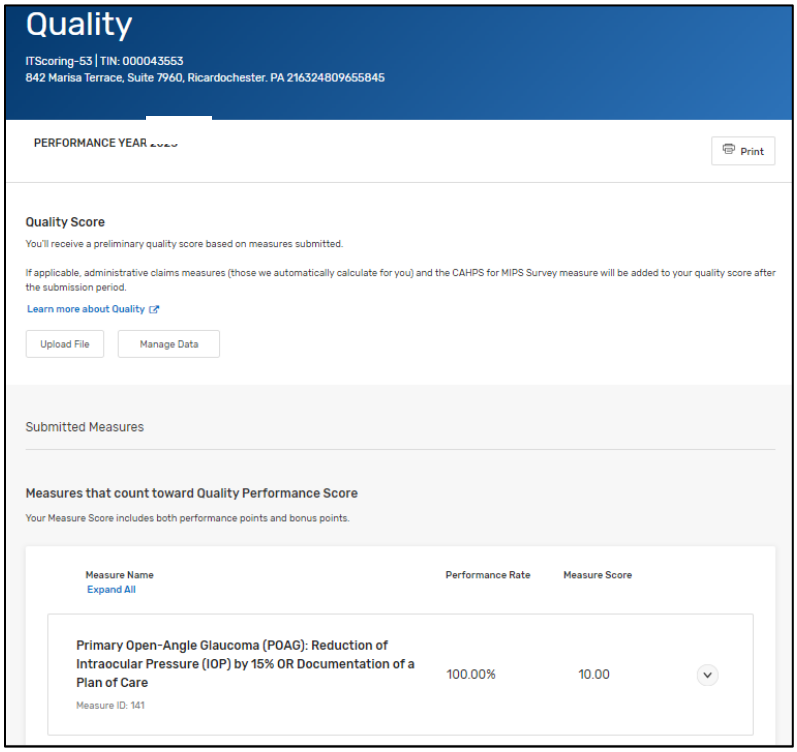
You can upload files for any or all performance categories from the Reporting Overview page. Alternately, if no quality data has been reported, you can upload your own QRDA III or QPP JSON file by clicking **View & Edit** in the Quality section of the Reporting Overview and then **Upload File**





Review Previously Submitted Data

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



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:

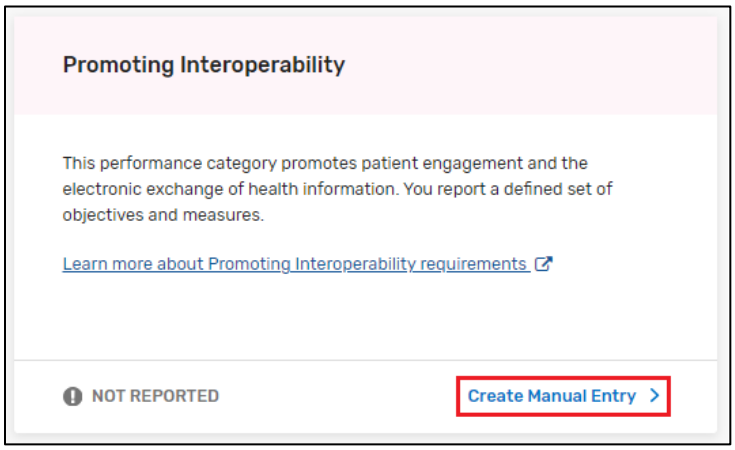
Submitting and Reviewing Promoting Interoperability Data

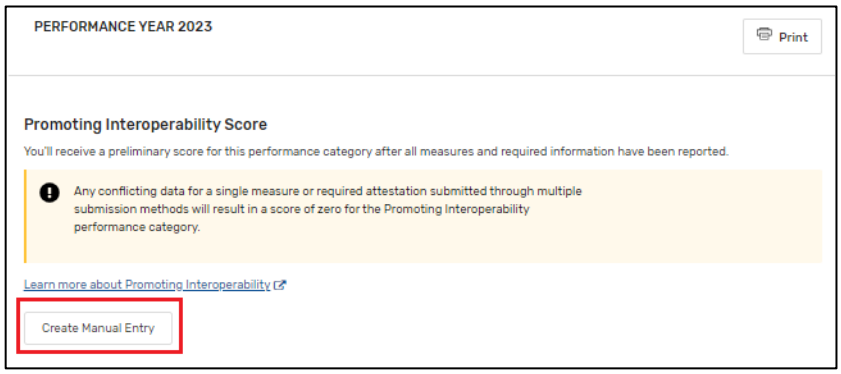
You can upload a QRDA III or QPP JSON file with your Promoting Interoperability data on the Reporting Overview page.

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.

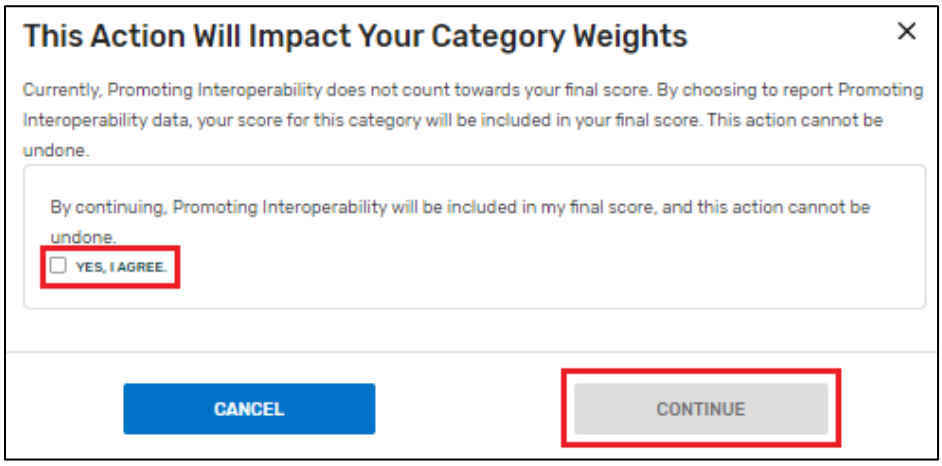
Click Create Manual Entry on the **Reporting Overview**, and then again on the **Promoting Interoperability** page.

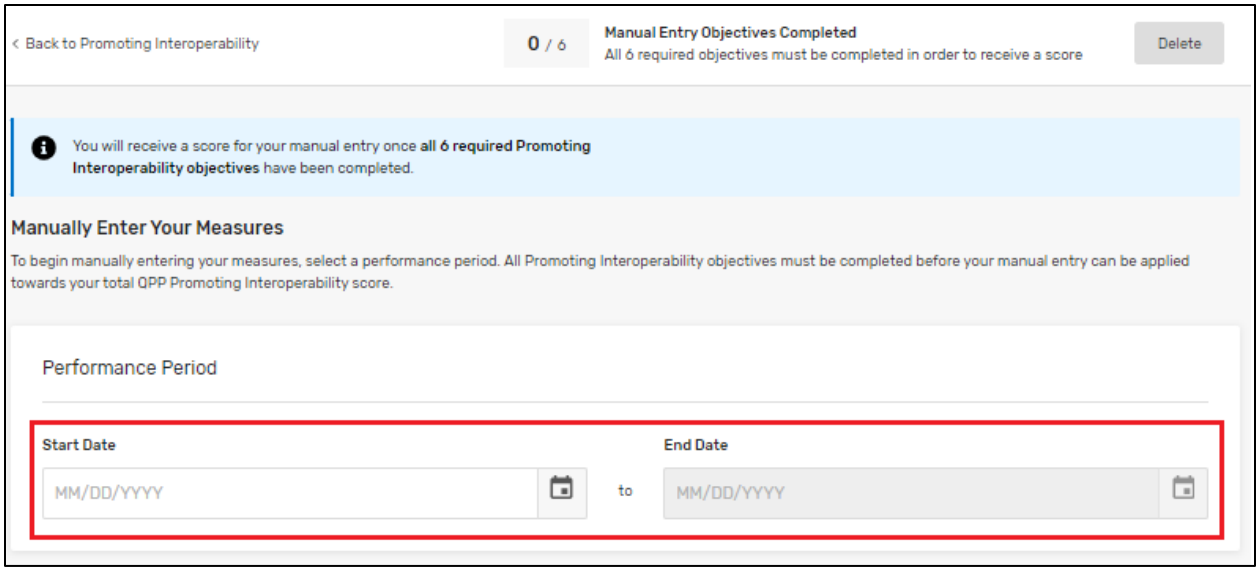


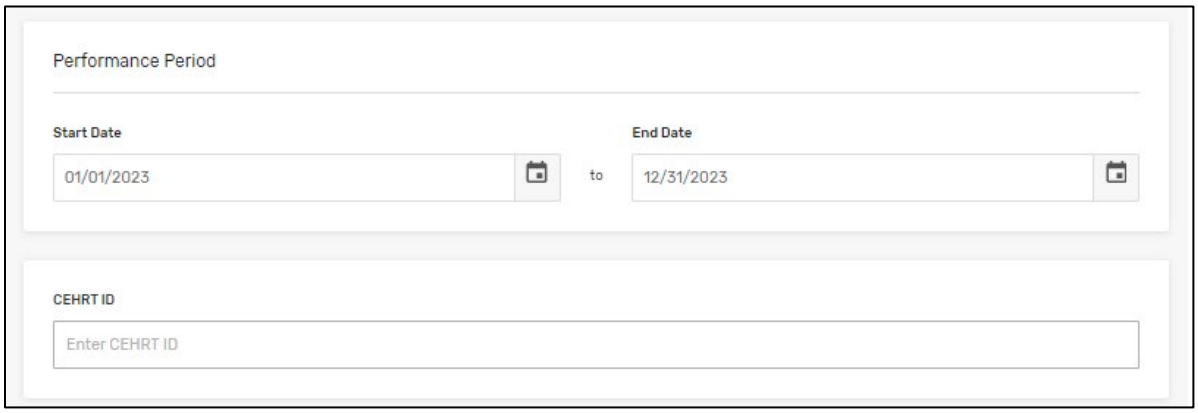


If your Promoting Interoperability performance category is currently weighted at 0%, you will be prompted to confirm that you wish to proceed (click **Yes I, Agree** then **Continue**).

If you click Continue and enter any data, including performance period dates, you will receive a score in this performance category.

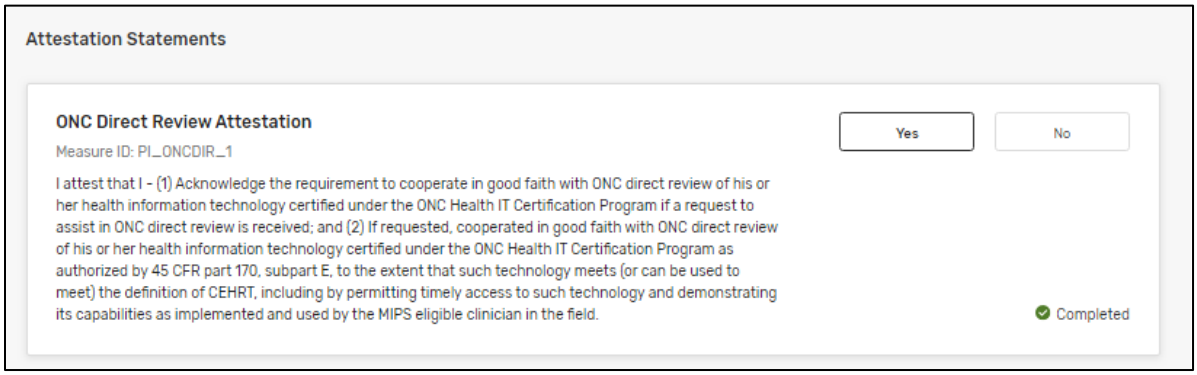






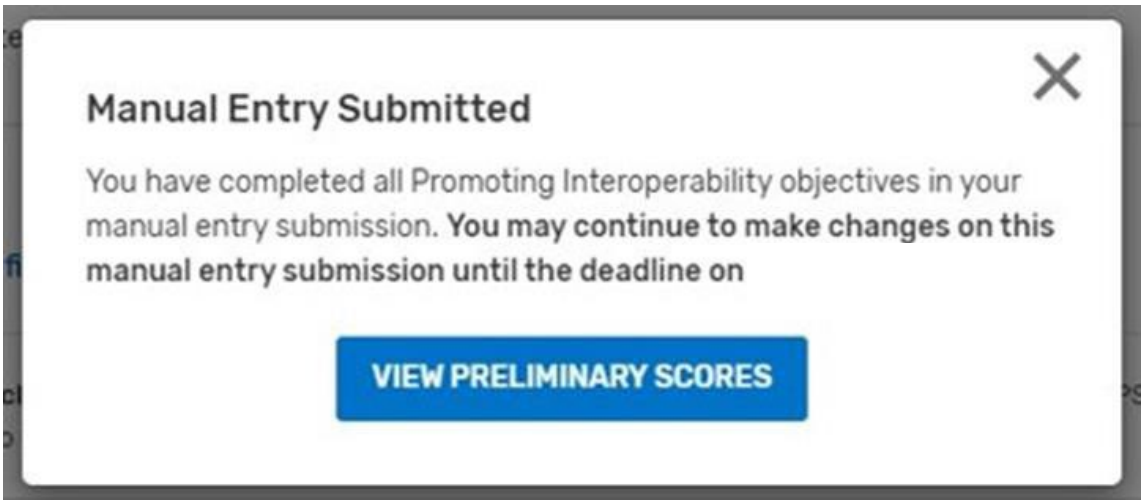
Complete Required Attestation Statements and Measures

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.**



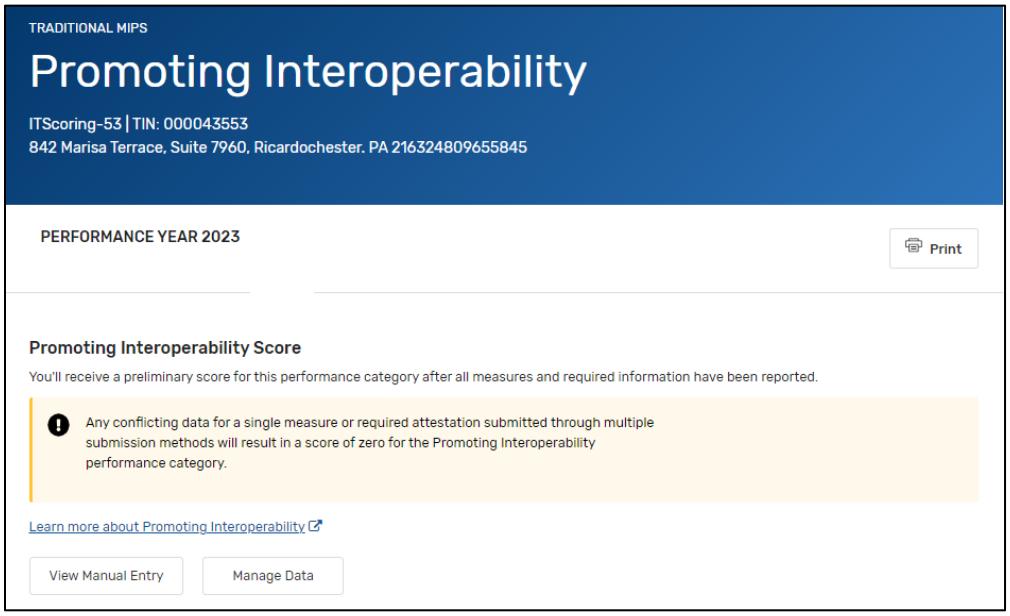
To manually report a measure, you will need to either select **Yes** or enter the **numerator/denominator** value, according to the measure. You can also claim an exclusion if you qualify.

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

From the Reporting Overview, click **View & Edit**.



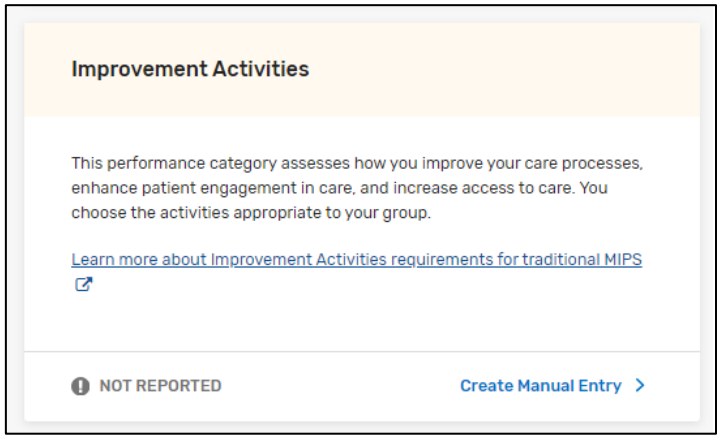
Submitting and Reviewing Improvement Activities Data

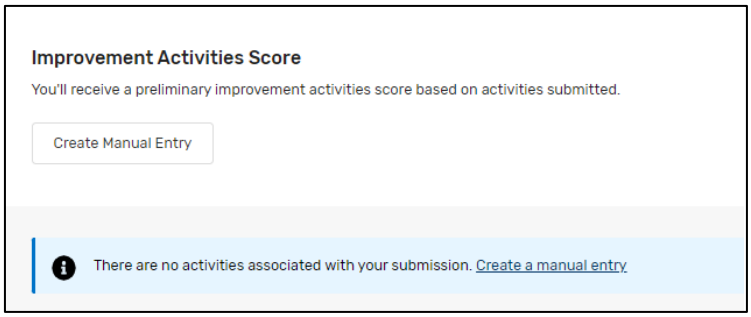
You can upload a QRDA III or QPP JSON file with your Improvement Activities data on the Reporting Overview page.

Manual Entry (Attestation)

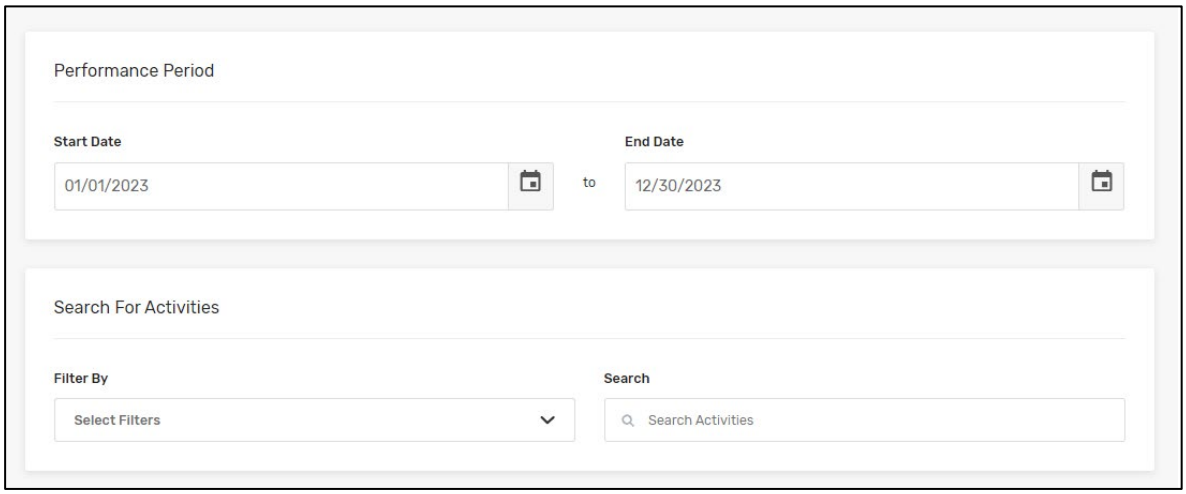
You can also attest to your Improvement Activities data by manually entering yes values to indicate you've completed the activity.

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





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.



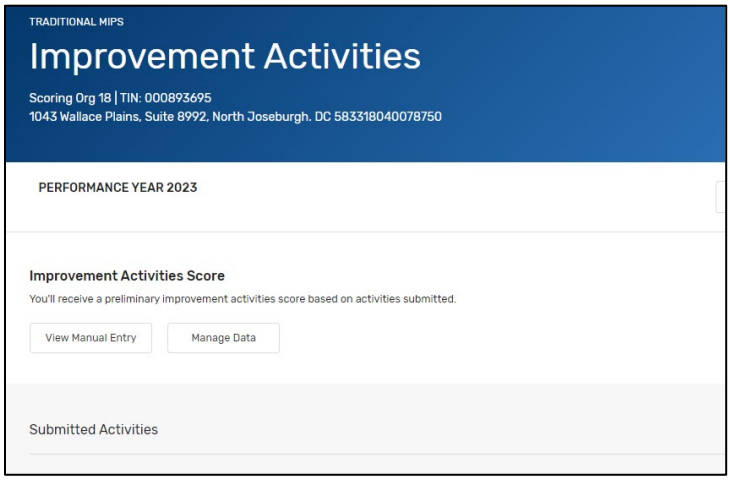
Each *activity* has a continuous 90-day performance period (or as specified in the activity description), but multiple activities don't have to be performed during the same 90- day period. If your improvement activities are performed at different times during the year, your performance period at the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

Review Previously Submitted Data

From the Reporting Overview, click **View & Edit**.



MIPS Value Pathways (MVPs)

Currently, you are not required to report on a MIPs Value Pathway (MVP). MVPs serve as an alternative reporting option that can be used to fulfill MIPS reporting requirements. MVPs consist of a specific set of measures and activities associated with a particular medical specialty or condition.

MVPs provide a more integrated evaluation of care quality, a simplified and condensed set of metrics and improvement initiatives, improved performance feedback, an opportunity to gain insight into MVPs and the future of MIPS and can potentially alleviate reporting burden across CMS programs.

For CY 2025, if you chose to report a MVP, the American Academy of Sleep Medicine (AASM) recommends submitting the Pulmonology Care MVP. The Pulmonology Care MVP concentrates on evaluating the best care for patients undergoing treatment for various pulmonology conditions, such as COPD, asthma, sleep apnea, and general pulmonary issues

.

Quality	Improvement Activities	Promoting Interoperability
Q047: Advance Care Plan Q052: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Q277: Sleep Apnea: Severity Assessment at Initial Diagnosis	IA_AHE_3: Promote use of Patient-Reported Outcome Tools (High) IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols (Medium) IA_AHE_12: Practice Improvements that Engage Community Resources to Address Drivers of Health (High) IA_BE_23: Integration of patient coaching practices between visits (Medium) IA_CC_9: Implementation of practices/processes for developing regular individual care plans (Medium)	• Security Risk Analysis • High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) • e-Prescribing • Query of Prescription Drug Monitoring Program (PDMP) • Provide Patients Electronic Access to Their Health Information • Support Electronic Referral Loops By Sending Health Information AND • Support Electronic Referral Loops By Receiving and Reconciling Health Information OR • Health Information Exchange (HIE) Bi-Directional Exchange OR

Q279: Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy Q398: Optimal Asthma Control Q487: Screening for Social Drivers of Health Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months ACEP25: Tobacco Use: Screening and Cessation Intervention for Patients with Asthma and COPD	IA_EPA_2: Use of telehealth services that expand practice access (Medium) IA_ERP_6: COVID-19 Vaccine Achievement for Practice Staff (Medium) IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways (High) IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation IA_PM_13: Chronic care and preventative care management for empaneled patients (Medium) IA_PM_16: Implementation of medication management practice improvements (Medium)	• Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) • Immunization Registry Reporting • Syndromic Surveillance Reporting (Optional) • Electronic Case Reporting • Public Health Registry Reporting (Optional) • Clinical Data Registry Reporting (Optional) • Actions to Limit or Restrict Compatibility or Interoperability of CEHRT • ONC Direct Review Attestation

Timeline and Important Dates:

Past Dates:

October 2, 2023

Virtual Group Election Opens for Performance Year (PY) 2024

November 2023

The 2024 CY Physician Fee Schedule (PFS) Final Rule is Released

Initial PY 2024 MIPS Eligibility Available

December 31, 2023

Virtual Group Election Closes for PY 2024

January 1, 2024

PY 2024 Begins

April 1, 2024

Registration Opens for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

If you want to administer the CAHPS for MIPS survey, you need to register between April 1 and July 1, 2024.

Registration Opens for MIPS Value Pathways (MVPs)

To report an MVP in the 2024 performance year, you'll need to register between April 1 and December 2, 2024.

Spring/Summer 2024

Quality Payment Program Exception Applications Window Opens (Window Closes December 31, 2024)

July 1, 2024

Registration Ends for CAHPS for MIPS Survey

If you'll report the CAHPS for MIPS Survey associated with an MVP, you must also complete the MVP registration by July 1, 2024 to align with the CAHPS for MIPS registration deadline.

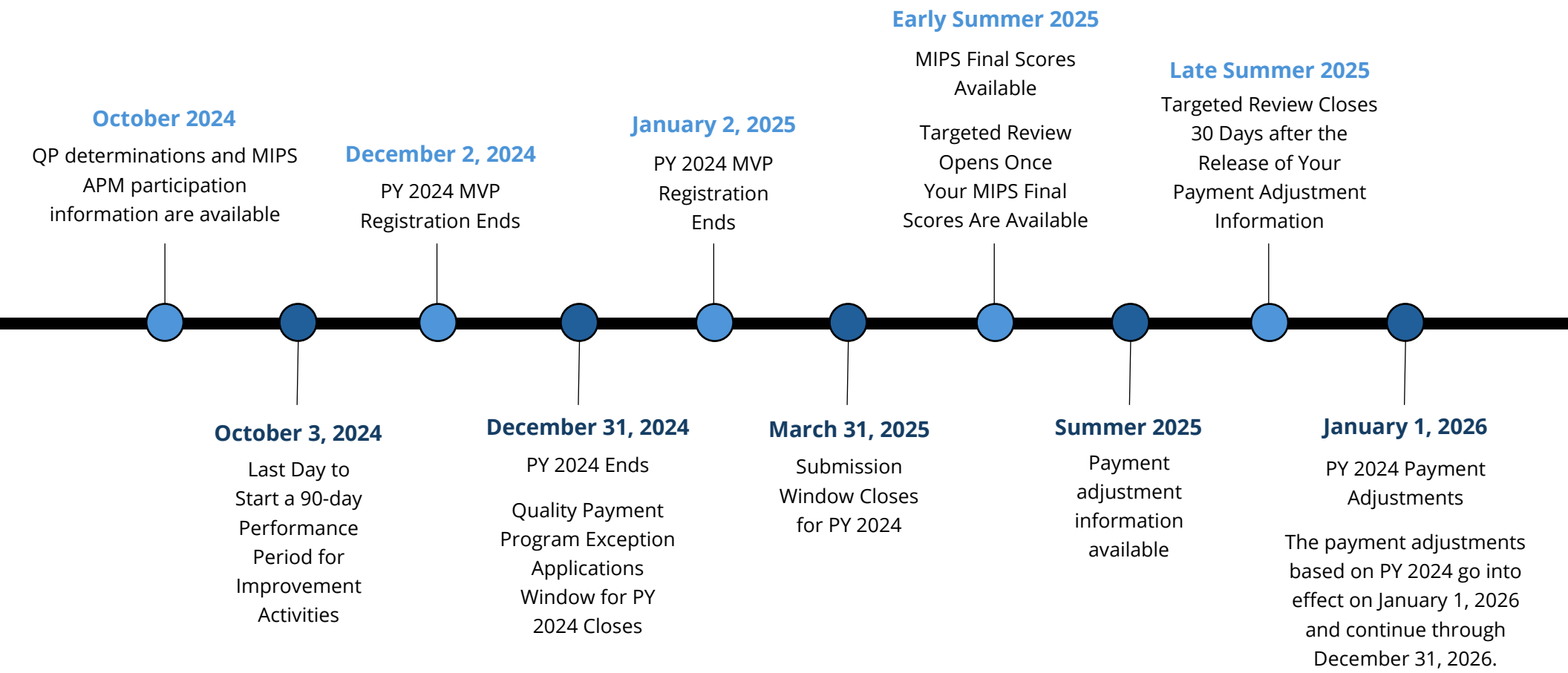
July 5, 2024

Last Day to Start a 180-day Performance Period for Promoting Interoperability

July 2024

Qualifying Participant (QP) determinations and MIPS APM participation information are available

OCTOBER 2024 – 2025 TIMELINE FOR PY 2024



Recommended Quality Measures

MEASURE NAME	MEASURE DESCRIPTION	QUALITY ID	MEASURE TYPE	HIGH PRIORITY MEASURE	PRIMARY MEASURE STEWARD
Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy.	Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea (OSA) that were prescribed an evidence-based therapy that had documentation that adherence to therapy was assessed at least annually through an objective informatics system or through self-reporting (if objective reporting is not available)	279	Process	FALSE	American Academy of Sleep Medicine
Sleep Apnea: Severity Assessment at Initial Diagnosis	Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI), a respiratory disturbance index (RDI), or a respiratory event index (REI) documented or measured within 2 months of initial evaluation for suspected obstructive sleep apnea.	277	Process	FALSE	American Academy of Sleep Medicine
Adult Immunization Status	Percentage of patients 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.	493	Process	FALSE	National Committee for Quality Assurance
Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	240	Process	FALSE	National Committee for Quality Assurance
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for	Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs).	484	Outcome	TRUE	Centers for Medicare & Medicaid Services

Patients with Multiple Chronic Conditions					
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	236	Intermediate Outcome	TRUE	National Committee for Quality Assurance
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	1	Intermediate Outcome	TRUE	National Committee for Quality Assurance
Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.	130	Process	TRUE	Centers for Medicare & Medicaid Services
Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	318	Process	TRUE	National Committee for Quality Assurance
Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups	This measure is a re-specified version of the measure, "Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition" (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.	479	Outcome	TRUE	Centers for Medicare & Medicaid Services
Immunizations for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine (serogroups A, C, W, Y), one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	394	Process	FALSE	National Committee for Quality Assurance

Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit during the measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization.	110	Process	FALSE	National Committee for Quality Assurance
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.	134	Process	FALSE	Centers for Medicare & Medicaid Services
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.	317	Process	FALSE	Centers for Medicare & Medicaid Services
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.	226	Process	FALSE	National Committee for Quality Assurance
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.	431	Process	FALSE	National Committee for Quality Assurance
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement period. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	239	Process	FALSE	National Committee for Quality Assurance

Recommended Improvement Activities

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	SUBCATEGORY NAME	ACTIVITY WEIGHTING
Drug Cost Transparency	Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.	IA_BE_25	Beneficiary Engagement	High
Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co- prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	IA_PSPA_31	Patient Safety And Practice Assessment	High
Promoting Clinician Well-Being	Develop and implement programs to support clinician well-being and resilience for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being using one of the following approaches: Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement.	IA_BMH_12	Behavioral And Mental Health	High
Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	IA_AHE_6	Achieving Health Equity	High
Regular training in care coordination	Implementation of regular care coordination training.	IA_CC_7	Care Coordination	Medium

Tobacco use	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	IA_BMH_2	Behavioral And Mental Health	Medium
Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	IA_BE_12	Beneficiary Engagement	Medium
Use of telehealth services that expand practice access	Create and implement a standardized process for providing telehealth services to expand access to care.	IA_EPA_2	Expanded Practice Access	Medium

Frequently Asked Questions (FAQs)

HARP Registration

1. **How is my identity verified?**

HARP uses Experian remote identity proofing to verify identity.

2. **Why do I have to enter my personal information?**

The personal information that uniquely identifies you, like your SSN, is used to verify your identity through Experian's remote proofing process.

This information is used to create personalized remote proofing questions later in the registration process that you will answer to verify your identity.

Connect to an Organization

1. **Which QPP Role should I select?**

Staff User - to view eligibility information, submit quality data, request a targeted view

Security Official - to view eligibility information, submit quality data, request a targeted view, approve or deny role requests from other users

2. **What if the information I provided for my Security Official role request could not be validated?**

If you receive a validation error message, please verify and re-enter the required information. If the issue persists, contact QPP for further assistance by phone at 1-866-288-8292 (TRS: 711) or by email at qpp@cms.hhs.gov.

Submission

1. **What If We Find an Error During Final Score Preview?**

If you believe there's an error with information displayed during the Final Score Preview period, please contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or call 1-866-288-8292 (Monday – Friday, 8 a.m. – 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

2. **What if my data doesn't successfully upload?**

You may have uploaded a file for a different NPI. Check that the 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.

General

1. **Where can I find more information on QPP policies finalized in the Calendar Year (CY) 2025 Physician Fee Schedule (PFS) Final Rule?**
2. **Does the American Academy of Sleep Medicine have a workbook that members can use to identify eligible patients for each quality measure?**

Yes, a workbook has been developed to help members identify eligible patients for each quality measure. This resource can be utilized to support MIPS preparation as well as individual quality improvement efforts and initiatives. The AASM Quality Measure Portfolio can be found here.

3. **Who can I reach out to with additional questions?**

For questions about the AASM MIPS Submission Toolkit, Measure Testing Workbooks, or MIPS please send emails to registry@aasm.org

Reference Page

Centers for Medicare and Medicaid Services. (April 2022). QPP Access at a glance

Centers for Medicare and Medicaid Services. (November 2023). Register for a HCQIS Access Roles and Profile (HARP) Account

Centers for Medicare and Medicaid Services. (December 2023). Connect to an Organization and Select a Role

Centers for Medicare and Medicaid Services. https://qpp.cms.gov/resources/resource-library