Physician Fee Schedule Proposed Rule for 2023
Summary Part III

Medicare and Medicaid Program: 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

[CMS-1770-P]

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2023[1] and other revisions to Medicare Part B policies. The proposed rule is scheduled to be published in the July 29, 2022 issue of the *Federal Register*. If finalized, policies in the proposed rule generally would take effect on January 1, 2023. **The 60-day comment period ends at close of business on September 6, 2022.**

HFMA is providing a summary in three parts. Part I covers sections I through III.N (except for Section G: Medicare Shared Savings Program Requirements) and the Regulatory Impact Analysis. Part II covers the Medicare Shared Savings Program Requirements.

Part III covers the updates to the Quality Payment Program, including the Traditional Merit-based Incentive Payment System (MIPS), MIPS Value Pathways, and the Alternative Payment Model Incentive.

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[1] Henceforth in this document, a year is a calendar year (CY) unless otherwise indicated.

IV. Quality Payment Program

A. Background and Impact

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for updates to the Physician Fee Schedule (PFS), replacing the SGR with the Quality Payment Program (QPP). Key features of the QPP for 2023 are as follows:

- Two participant tracks: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs);[2]
- Continued development of the APM Performance Pathway and MIPS Value Pathways (MVPs) within the MIPS track as well as continuation of Traditional MIPS;
- Two-year lag between each performance year and its corresponding payment year;[3]
- Payment adjustments (two-sided risk) for MIPS-eligible clinicians based on their reported data for four performance categories: Quality, Cost, Improvement Activities (IA) and Promoting Interoperability (PI); per statute, adjustments plateaued at a maximum of ± 9 percent starting in performance year 2020/payment year 2022 and for subsequent years;
- Lump sum ("bonus") APM incentive payments through payment year 2024 to clinicians whose participation in Advanced APMs exceeds pre-set thresholds that increase over time per statute ("APM Qualifying Participants" or "QPs");
- No APM track incentive payment or adjustment for QPs;
- Bonus replacement, per statute, in payment year 2026 by a higher annual PFS update percentage for QPs than non-QPs (0.75 vs. 0.25 percent, respectively); and
- QPP annual updates that are implemented as part of the PFS rulemaking process.

CMS describes "Traditional MIPS" as the original framework available to MIPS eligible clinicians for collecting and reporting data to MIPS that was established in the first year of the QPP, including the four statutory performance categories.[4] MIPS eligible clinicians who are also participants in MIPS APMs (e.g., Bundled Payments for Care Improvement, Advanced model – BPCI Advanced) may report to MIPS through the APP.[5] Beginning with performance year 2023, all MIPS eligible clinicians may report to MIPS through an MVP that is relevant to their practices, if available.

2023 will be the QPP's seventh performance year and fifth payment year. MIPS payment adjustments will be applied, and APM incentive payments will be made, to eligible clinicians

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[2] QPP participants include the following practitioner types: physician (as defined in section 1861(r) of the Act), physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, physical therapist, occupational therapist, clinical psychologist, qualified speech-language pathologist, qualified audiologist, and registered dietician and nutrition professional, clinical social workers, and certified nurse-midwives.

[3] 2017 was the program's first performance year and 2019 was the associated first payment year. CMS also uses the term "QPP Year". QPP Year 1 is the same as 2017, so that 2023 will be QPP Year 7.

[4] See the Traditional MIPS Overview section of the QPP Resource Library at https://qpp.cms.gov/mips/traditional-mips#:~:text=Traditional%20MIPS%2C%20established%20in%20the,%2C%20Promoting%20Interoperability%2C%20and%20cost.

[5] MIPS APMs are a subset of APMs that are designated as such by CMS who participate under an agreement with CMS and base payment on quality measures and cost/utilization. See §414.1376(b).

based upon their 2021 performance data.[6] Performance category weights would be unchanged, as shown in a table below. MIPS adjustments will range from -9 to +9 percent, made to payments for covered Part B professional services furnished during 2023. CMS proposes to set at 75 points the overall MIPS performance score threshold on which adjustments would be based. Some clinicians who met a separately-specified, higher performance threshold in 2021 are receiving an additional positive adjustment in payment year 2023 for exceptional performance. Per statute, 2022 was the final performance year for the exceptional performance bonus, and final payments will be made in 2024 based on 2022 data.

Budget neutrality is required within MIPS by statute. CMS estimates that positive and negative payment adjustments distributed in payment year 2024 will each total $499 million. CMS further estimates that the maximum possible MIPS positive payment adjustment attainable for payment year 2025 will be approximately 6.9 percent.[7] CMS emphasizes that estimates are based on modeling with 2019 performance data and are likely to change as newer data become available, particularly since a substantial number of clinicians subject to MIPS are projected to have total performance scores very close to the proposed MIPS payment adjustment threshold of 75 points for performance year 2023/payment year 2025.

The 2023 APM incentive payment is set by statute at 5 percent of a QP's covered Part B professional services and will be calculated using services furnished during 2022. Also per statute, 2022 is the final performance year for the APM incentive payment, and final bonus payments will be made in payment year 2024 based on services furnished in 2023. The thresholds of payments or patients treated through APMs necessary to reach QP status are set to increase for performance year 2023 and subsequent years. The thresholds will revert to levels previously specified in statute to begin with performance year 2021 but delayed until 2023 by the Consolidated Appropriations Act, 2021. CAA provided that thresholds be held constant at 2020 levels for performance years 2021 and 2022. Because the 5 percent APM bonus expires at the end of performance year 2022, there will be no QPP APM bonus expenditures from the Medicare program for performance year 2023/payment year 2025. The bonus is replaced by a conversion factor differential starting in payment year 2026.

For the QPP overall, CMS estimates that approximately 865,000 clinicians will be MIPS-eligible during the 2023 performance period, while another 425,000 would be potentially MIPS-eligible but not required to participate. CMS further estimates that between 144,700 and 186,000 eligible clinicians will become QPs and thereby excluded from MIPS.

More information about all aspects of the QPP is available for download at https://qpp.cms.gov/resources/resource-library.

[6] CMS responses to the COVID-19 PHE may continue to affect some 2023 QPP data reporting and scoring policies.
[7] CMS makes estimates under several sets of assumptions, which produce varying results as discussed in detail in the Regulatory Impact Analysis. The result shown here assumes all proposed policies are finalized.

Performance Category Weights by Performance Year					
Performance Category	**Performance Year 2020** ***Final PHE-modified****	**Performance Year 2021** ***Final Rule***	**Performance Year 2021** ***Final PHE-modified****	**Performance Year 2022** ***Final Rule***	**Performance Year 2023** ***Proposed***
Quality	55%	40%	55%	30%	30%
Costs	0%	20%	0%	30%	30%
Improvement Activities	15%	15%	15%	15%	15%
Promoting Interoperability	30%	25%	30%	25%	25%

*Due to COVID-19 PHE impacts on 2020 and 2021 Cost category measure data reliability, CMS reweighted the Cost category to 0% after the respective final rules were published (for 2020 see https://qpp-cm-prod-content.s3.amazonaws.com/uploads/816/2020 Cost Quick Start Guide.pdf and for 2021 see https://qpp.cms.gov/mips/cost?py=2021). For clinicians eligible for reweighting of additional categories, reweighting policies at §414.1380(c)(ii)(2) are applicable.

B. Summary of Major Proposals for 2023 (QPP Year 7)

Changes to the QPP for 2023 are proposed in Section IV of the rule and if finalized would become effective January 1, 2023, unless otherwise noted. Changes to Traditional MIPS generally are applicable to the MIPS Value Pathways (MVPs) and the APM Performance Pathway (APP) unless precluded by pathway-specific policies.

CMS proposes a number of changes involving MVPs, including:

- Additional requirements regarding subgroup reporting,
- 5 new MVPs, involving care of cancer, kidney disease, and neurological conditions as well as provision of optimal preventive care,
- Revised specifications for all 7 MVPs previously finalized for implementation beginning with performance year 2023, and
- Adding opportunities for public comment on candidate MVPs prior to rulemaking.

Proposals related to the APM track include the following.

- Modifying the Advanced APM criterion for payment to be linked to quality to allow linkage to be met through performance on a single outcome measure,
- Modifying the Advanced APM generally applicable nominal risk standard to permanently adopt a revenue-based risk threshold of 8 percent, and
- Modifying the Advanced APM 50-clinician limit provision of the medical home model risk-bearing standard to apply at the APM Entity level rather than at the parent organization level.

Changes being proposed for Traditional MIPS include:

- Increasing the data completeness threshold for quality measures from 70 percent to 75 percent,
- Establishing a maximum Cost category improvement score of 1 percentage point, and

- Discontinuing automatic reweighting of the Promoting Interoperability category to zero percent for physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists.

CMS invites general comments on all of its QPP proposals; more specific comment requests will be highlighted below in the relevant sections of this summary. CMS also issues multiple Requests for Information (RFIs) that involve the APM track and Traditional MIPS. Topics newly addressed include transitioning from the lump sum APM bonus payment to the differential conversion factor update for QPs versus non-QPs and making QP determinations at the individual clinician level rather than at the APM Entity level. Follow-on requests are made for further input on health equity and digital quality measurement as applicable to the QPP.

C. Requests for Information

1. Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs

CMS has previously stated its plan to move fully to digital quality measurement across its quality reporting and value-based purchasing programs, and sought input about doing so in the QPP through an RFI in the 2022 PFS final rule (86 FR 65377 through 65382). CMS now follows up by inviting comments on initiatives for continuing to advance towards digital quality measurement and the use of Fast Healthcare Interoperability Resources (FHIR®) in the QPP. Specifically, **CMS requests input relating to a refined definition for *digital quality measure (dQM)*, data standardization, and approaches to reporting electronic clinical quality measures (eCQMs) based on FHIR standards, as follows.**

- Provide feedback on defining dQMs as "quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems".
- Are there potential considerations or challenges related to using non-EHR data sources for dQMs?
- Provide feedback on the specific implementation guides being considered by CMS.
- Suggest additional FHIR implementation guides to be considered.
- Describe other data and reporting components where standardization should be considered to advance data standardization for a learning health system.
- Are there additional venues beyond those described in the rule by which to engage with implementors during the transition to digital quality measurement?
- What data flow options should CMS consider for FHIR-based eCQM reporting, including retrieving data from EHRs via FHIR APIs and other mechanisms, and are there other critical considerations during the transition to FHIR-based measures?

2. Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS describes the structure of TEFCA and the history of its development. Version 1 was released by the Office of the National Coordinator (ONC) for Health Information Technology

(HIT) on January 18, 2022. Goals set by ONC for TEFCA include establishing a universal policy and technical floor for interoperability, simplifying connectivity for organizations to securely exchange HIT to improve patient care, and enabling individuals to gather their own healthcare information. **CMS asks the following questions about the role of TEFCA in its programs:**

- What are the most important use cases for different stakeholder groups that could be enabled through widespread information exchange under TEFCA? What key benefits would be associated with effectively implementing these use cases, such as improved care coordination, reduced burden, or greater efficiency in care delivery?
- What are key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different stakeholders, including those in rural areas, under TEFCA? In addition to the ideas discussed previously, are there other programs CMS should consider in order to advance exchange under TEFCA?
- How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs? Under what conditions would it be appropriate to require information exchange under TEFCA by stakeholders for specific use cases?
- What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some stakeholders? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?

D. Definitions

At §414.1305, CMS proposes to revisions to definitions for 6 terms: Multispecialty group, Single specialty group, Facility-based group, Facility-based MIPS eligible clinician, High priority measure, and Third party intermediary. Each term is discussed later in the rule and this summary in its utilization context.

E. MIPS Value Pathways (MVPs)

CMS introduced the concept of MVPs during the 2020 PFS rulemaking cycle as "the future state of MIPS" and has continued their development through subsequent cycles. Each MVP contains quality and cost measures and improvement activities with a definable focus (e.g., a disease, a specialty, an episode of care) that are superimposed on a population health measure(s) (e.g., all-cause readmission for patients with chronic conditions). All MIPS Promoting Interoperability performance category requirements are incorporated into each MVP. The first 7 MVPs were adopted into the QPP in the 2022 PFS final rule (86 FR 65998 through 66031).

CMS states goals to be achieved through moving from Traditional MIPS to MVPs include advancing value-based care, informing patient healthcare decision making, enabling clinicians to achieve better outcomes through more robust and interoperable data, and facilitating clinician movement into APMs. CMS also states plans to use MVPs and the APP as part of its broad initiative to advance health equity throughout the agency's quality enterprise, including the QPP. CMS confirms its intention for MVPs to become the only method available to participate in

MIPS in future years. However, CMS notes having not yet finalized the timing for the sunset of Traditional MIPS and makes no proposals for doing so in this rule.

Several MVP-related proposals in this rule address operational aspects of subgroup reporting (e.g., establishing a subgroup determination period). Other proposed policies incorporate public comment opportunities into the MVP development and maintenance processes, modify MVP performance scoring, add 5 new MVPs, and revise all 7 existing MVPs. All 12 MVPs would be available for reporting by clinicians beginning with performance year 2023/payment year 2025. The MVPs are fully described later in the rule as Appendix 3: MVP Inventory. CMS also issues an RFI addressing alignment of MVP and APM Participant Reporting. Later in the rule, CMS indicates that the agency is unable to quantify the additional burden, if any, imposed by the subgroup proposals.

1. MVP Development and Maintenance

a. Public Comment Opportunities

CMS proposes to modify the established MVP development process by creating a formal opportunity for public comment on candidate MVPs. Once CMS determines that a newly submitted MVP is "ready for feedback", a draft version would be posted for a 30-day comment period on the QPP website (https://qpp.cms.gov). CMS does not state how the public would be informed that an MVP draft was available. From feedback received, CMS would determine whether revisions of the draft were appropriate and incorporate them into the candidate MVP prior to proposing to add that MVP to the QPP during PFS rulemaking. CMS notes that the submitters of the candidate MVP would not be notified about changes made prior to PFS proposed rule publication.

Similarly, CMS proposes to modify the established MVP annual review and maintenance process. CMS would select from recommendations it has received about each existing MVP those the agency judges to be potentially feasible and appropriate.[8] Recommendations selected would be shared and open to comment during a CMS-hosted public-facing webinar that would be announced through the QPP listserv. CMS would determine what if any MVP revisions are necessary based on input from the webinar and incorporate them into proposals made during PFS rulemaking.

CMS believes that adding the two formal opportunities for feedback proposed above would reach a wider audience (e.g., patients and patient advocates, clinicians from rural and underserved areas) and provide a broader set of perspectives for consideration by CMS during development and maintenance of MVPs.

b. New and Revised MVPs

[8] The established MVP maintenance process begins with an annual public solicitation for recommendations about all existing MVPs.

CMS proposes to add 5 new MVPs to the MVP Inventory and refers readers to Appendix 3 where their respective measures and activities are specified and the clinician types for which each MVP is likely to be relevant are identified. The new MVPs address the areas listed below.

- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Neurological Conditions
- Supportive Care for Cognitive-Based Neurological Conditions
- Promoting Wellness

The areas addressed by existing MVPs are listed below. CMS proposes revisions to all 7 to align them with proposals made elsewhere in the rule to add quality measures and remove improvement activities that are not relevant to these MVPs. Readers are referred to Appendix 3 where measures and improvement activities are specified and rationales for changes provided.

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support of Positive Experiences with Anesthesia

c. MVP Reporting Requirements and Scoring Policies

CMS notes that each MVP is required to include the full set of MIPS Promoting Interoperability (PI) performance category measures as found in Traditional MIPS. Proposals for Traditional MIPS PI category measure and policy changes are fully described later in the rule and this summary, including:

- Requiring for mandatory reporting the Query of Prescription Drug Monitoring Program measure and expanding the drugs covered in the measure,
- Revising reporting requirements within the Public Health and Clinical Data Exchange Objective,
- Adding a new measure to the Health Information Exchange Objective,
- Revising the types of non-physician practitioners eligible for automatic reweighting of the PI category to 0 percent, and
- Modifying the PI category scoring methodology.

CMS states that scoring policies from Traditional MIPS are routinely adopted for MVP scoring unless CMS determines otherwise. Proposals for changes to Traditional MIPS scoring policies are listed below and are fully described later in the rule and this summary. If finalized, they will apply to all MVPs.

- Determining benchmarks for administrative claims quality measures,
- Assigning measure achievement points for topped out quality measures, and
- Establishing improvement scoring values for Cost performance category measures.

Finally, CMS responds to stakeholder queries seeking clarification about how multispecialty groups practicing team-based care can report MVPs. CMS encourages these groups to review the MVP Inventory. If a single MVP includes measures attributable to all of a group's participating clinician types, the group may report to MIPS through that MVP for PYs 2023 through 2025. However, after that time, reporting options for multispecialty groups will change, as discussed later in the rule and this summary (i.e., subgroup reporting will mandatory). CMS strongly urges these groups instead to proactively adopt subgroup reporting before the deadline, as multiple specialties may be represented within a single subgroup as long as they can report using a shared MVP.

d. Request for Information: MVP and APM Participant Reporting

CMS seeks feedback on ways to better align clinician experience between MVPs and APMs. In considering approaches, CMS plans to prioritize those that enhance information available to patients by using specialty-specific performance measurement and that minimize complexity wherever possible. **CMS asks the following:**

- How should CMS use MVPs to obtain more meaningful performance data from both primary care and specialty clinicians and drive improvements for APP reporters and APM participants? What are the associated pros and cons for the suggested solution(s)?
- How should CMS better align clinician experience with MVPs and APMs, and ensure that MVP reporting serves as a bridge to APM participation?
- How should CMS best limit burden and develop scoring policies for APM participants in multispecialty groups who choose to participate in MVPs and report specialty care performance data? Should the agency require APP participants to focus on those clinicians who work in the associated quality measurement clinical area and require subgroup reporting of relevant MVPs for others? Should the agency develop a process for a composite score that incorporates APP measures and other MVP specialty measures?
- What other policy options for MIPS specialty clinician performance data reporting should CMS consider?

2. Subgroup Reporting

a. Definitions

CMS proposes revisions to the definitions of single and multispecialty groups that have consequences for subgroup reporting to MIPS through MVPs. The revisions would stipulate that group member specialty types would be determined by CMS using the specialty codes assigned to clinicians by the agency's Medicare Administrative Contractors (MACs) and that are derived based on Part B claims submitted by clinicians. Single specialty group members would share a common specialty type while multispecialty groups would have members from two or more specialty types. CMS considered basing specialty assignment on data from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) but believes the use of Part B claims to be a better approach (e.g., PECOS in some cases allows a clinician to select more than one primary specialty). Simulation of specialty assignments through both methods were highly

congruent with the variance rate being less than 1 percent. **CMS seeks comment on additional data sources that could be used for specialty type determinations, including the alternative of the provider taxonomy codes used on applications for National Provider Identifiers (NPIs).**

As a result of the revised definitions, the specialty types of subgroup members would also be those assigned by the MACs, as CMS has previously defined a subgroup for the purposes of MVP reporting as a subset of a group that contains at least one MIPS eligible clinician. The proposed definitions if finalized would be applicable to the participation options described in the next section of this summary.

b. MVP Participation Options

CMS established an option for subgroup reporting to MIPS through MVPs in the 2022 PFS final rule (86 FR 65392 through 65394) to begin with performance year 2023. Other MVP participant options include individual clinician, single specialty group, and multispecialty group. The participant options are scheduled to evolve over time as shown in the table below. The timeline for transition from Traditional MIPS to MVPs shown in the table was finalized during 2022 PFS rulemaking and would be unchanged by proposals in this rule. CMS indicates that the date for the sunset of Traditional MIPS has not yet been determined. During 2022 PFS rulemaking, CMS indicated consideration of the end of performance year 2027 as a potential sunset date (86 FR 39356) but has not since referred again to that date.

Table: Potential Timeline for Transition from MIPS to MVPs
(from 2022 PFS Proposed Rule Table 31 with participant option information added by HPA)

Performance Year (PY)	Reporting Options for Clinicians Subject to MIPS
Through end of PY 2022	Traditional MIPS is the sole reporting option for all MIPS eligible clinicians
PYs 2023, 2024, and 2025	Traditional MIPS and MVPs are independent, permissible reporting options; MVP reporting is voluntary Individuals and single and multispecialty groups can report through Traditional MIPS Subgroups may not report through Traditional MIPS MVPs may be reported by individuals, single and multispecialty groups, and subgroups
PY 2026 and subsequent years	Traditional MIPS and MVPs are independent, permissible reporting options until Traditional MIPS sunsets and MVP reporting remains voluntary until that time MVPs may be reported by individuals, single specialty groups, and subgroups Multispecialty groups can no longer report through MVPs as groups but may reconfigure as subgroups to report MVPs Multispecialty groups can continue to report as groups through Traditional MIPS until the sunset of Traditional MIPS
Date Uncertain	Traditional MIPS sunsets and is no longer permissible as a reporting option for any MIPS eligible clinicians Reporting via MVPs is mandatory for all MIPS eligible clinicians and may be done as individuals or subgroups

Table: Potential Timeline for Transition from MIPS to MVPs (from 2022 PFS Proposed Rule Table 31 with participant option information added by HPA)	
Performance Year (PY)	**Reporting Options for Clinicians Subject to MIPS**
End of PY 2027	Potential sunset date for Traditional MIPS
PY 2028 and future years	Assuming a Traditional MIPS sunset date of end of PY 2027, MVPs become the sole reporting option for all MIPS eligible clinicians other than those excluded by other specific policy provisions (e.g., APM QPs and partial QPs, meeting low-volume threshold criteria)

c. Subgroup Registration Requirements

CMS proposes to require that each subgroup provide a description of the composition of the subgroup at the time of subgroup registration. The description may be selected from a list of scenarios provided by CMS or be provided by the subgroup in narrative form. CMS states that narratives are not expected to be lengthy but should reflect the nature of the practice and the subgroup's composition. Several examples are provided, such as *This subgroup represents our cardiovascular line, which includes cardiologists, cardiothoracic surgeons, and other associated professionals*.

CMS has previously established a subgroup registration process to facilitate information exchange between the agency and subgroups (e.g., quality measures selected by the subgroup). Subgroup identifiers will be assigned by CMS once registration is successfully completed. The proposed subgroup description requirement would be added to the following actions to be completed by the subgroup during registration.

- Identify the MVP the subgroup will report (along with specific selections made as required under the chosen MVP such as population health measure to be reported),
- Identify the clinicians in the subgroup by TIN/NPI, and
- Provide a plain language name for the subgroup for purposes of public reporting (e.g., West Side Oncology).

d. Subgroup Composition

CMS proposes to limit each clinician to membership in a single subgroup within each TIN to which the clinician belongs. CMS states that this limitation is necessary in order to properly score each subgroup given confounding operational factors such as the absence of subgroup identifiers on Part B claims. **CMS invites comments on ways to match clinicians to subgroups for MIPS measures reported through Part B claims or calculated using administrative claims.**

CMS notes having not yet otherwise imposed limits on specialty number and types nor on the number of clinicians that may be included in a subgroup and does not propose to do so in this rule. Some limits on subgroup specialty composition might be expected to evolve during subgroup formation because of the shared MVP reporting requirement for subgroups.

e. Subgroup Determination Period (§414.1318(a))

CMS proposes to use the first segment of the MIPS determination period to determine the eligibility of clinicians intending to participate and register as a subgroup in relation to the MIPS low-volume threshold. CMS does so because of technical challenges that arise when merging the MVP subgroup participation framework with the existing 2-year MIPS determination period. If this proposal is finalized, eligibility determined during the first segment will be reviewed by CMS at the time of subgroup registration. To successfully register, a subgroup would be required to include at least one clinician member who does not meet criteria for applicability of the low-volume threshold.

CMS uses the MIPS determination period to identify clinicians eligible to participate in MIPS, though not all will ultimately be required to do so for a given performance year based on other policies (e.g., those in their first year of Medicare enrollment). The period has been established as having 2 segments: (1) an initial 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period, and that includes a 30-day claims run out; and (2) a second 12-month segment beginning on October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the applicable performance period occurs. For the two segments, CMS determines MIPS eligibility using previously established low-volume threshold criteria that take into account the number of and allowed charge amounts for Part B professional services furnished as well as the number of beneficiaries to whom services are furnished.[9]

f. Subgroup Scoring (§§414.1318(b) and 414.1365(d))

CMS proposes to assess subgroups based on their affiliated (parent) group performances for measures in the Cost performance category as well as population health measures and outcomes-based administrative claims measures in the Quality performance category. CMS further proposes that:

- For each cost measure selected by a subgroup from its chosen MVP, the subgroup would be assigned its affiliated group's Cost category score on that measure, if available. Each measure for which a group score is unavailable would be excluded from the subgroup's final score.
- For each selected population health measure in their chosen MVP, a subgroup would be assigned the affiliated group's score on that measure, if available. Should a group score not be available, the measure would be excluded from the subgroup's final score.
- For each selected outcomes-based administrative claims measure in their chosen MVP, a subgroup would be assigned the affiliated group's score on that measure, if available. Should a score not be available, the measure would be assigned a zero score.

CMS makes these proposals because of concerns about the ability of subgroups to meet case minimums for administrative claims measures and to make sure that population health measures

[9] Specific criteria are: allowed charges for covered professional services less than or equal to $90,000; covered professional services furnished to 200 or fewer Medicare Part B-enrolled individuals; or 200 or fewer covered professional services. More information is available at https://qpp.cms.gov/mips/how-eligibility-is-determined#low-volume-threshold.

are scored for all subgroups. Further, CMS is concerned about the transferability of these measures from group to subgroup level reporting. These 3 measure types all have attribution and risk adjustment methodologies within their specifications and have been tested for validity and reliability at the group level. Since the measure data are taken from claims and those claims do not include subgroup identifiers, it is not possible currently to test the measures for validity and reliability at the subgroup level. Also, proper beneficiary attribution to measure cohorts and related risk adjustment for subgroup scoring would be infeasible for most measures in the absence of subgroup identification. For example, the same beneficiary could be attributed to multiple subgroups and groups.

CMS desires to have more granular and better targeted performance data and believes such data could flow from subgroup reporting. CMS states an intent, therefore, to pursue technical solutions to the agency's concerns and enable subgroup reporting across all measures and performance categories in the future. CMS also acknowledges that gaming could be facilitated by the MVP subgroup framework as multispecialty groups could split into subgroups in a manner that avoided being scored on costs, and it intends to monitor for this behavior.

g. Registered Subgroups Without Submitted Data

CMS proposes that a final score will not be assigned to a registered subgroup that does not submit data as a subgroup. During the early, voluntary years of MVP reporting, CMS wants to encourage MVP subgroup participation. However, CMS indicates it will monitor subgroup participation and reporting trends and may revise this policy in the future in anticipation of mandatory MVP reporting. CMS reiterates that MIPS eligible clinician members of subgroups that are registered but do not submit subgroup data are expected to report to MIPS using other options.

h. Subgroup Reporting Examples

CMS notes that its current subgroup policies, and those proposed in this rule if finalized, require that parent groups will continue to submit data for all of their group members, including those who belong to subgroups. As a result, performance data could be submitted at both the group and subgroup level for a single clinician. During 2022 PFS rulemaking, CMS finalized a MIPS final score hierarchy that applies to clinicians with multiple final scores (i.e., based on more than one submission mechanism) that is shown below (86 FR 65537, Table 73).

MIPS Final Scoring Hierarchy	
Scenario	**Final Score to be Used for Payment Adjustments**
TIN/NPI has a virtual group final score, an APM Entity final score, a subgroup final score, and/or an individual final score from MVPs, Traditional MIPS, and/or the APP	Virtual group final score
TIN/NPI has an APM Entity final score, a group final score, a subgroup final score and/or an individual final score from MVPs, Traditional MIPS, and/or the APP	Highest of the available final scores

CMS provides multiple examples illustrating application of the scoring hierarchy in scenarios where a clinician is part of a TIN that includes both clinicians who choose, or not, to participate in subgroups within the TIN. The examples are presented in Tables 76-81 of the rule to which the reader is referred for more information. The table below tracks results for two clinicians using selected portions of Tables 76 and 77.

Clinician A participates in a full group under MVP #1, in a subgroup under MVP #2, and through Traditional MIPS as an individual. Clinician G participates in a full group under MVP #1, in a subgroup under MVP #3, and through Traditional MIPS as an individual. Neither clinician is in a virtual group so the final score awarded to each is the highest of all their available final scores as directed by the hierarchy in the table above.

Clinician	Full Group Score	Subgroup Final Score	Individual Final Score	Clinician FINAL MIPS Score
A (Subgroup #1)	90	80	**98**	**98**
G (Subgroup #2)	90	**97**	60	**97**

F. APM Performance Pathway (APP)

1. Subgroup Reporting through the APP

CMS proposes to disallow reporting through the APM Performance Pathway (APP) by a subset of clinicians within a group, irrespective of whether the group is a single or multispecialty group. This proposal would be implemented by removing a reference to scoring clinician performance at the subgroup reporting under the APP, found currently at §414.1318(c)(2).

CMS states the revision would accomplish 2 purposes: (1) limit potential ambiguity caused if subgroup reporting were to be allowed through 2 different pathways (APP and MVP); and (2) clearly capture in regulation text the agency's original intent that scoring clinicians who report through the APP would be scored only at the group or individual level (i.e., no intervening "subgroup" level). CMS notes that when the APP was introduced as a MIPS participation option, subgroup reporting through MVPs had not yet been established.

The APP was finalized during CY 2021 PFS rulemaking as a MIPS reporting and scoring option for MIPS eligible clinicians belonging to an APM Entity that participates in a MIPS APM. MIPS APMs are a subset of APMs that are designated as such by CMS. Participation in a MIPS APM is governed under an agreement between the APM Entity and CMS, and payments made to MIPS APM clinicians are based on specified quality and cost/utilization metrics (§414.1367(b)). Most Advanced APMs also meet criteria to be MIPS APMs (e.g., BPCI Advanced, Comprehensive Care for Joint Replacement – CJR, Primary Care First). MIPS APM clinicians reporting through the APP receive special treatment when scored for the Cost and Improvement Activities MIPS performance categories.

CMS discusses the possibility that MIPS APM clinicians could desire to form subgroups for reporting through the APP based on shared characteristics (e.g., team-based care groups, similar types of clinical activities, co-located practice sites, or common EHRs). CMS also views

subgroup reporting through the APP as a step towards APM participation for clinicians who have gained experience reporting through a shared MVP. Based on these considerations, CMS requests comment on an alternative – allowing APP reporting at the subgroup level (i.e., not making the proposed change to §414.1318(c)(2)). CMS notes that allowing subgroup reporting through the APP would necessitate creating an APP subgroup registration process, adding to MIPS APM clinician burden. **CMS specifically asks commenters to indicate which option – to allow or to disallow APP reporting at the subgroup level – best balances reporting flexibility with administrative burden.**

2. Performance Category Scoring for Clinicians Reporting though the APP

a. Quality

The APP's Quality performance category measures are drawn from the MIPS Quality Measure Inventory (Appendix 1 of the rule). They are reviewed along with the Shared Savings Program quality standard in section III.J.4 of the rule and section III.G.4. of this summary (this summary section can be found in Part II of HPA's CY 2023 proposed rule summary). The APP quality measure set for performance year is largely unchanged except for a proposal to retitle 1 measure and is listed below.

Measure ID #	Measure Title
Q321	CAHPS for MIPS Survey
Q479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups
Q484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*
Q001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control
Q134	Preventive Care and Screening: Screening for Depression and Follow-up Plan
Q236	Controlling High Blood Pressure
* New measure title as proposed by CMS, otherwise unchanged	

CMS notes that two new measures being considered for future addition to the Inventory and to the APP quality measure set – *MUC21-136: Screening for Social Drivers of Health* and *MUC 21-134: Screen Positive Rate for Social Drivers of Health*. CMS refers readers to section III.J.4 of the rule for a discussion of these measures and of an RFI about their adoption. These measures and the RFI also are discussed in section III.G.4. of this summary (also found in Part II).

Also under consideration by CMS are addition of new questions to the CAHPS for MIPS Survey measure. The questions are intended to address health equity and healthcare price transparency. The questions and a related RFI are discussed in section III.J.4 of the rule to which CMS refers readers. They are also reviewed in section III.G.4. of this summary (also found in Part II).

b. Improvement Activities

Each MIPS APM has associated specified Improvement Activities. These are reviewed annually by CMS and point values assigned to them based on their similarity to measures in the MIPS Improvement Activities Inventory (Appendix 2 of the rule). The activities required by the MIPS APMs generally are assigned values such that a maximum Improvement Activities performance category score is achieved by all MIPS APM participants reporting through the APP.

CMS clarifies that MIPS APM participants may report additional activities from the general MIPS activity inventory but that no additional/bonus category scoring points will be earned.

c. Other Performance Categories

MIPS APM clinicians reporting through the APP will continue to have the Cost performance category reweighted to 0 percent and to follow the reporting policies and requirements of the Performing Interoperability performance category as applicable to Traditional MIPS.

G. MIPS Performance Category Measures and Activities

1. Quality Performance Category

CMS proposes the following changes to the MIPS Quality performance category, to begin with performance year 2023 unless otherwise noted:

- Amend the definition of the term "high priority measure" to include quality measurement pertaining to health equity.
- Replace the "Asian language survey completion" variable with "language other than English spoken at home" variable in the case-mix adjustment model for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey.
- Increase the data completeness criteria threshold to at least 75 percent for 2024 and 2025 performance periods/2026 and 2027 MIPS payment years.
- Modify the MIPS quality measure set as described in Appendix 1 of this rule, including through the addition of new measures, updates to specialty sets, the removal of existing measures, and substantive changes to existing measures.

High Priority Measure Definition
A high priority measure is defined as an outcome (including intermediate-outcome and patient-reported outcome) quality measure, appropriate use quality measure, patient safety quality measure, efficiency quality measure, patient experience quality measure, care coordination quality measure, or opioid-related quality measure.

Starting with the 2023 performance period, CMS proposes to expand the definition of a high-priority measure to include health-equity related quality measures.

CAHPS for MIPS Survey
The case-mix adjustment models for CAHPS for MIPS adjust for patients' characteristics that may impact survey responses but are outside the control of the group. This case-mix adjustment model includes the following characteristics: age, education, self-reported general health status,

self-reported mental health status, proxy response, Medicaid dual eligibility, eligibility for Medicare's low-income subsidy, and Asian language survey completion.

CMS proposes to revise the CAHPS for MIPS Survey measure case-mix adjustment model to remove the existing adjustor for Asian language survey completion and to add adjustors for Spanish language spoken at home, Asian language spoken at home, and other language spoken at home. CMS believes this refinement will capture language preferences more accurately.

a. Data Completeness Criteria

Data completeness refers to the volume of performance data reported for the measure's eligible population. For 2022 and 2023 performance periods, the data completeness threshold is 70 percent.

For 2024 and 2025 performance periods, CMS proposes to increase the data completeness threshold to 75 percent. The data completeness threshold applies to QCDR measures, MIPS CQMs, and eCQMs, regardless of payer. MIPS eligible clinicians or groups who submit quality measure data on Medicare Part B claims must submit data on at least 75 percent of the Medicare patients seen during the performance period, as applicable to the measure being reported.

CMS notes this proposal doesn't apply to CMS Web Interface measures which in the 2023 performance period is only available to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP)

b. Selection of MIPS Quality Measures

For the 2023 performance period, CMS proposes a total of 194 quality measures.[10] Specifically, CMS proposes:

- The addition of 9 new MIPS quality measures, including 1 administrative claims measure; 1 composite measure; 5 priority measures, and 2 patient-reported outcome measures. Table Group A of Appendix 1 lists proposed quality measures.

- Modifications to existing specialty sets and new specialty sets, including recommendations submitted for review as potential new specialty measure sets or revisions to existing measure sets in response to CMS' January 3, 2022 call for specialty set recommendations. Table Group B of Appendix 1 lists these proposals.

- Removal of 15 MIPS quality measures and partial removal of 2 quality measures. Two of the measures proposed for removal from the Traditional MIPS program are proposed for retention for MVP use only. Table Group C of Appendix 1 lists the quality measures and the rationale for the measure removal. Table Group DD lists the measures proposed for retention in the MVP.
    - The MIPS measures proposed for removal include 1 measure that is duplicative of a proposed new measure; 4 measures duplicative of current measures; 7 measures

[10] Qualified Clinical Data Registry (QCDR) measures are approved outside the rulemaking process and are not included in this total.

that do not align with the Meaningful Measure Initiative; 2 measures that are under the topped out lifecycle; and 1 measure that is extremely topped out.

- Substantive changes to 75 existing MIPS quality measures (Table Group D) including s 2 quality measures proposed for retention for the purposes of utilization under MVP (Table Group DD). CMS reviews the established MIPs quality measure inventory on an annual basis.

- Substantive changes to CMS Web Interface measures for MSSP ACO's meeting reporting requirements under the APP; Table Group E of Appendix 1 lists these proposals.

Screening for Social Drivers of Health Proposed Measure
CMS discusses the evidence demonstrating that social risk factors impact health care outcomes, as well as healthcare utilization, costs, and performance. CMS defines health-related social needs (HRSNs) as individual-level, adverse social conditions that negatively impact a person's health or healthcare, are significant risk factors associated with a worse health outcomes as well as increased healthcare utilization.[11]

CMS notes that conceptually, HRSNs exist along a continuum with other equity-related terms, such as "social determinants of health" and "social risk factors" and that the variety of terms has created confusion. CMS decided it will utilize "drivers of health (DOH) to describe the factors that can adversely affect the health of individuals and communities.[12]

To address DOH, CMS proposes the adoption of an evidence-based DOH measure (Table Group A.3) that would enable systematic collection of DOH data. The "Screening for Social Drivers of Health" measure assesses the percent of patients who are 18 years or older screened for food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety.

c. MIPS Quality Performance Category Health Equity Request for Information (RFI)

CMS is considering future inclusion of additional health equity measures in MIPS including a measure similar to the MUC2021-134 Screen Positive Rate for Social Drivers of Health measure that was included on the 2021 Measures Under Consideration (MUC) List.[13] **CMS seeks comments on the following questions to better understand what measures would be appropriate for MIPS**.

- How would a measure best capture health equity needs under MIPS in the future?

[11] CMS (2021). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. June 2021. Available at https://innovation.cms.gov/media/document/ahcm-screeningtool-companion.
[12] "What We Need to Be Healthy-And How To Talk About It," Health Affairs Blog, May 3 2021. Available at https://www.healthaffairs.org/do/10.1377/forefront.20210429.335599/
[13] https://www.cms.gov/files/document/overview-2021-muc-list-20220308-508.pdf

- How would a measure's quality action provide actionable information and link to improvement in the quality of care provided to populations with health inequities? Would a measure be meaningful to clinicians in small practices or FQHCs that may have limited or no access to referral services?
- What, if any, would be the limitations in data interpretation if a future health equity related measure would not be risk-adjusted?
- Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure? Should such a future measure support flexibility in choice of tools while requiring standardized coding of responses to support interoperability?

CMS also seeks comment on the following two potential approaches for measuring health equity in MIPS and MVP: assessing the collection and use of self-reported patient characteristics and assessing patient-clinician communication.

(i) Assessing the Collection and Use of Self-reported Patient Characteristics
CMS acknowledges that a prerequisite for measuring and reporting quality for patients with social risk factors is collecting standardized, complete, and accurate patient data. CMS is considering ways to encourage clinicians to collect social risk factors through the development of a measure that tracks the completeness of self-reported patient characteristics.

CMS seeks comment on the following questions to understand the feasibility and usefulness of a measure that promotes the collection of self-reported patient characteristics data to help understand the status of health and health equity:

- Which self-reported patient characteristics, including but not limited to race, ethnicity, preferred language, gender identity, sexual orientation, disability status, income, education, employment, food insecurity, housing instability, transportation problems, utility help needs and interpersonal safety, are important to collect in a standardized format to facilitate future use in quality measures, such as stratification? What characteristics are lower priority for collection in a quality measure?
- Are there certain characteristics that are important to collect together to more meaningfully categorize patient populations (e.g., examining the intersection of race and gender identity)?
- How important is it to use a standardized tool with coded questions and data elements to collect self-reported patient characteristics across clinicians and practices and what challenges and limitations present without the use of a coded and standardized instrument? How are clinicians collecting and using this information to inform clinical care?
- Would the use of a consistent screening tool(s) improve CMS' ability to meaningfully compare performance across clinicians, (i.e., performance on a measure assessing referrals for identified social needs or measures stratified based on identified needs)?
- What is a meaningful approach for monitoring improvement in standardized collection of self-reported patient characteristic data while minimizing reporting burden?
- Is the proposed quality measure, "Screening for Social Drivers of Health" appropriate for use in the foundational layer of MVPs (Table Group A lists this proposed measure)?

CMS notes that if this is appropriate, then inclusion would require most or all eligible clinicians to screen for social drivers of health during patient encounters.

- Is it appropriate to develop a quality measure to assess clinician referrals to community-based services upon screening positive for a social driver of health, including food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety?

CMS is also interested in understanding differences in clinician's performance on MIPS measures for different patient populations. **CMS seeks comments on the following question:**

- Would it be beneficial to: stratify either outcome or process measures by patient demographics; and/or stratify either outcomes or process measures by identified social needs, such as food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety?

(ii) Assessing Patient-Clinician Communication
CMS is considering the development of a patient-reported outcome measure that assesses the receipt of appropriate language services and/or the extent of clinician-patient communication. **CMS seeks feedback on the feasibility and usefulness of such a measure(s) and the appropriateness of requiring all clinicians to report on such measure(s)**.

d. RFI: Developing Quality Measures that Address Amputation Avoidance in Diabetic Patients

CMS believes lower extremity amputation (LEA) avoidance in diabetic patients is a priority clinical topic for development of both a process quality measure and a composite measure for MIPS. CMS is prioritizing the potential future development of a measure (Ulcer Risk Assessment and Follow-up) which would assess the percent of patients with diabetes who receive neurologic and vascular assessment of their lower extremities to determine ulcer risk, have a documented risk level, and who receive a follow-up plan of care if identified as having a high risk for ulcer. CMS is considering either adoption and modification of an existing measure or development of a new measure.

CMS seeks feedback on the following questions to help development of the process measure.

- Are neurological and vascular assessments, and the determination of risk the most important care processes in the prevention of foot ulceration among individuals with diabetes?
- Once a process quality measure concept would be developed and implemented, would high performance on the measure contribute to a reduction in diabetes-related LEA? Why or why not?
- Once a process quality measure concept were developed and implemented, should performance be measured at the clinician level or group level? Is the measure appropriate for all clinicians? If not, to whom should the measure apply?
- What would be the benefits and/or unintended consequences of the process quality measure concept?

- Would a process quality measure concept contribute to health equity? Why or why not?

A composite measure might include individual measures focused on A1C control, cardiovascular risk factors (e.g., blood pressure control, tobacco non-use), peripheral neuropathy screening, peripheral arterial disease (PAD) screening, evaluation of footwear and offloading when ulcers occur. **CMS seeks feedback on the following questions to help develop a composite measure.**

- Would the single measure comprising the composite be appropriate? Why or why not?
- Once a composite quality measure concept would be developed and implemented, would high performance on the measure contribute to a reduction in diabetes-related LEA?
- Once a composite quality measure concept were developed and implemented, should performance be measured at the clinician level or group level? Would the measure be appropriate for all clinicians? If not, to whom should the measure apply?
- Once a composite quality measure concept would be developed and implemented, would clinicians be able to report performance without undue burden? Why or why not?
- What would be the benefits and/or unintended consequences of a composite quality measure concept?
- Would a composite quality measure contribute to health equity? Why or why not?

2. Cost Performance Category

CMS proposes to update the operational list of care episode and patient condition groups and codes by adding the Medicare Spending Per Beneficiary (MSPB) Clinician cost measure as a care episode group.

The current operation list is available at the MACRA Feedback page.[14] The operation list includes 21 episode groups and 2 patient condition groups. CMS did not include the two population-based measures, the MSPB Clinician and total per capita cost measures, in the operational list after they were comprehensively re-evaluated in 2019 and revised for use in MIPS.

CMS proposes to add the MSPB Clinician measure to the operational list as a care episode group. The MSPB Clinician measure takes into account the patient's clinical diagnosis at the time of an inpatient hospitalization and the costs of various items and services furnished during an episode of care. The measure attributes episodes under MS-DRGs to clinician groups billing at least 30 percent of E/M services during an inpatient stay, the same attribution logic as the one used for acute inpatient medical episode-based measures.[15] CMS believes that designating the MSPB Clinician measure as a care episode group alongside the episode-based measures would ensure that these similarities are reflected in the operational list. CMS has updated the operational list to include the MSPB Clinician measure.[16]

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[14] https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/GiveFeedback

[15] The measure specification documents are available on the QPP Resource Library at https://qpp.cms.gov/about/resource-library.

[16] https://www.cms.gov/Medicare/Quality-Initiative-Patient-Assessment-Instruments/Value-BasedPrograms/MACRA-MIPS-and-APMs/MACRA-Feedback.html

CMS is not proposing to add the total per capita cost measure to the operational list as a care episode group or patient condition group. CMS states this measure is not constructed based on episodes of care but includes all costs after a primary care-type relationship has been identified.

3. Improvement Activities Category

CMS is not proposing any changes to the traditional improvement activities (IA) policies for the 2023 performance period/2025 MIPS payment year but is proposing changes to the IA measure inventory. CMS reminds readers of the Annual Call for Activities process for the addition of possible new activities and modifications to current IA. Stakeholders must submit a nomination form (OMB control #0938-1314) available at www.qpp.cms.gov during the Annual Call for Activities.

CMS is proposing the following changes to the IA Inventory for the 2023 performance period and future years: the addition of four new IAs; modification of five existing IAs; and removing six previously adopted IAs. All of the new proposed activities relate to CMS' Six Health Equity Priorities for Reducing Disparities in Health. CMS proposes to remove six IAs to align with current clinical guidelines and to eliminate duplication. Detailed proposals are provided in Appendix 2 of the rule. New measures proposals are found in Table A, changes to existing IAs are found in Table B; and proposals for removal are found in Table C.

The four proposed new IAs are:

- Use Security Labeling Services Available in Certified Health Information Technology (IT) for Electronic Health Record (EHR) Data to Facilitate Data Segmentation; (IA_AHE_XX);
- Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients (IA_AHE_XX);
- Create and Implement a Language Access Plan (IA_EPA_XX); and
- COVID-10 Vaccine Promotion for Practice Staff (IA_ERP_XX).

4. Promoting Interoperability Performance Category

The Medicare statute includes the meaningful use of certified electronic health record technology (CEHRT) as a performance category under MIPS, which CMS now refers to as the Promoting Interoperability performance category.[17] CMS reviews the history of regulatory changes to this performance category.

a. Performance Period for Promoting Interoperability Performance Category

Based on changes in the 2021 PFS final rule affecting the 2024 MIPS payment year and subsequent MIPS payment years, the performance period for the Promoting Interoperability performance category is a minimum of any continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full

[17] In past rulemaking, CMS referred to it as the advancing care information performance category.

calendar year. Thus, for the CY 2025 MIPS payment year, the performance period is a minimum of any continuous 90-day period within 2023, up to and including the full 2023.

CMS proposes no change to the performance periods.

b. CEHRT requirements

The Promoting Interoperability Program and the QPP require the use of CEHRT, which since 2019 has generally consisted of EHR technology certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program that meets the 2015 Edition Base EHR definition and has been certified to certain other 2015 Edition health IT certification criteria. A 2020 rule finalized a number of updates to the criteria, introduced new criteria, and gave developers 24 months (until May 2, 2022) to make technology available that is certified to the updated or new criteria. Since then, ONC has extended the transition timeline until December 31, 2022 (and until December 31, 2023 for 45 CFR §170.315(b)(10), "electronic health information ((EHI) export").

In the 2021 PFS final rule, CMS aligned the transition period for health care providers participating in the Promoting Interoperability Program or QPP using technology certified to the updated certification criteria to the December 31, 2022 date established by ONC for health IT developers to make updated certified health IT available. After this date, health care providers will be required to use only certified technology updated to the 2015 Edition Cures Update for an EHR reporting period or performance period in 2023.

CMS proposes no change to this policy. CMS also notes that health care providers would not be required to demonstrate that they are using updated technology to meet the CEHRT definitions immediately upon the transition date of December 31, 2022. Participants are only required to use technology meeting the CEHRT definitions during a self-selected EHR reporting period or performance period of a minimum of any consecutive 90 days in CY 2023, including the final 90 days of 2023. The eligible hospital, CAH, or MIPS eligible clinician is not required to demonstrate meaningful use of technology meeting the 2015 Edition Cures Update until the EHR reporting period or performance period they have selected.

c. Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective

A measure for Query of Prescription Drug Monitoring Program (PDMP) exists under the Electronic Prescribing objective. CMS reviews a history of the measure, which has remained optional and eligible for 10 bonus points in recent years, including for the 2022 performance period/CY 2024 MIPS payment year.

CMS notes commenter concerns expressed in the three prior PFS rules stating it was premature for the Promoting Interoperability performance category to require the Query of PDMP measure and score it based on performance. In the 2022 PFS proposed rule (86 FR 39410), CMS discussed its support of efforts to expand the use of PDMPs, describing federally supported activities aimed at developing a more robust and standardized approach to EHR-PDMP

integration, and additional discussions on the feedback received from health IT vendors and MIPS eligible clinicians. Feedback also indicated that effectively incorporating the ability to count the number of PDMP queries in the EHR would require more robust measurement specifications, that EHR developers may face significant cost burdens if they fully develop numerator and denominator calculations and are then required to change the specification at a later date, and that the costs of additional development would likely be passed on to health care providers without additional benefit, as this development would be solely for the purpose of calculating the measure rather than furthering the clinical goal of the measure.

CMS recognizes that while a numerator/denominator-based measure remains challenging, the widespread availability of PDMPs across the country, and recent progress toward solutions for connecting PDMPs with health care provider EHR systems, has made use of PDMPs feasible through a wide variety of approaches. CMS then reviews the use of PDMPs, noting that all 50 States and several localities now host PDMPs. CMS notes a number of enhancements to PDMPs occurring across the country, including enhancements to RxCheck, which is a free, federally supported interstate exchange hub for PDMP data.[18] The SUPPORT for Patients and Communities Act included new requirements for PDMP enhancement and integration, to help reduce opioid misuse and overprescribing and promote the effective prevention and treatment of opioid use disorder beginning October 2021. Enhanced federal matching funds were available to states to support related PDMP design, development, and implementation activities during FYs 2019 and 2020.

CMS proposes to change the Query of PDMP measure. Currently, the measure provides that for at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. CMS proposes, beginning with the performance period in 2023, to require the Query of PDMP measure for MIPS eligible clinicians participating in the Promoting Interoperability performance category, with the following two exclusions:

- Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period, and
- Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

While work continues to improve standardized approaches to PDMP and EHR interoperability, CMS believes it is now feasible to require MIPS eligible clinicians to report the current Query of PDMP measure, which requires reporting a "yes/no" response. Given CMS policies for the

[18] RxCheck is connected to 50 out of 54 PDMPs in states and territories and does not require providers to pay to have the PDMP data integrated into the EHR. The goal of the project is to allow any health care provider who is live on the eHealth Exchange to use that existing connection to query a patient's record on the RxCheck Hub, which routes the query to individual State PDMPs that are also live on RxCheck. Most states use either RxCheck or Prescription Monitoring Program (PMP) InterConnect or both to facilitate the sharing of PDMP information between states, allowing health care providers to query other states' PDMP information from within their own state PDMP.

Query of PDMP measure that included increasing the eligible bonus points to reward MIPS eligible clinicians that could report the measure, as well as the recent progress in the availability of PDMPs in all 50 States, and solutions which support accessibility of PDMPs to health care providers, CMS believes MIPS eligible clinicians have had time to grow familiar with what this measure requires of them, even as technical approaches to the use of PDMPs continue to advance. CMS proposes to maintain the associated points at 10 points for reporting a "yes/no" response for the Query of PDMP measure.

CMS also proposes changes to the Query of PDMP Measure to include not only Schedule II opioids but also Schedule III and IV drugs. The DEA classifies drugs into 5 categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. Schedule I medications have the highest abuse potential (for example, heroin) while medications in Schedule V have a low abuse potential (for example, cough syrups containing codeine). CMS notes that every state currently collects data on schedules II, III and IV. CMS invites public comment on these proposals, as well as on whether to expand this measure to include Schedule V or other drugs with potential for abuse.

Because the Query of PDMP measure has been voluntary, CMS had not finalized any exclusions. CMS is now proposing that the Query of PDMP measure become mandatory beginning with the performance period in 2023 for the Promoting Interoperability performance category with the exclusions proposed above.

CMS proposes that if a MIPS eligible clinician claims an exclusion for the Query of PDMP measure, the points associated with the Query of PDMP measure would be redistributed to the e-Prescribing measure under the Electronic Prescribing Objective.

CMS invites feedback on these proposals and on barriers to reporting on this measure; barriers related to technology solutions, cost and workflow that should be considered for MIPS eligible clinicians; and on any additional exclusions that CMS should consider for this measure in future rulemaking.

d. Health Information Exchange (HIE) Objective: Proposed Addition of an Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS emphasizes that the HIE Objective and its 3 associated measures for MIPS eligible clinicians hold particular importance because of the role they play within the care continuum, encouraging and leveraging interoperability on a broader scale and promoting health IT-based care coordination. CMS reviews the history of the HIE Objective and its measures, which are as follows:

- Support Electronic Referral Loops by Sending Health Information;
- Support Electronic Referral Loops by Receiving and Reconciling Health Information; and
- HIE Bi-Directional Exchange (40 points, the maximum number of points in the HIE Objective, and an alternative to reporting the other two measures).

To meet the Bi-Direction Exchange measure, MIPS eligible clinicians must attest to the following 3 statements:

- I participate in an HIE to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral and record stored or maintained in the EHR during the performance period in accordance with applicable law and policy.
- The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and not engaging in exclusionary behavior when determining exchange partners.
- I use the functions of CEHRT to support bi-directional exchange with an HIE.

The 21st Century Cures Act (Pub. L. 114-255), enacted in 2016, required HHS to take steps to advance interoperability for the purpose of ensuring full network-to-network exchange of health information. As a result, HHS has pursued development of a Trusted Exchange Framework and Common Agreement, or TEFCA. ONC's goals for TEFCA are as follows:

- Goal 1: Establish a universal policy and technical floor for nationwide interoperability.
- Goal 2: Simplify connectivity for organizations to securely exchange information to improve patient care, enhance the welfare of populations, and generate health care value.
- Goal 3: Enable individuals to gather their health care information.

Since CMS adopted the HIE Bi-Directional Exchange measure, important additional developments have occurred with respect to TEFCA. On January 18, 2022, ONC released the Trusted Exchange Framework and Common Agreement Version 1.[19] The Common Agreement is a legal contract that Qualified Health Information Networks (QHINs) can sign with the ONC Recognized Coordinating Entity (RCE), a private-sector entity that implements the Common Agreement and ensures QHINs comply with its terms. In 2022, prospective QHINs are anticipated to begin signing the Common Agreement and applying for designation. The RCE will then begin onboarding and designating QHINs to share information. In 2023, HHS expects interested parties across the care continuum to have increasing opportunities to enable exchange under TEFCA. TEFCA is expected to give individuals and entities easier, more efficient access to more health information.

Compared to most nationwide exchange today, the Common Agreement also includes an expanded set of Exchange Purposes beyond Treatment to include Individual Access Services, Payment, Health Care Operations, Public Health, and Government Benefits Determination—all built upon common technical and policy requirements and to meet key needs of the U.S. health care system. This flexible structure allows interested parties to participate in the way that makes the most sense for them, while also supporting simplified, seamless exchange.

[19] The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement for Nationwide Health Information Interoperability Version 1 (also referred to as Common Agreement) is a contract that advances those principles. The Common Agreement and the incorporated by reference Qualified Health Information Network (QHIN) Technical Framework Version 1 (QTF) establish the technical infrastructure model and governing approach for different health information networks and their users to securely share clinical information with each other—all under commonly agreed-to terms.

By connecting to a network that connects to a QHIN or directly to a QHIN, a MIPS eligible clinician can share health information in the same manner as described in the attestation statements for the HIE Bi-Directional Exchange measure. Thus, beginning with the performance period in 2023, CMS is proposing to add an additional measure through which a MIPS eligible clinician could earn credit for the HIE Objective— Enabling Exchange Under TEFCA measure—by connecting to an entity that connects to a QHIN or connecting directly to a QHIN.

The Enabling Exchange Under TEFCA measure would be worth the total amount of points available for the Health Information Exchange Objective. Although the Health Information Exchange Objective is worth a total of 40 points under the current scoring methodology, CMS is also proposing to have the HIE Objective be worth no more than 30 points (as described earlier), beginning with the performance period in 2023. This proposed change in scoring is the result of the proposal described earlier to make the Query of PDMP measure required and worth 10 points.

CMS is proposing a MIPS eligible clinician would report the Enabling Exchange Under TEFCA measure by attestation, with a "yes/no" response. A "yes" response would enable a MIPS eligible clinician to earn the proposed 30 points. The MIPS eligible clinician would attest to the following:

- Participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website) in good standing (that is, not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy.
- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.

CMS is inviting public comment on these proposals and on other ways that TEFCA can advance CMS policy and program objectives, including how TEFCA can support exchange of information required under other measures in the Promoting Interoperability performance category.

e. Modifications to the Public Health and Clinical Data Exchange Objective

CMS notes that the Public Health and Clinical Data Exchange Objective has been an important mechanism for encouraging healthcare data exchange for public health purposes by MIPS eligible clinicians—particularly for effective responses to public health events such as the COVID-19 PHE. CMS reviews the history of the five measures in the objective:

- Two required measures beginning with the performance period in 2022 (maximum 10 points):
    - Immunization Registry Reporting; and
    - Electronic Case Reporting; and

- Required reporting on one of these 3 measures (maximum 5 bonus points):
    - Syndromic Surveillance Reporting;
    - Public Health Registry Reporting; and
    - Clinical Data Registry Reporting.

CMS believes requiring MIPS eligible clinicians to report on the Immunization Registry Reporting measure and Electronic Case Reporting measure will motivate EHR vendors to implement the necessary capabilities in their products and encourage MIPS eligible clinicians to engage in the reporting activities described in the measures. Despite these gains, ensuring the nation's thousands of clinicians implement and initiate data production for these vital public health capabilities remains an ongoing and important effort. CMS says that the Promoting Interoperability performance category provides an opportunity to continue strengthening the incentives for MIPS eligible clinicians to engage in these essential reporting activities.

CMS previously established a definition for active engagement under the Public Health and Clinical Data Exchange Objective: when a MIPS eligible clinician is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.[20] CMS had established 3 options to demonstrate active engagement:

- Option 1— Completed registration to submit data;
- Option 2—Testing and validation; and
- Option 3—Production.

Although option 1 was an important option in 2016, CMS now believes MIPS eligible clinicians have had ample time to complete option 1. CMS now proposes to consolidate options 1 and 2 into one option beginning with the performance period in 2023, as follows:

- Proposed Option 1. Pre-production and Validation (a combination of current option 1, completed registration to submit data, and current option 2, testing and validation). The MIPS eligible clinician must first register to submit data with the public health agency (PHA) or, where applicable, the clinical data registry (CDR) to which the information is being submitted. Registration must be completed within 60 days after the start of the EHR reporting period, while awaiting an invitation from the PHA or CDR to begin testing and validation. MIPS eligible clinicians that have registered in previous years do not need to submit an additional registration for subsequent performance periods. Upon completion of the initial registration, the MIPS eligible clinician must begin the process of testing and validation of the electronic submission of data. The MIPS eligible clinician must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a performance period would result in the MIPS eligible clinician not meeting the measure.

[20] "Production data" refers to data generated through clinical processes involving patient care and it is used to distinguish between this data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.

- Proposed Option 2. Validated Data Production (current option 3, production). The MIPS eligible clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Under this proposal, a MIPS eligible clinician must also demonstrate their level of active engagement at either proposed Option 1 (pre-production and validation) or proposed Option 2 (validated data production) to fulfill each measure, which is not currently required. CMS is inviting public comment on these proposed changes to the options for active engagement. CMS believes this information would be helpful to enable HHS to identify registries and PHAs that may be having difficulty onboarding MIPS eligible clinicians and moving them to the Validated Data Production phase.

During the recent COVID-19 PHE, CMS recognized the importance of public health reporting and believes that knowing the level of active engagement that a MIPS eligible clinician selects would provide information on the types of registries and geographic areas with health care providers in the Pre-production and Validation stage. CMS' goal is for all health care providers nationwide to be at the Validated Data Production stage so that data will be actively flowing and public health threats can be monitored. Therefore, for the Public Health and Clinical Data Exchange Objective, in addition to submitting responses for the required measures and any optional measures a MIPS eligible clinician chooses to report, CMS proposes to require MIPS eligible clinicians to submit their level of active engagement—either Pre-production and Validation or Validated Data Production—for each measure they report beginning with the performance period in 2023. CMS is inviting public comment on this proposed change to require submission of the level of active engagement.

MIPS eligible clinicians currently are not required to advance from one option of active engagement to the next within a certain period of time. Beginning with the performance period in 2023, CMS is proposing that MIPS eligible clinicians may spend only one performance period at the Pre-production and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level in the next performance period for which they report a particular measure—otherwise they would fail to satisfy the Public Health and Clinical Data Exchange Objective.[21]

In the next section, among many other changes, CMS proposes increasing the maximum score for the 2 required measures (Immunization Registry Reporting and Electronic Case Reporting) to 25 points, from 10 points, beginning with the performance period in 2023 (Table 86 of the proposed rule).

f. Proposed Changes to the Scoring Methodology for the Performance Period in CY 2023

[21] In this section of the proposed rule, CMS also describes tangentially related public health reporting and information blocking. In a recent FAQ, ONC said that if an actor is required to comply with another law that relates to the access, exchange, or use of EHI, failure to comply with that law may implicate the information blocking regulations. For example, many states legally require reporting of certain diseases and conditions to detect outbreaks and reduce the spread of disease. Should an actor that is required to comply with such a law fail to report, the failure could be an interference with access, exchange, or use of EHI under the information blocking regulations. It is unclear why this information is included here as it is unrelated to MIPS eligible clinicians progressing through stages of active engagement for the Public Health and Clinical Data Exchange Objective.

In this proposed rule, CMS is making various proposals that would affect the scoring of the objectives and measures for the performance period in 2023, most of which were already summarized above. CMS provides several tables spanning multiple pages, including the following:

- Table 84. Objectives and Measures for the Promoting Interoperability Performance Category for the Performance Period in CY 2023. For each measure, this table shows the objective, numerator and denominator (if measure is not Y/N), and any exclusions.
- Table 85: Scoring Methodology for the Performance Period in CY 2022. For each measure, this table shows the objective and maximum points.
- Table 86: Scoring Methodology for the Performance Period in CY 2023. For each measure, this table shows the objective, the maximum points, and whether the measure is required or optional.
- Table 87: Exclusion Redistribution for Performance Period in CY 2023. For each measure, this table shows the objective and the redistribution policy if exclusion is claimed.

Table 86 is reproduced below as the best, most succinct summary of the effects of the changes. Most of these changes were already summarized above under their respective topic areas.

Table 86: Scoring Methodology for the Performance Period in CY 2023

Objective	Measure	Maximum Points	Required/ Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP*	10 points*	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points*	Required (MIPS eligible clinician's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points*	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points*	
	-OR-		
	Enabling Exchange under TEFCA*	30 points*	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points*	Required
Public Health and Clinical Data Exchange	Report the following two measures*: • Immunization Registry Reporting • Electronic Case Reporting	25 points*	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	5 points (*bonus*)*	Optional

Notes: The Security Risk Analysis measure and the SAFER Guides measure are required, but will not be scored. In addition, MIPS eligible clinicians must submit an attestation regarding ONC direct review and actions to limit or restrict the compatibility or interoperability of CEHRT, as required by § 414.1375(b)(3).
*Signifies a proposal made in this CY 2023 PFS proposed rule.

As a recap, to make the Query of PDMP required, CMS would retain the 10 points associated with it and reduce the points associated with the HIE Objective measures from the current 40 points to 30 points beginning with the 2023 performance period. To create a more meaningful incentive for MIPS eligible clinicians to engage in the electronic reporting of public health information and recognize the importance of public health systems affirmed by the COVID-19 pandemic, CMS proposes to increase the points allocated to the Public Health and Clinical Data Exchange Objective to 25 points, from 10. To balance the increase in the points associated with the Public Health and Clinical Data Exchange Objective, CMS is proposing to reduce the points associated with the Provide Patients Electronic Access to Their Health Information measure from the current 40 points to 25 points beginning with the 2023 performance period. CMS invites public comment on these proposed changes to the scoring methodology.

g. Additional Considerations Regarding Non-Physician Practitioners [(h)—1241]

(1) Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

For the performance periods in 2017 through 2022 (2019 through 2024 MIPS payment years), CMS established a policy to assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score if there are not sufficient measures applicable and available to nurse practitioners (NPs), physician assistants (PAs), certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs). If these practitioners choose to report, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians, and the performance category will be given the prescribed weighting.

CMS reviews the history of such reporting by these practitioners. Most recently, for the 2021 performance period, of the MIPS eligible clinicians who are NPs, PAs, CRNAs, or CNSs and submitted data individually for MIPS, approximately 21.3 percent submitted data individually for the Promoting Interoperability performance category, a decrease from 2020. Although CMS considered a reweighting policy, CMS believes that incentivizing more of these types of MIPS eligible clinicians to adopt and use CEHRT and submit data for the Promoting Interoperability performance category is important for increased interoperability and data exchange nationwide.

CMS believes that there has been sufficient time for NPs, PAs, CRNAs, and CNSs to adopt and implement CEHRT and that it is possible that these clinician types are now able to submit data individually on the measures for the Promoting Interoperability performance category. However, they are choosing not to because they would prefer for the performance category to be reweighted and not to contribute to their final score. Further, CMS believes that there are sufficient measures applicable and available in the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs. The measures that may not apply to these clinician types, such as the e-Prescribing measure, have exclusions that can be claimed, if applicable.

As a result, CMS is not proposing to continue the reweighting policy at §414.1380(c)(2)(i)(A)(*4*)(*ii*) to assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score for NPs, PAs, CRNAs, or CNSs for the 2023

performance period/2025 MIPS payment year. However, CMS is requesting public comment on whether this policy should continue for the 2023 performance period/ 2025 MIPS payment year, and that CMS may decide to take a different approach in the final rule depending on the comments received. CMS is particularly interested in comments on potential barriers to CEHRT adoption and implementation that may impact one or more of these clinician types, as well as comments on the applicability of the Promoting Interoperability performance category measures to NPs, PAs, CRNAs, or CNSs.

(2) Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Qualified Audiologists, Clinical Psychologists, and Registered Dieticians or Nutrition Professionals

CMS had established the same reweighting policy for the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals. Even fewer of these practitioner types submitted data individually for the Promoting Interoperability performance category.

Based on low participation, it is possible that these clinician types may be finding that there are not sufficient measures that are applicable to them. As with NPs, PAs, CRNAs, and CNSs, however, it is also possible that the reweighting policy itself might be serving as a disincentive to these types of MIPS eligible clinicians adopting and using CEHRT, and that they are choosing not to submit data individually on the measures because they would prefer for the performance category to be reweighted and not to contribute to their final score.

Because these clinician types were added to the definition of a MIPS eligible clinician under §414.1305 more recently than NPs, PAs, CRNAs, and CNSs, CMS believes it would be appropriate to continue the existing reweighting policy for them for one more year. Therefore, CMS is proposing to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals only for the 2023 performance period/2025 MIPS payment year and to revise §414.1380(c)(2)(i)(A)(*4*)(*i*) to reflect the proposal.

CMS invites comments on this proposal.

(3) Clinical Social Workers

2022 is the first year that clinical social workers are considered MIPS eligible clinicians, with the same reweighting policy for the Promoting Interoperability performance category that previously adopted for NPs, PAs, CNSs, CRNAs, and other types of MIPS eligible clinicians who are non-physician practitioners. CMS does not yet have any performance period data to evaluate whether the Promoting Interoperability performance category measures are applicable and available to this type of MIPS eligible clinician. CMS proposes to continue the existing policy of reweighting the Promoting Interoperability performance category for clinical social workers for the 2023 performance period/2025 MIPS payment year and to revise §414.1380(c)(2)(i)(A)(*4*)(*iii*) to

reflect the proposal, but will evaluate whether the policy should be continued for future years when performance period data are available.

h. Patient Access to Health Information Measure—Request for Information (RFI) [(i)—1247]

CMS notes that patient use of portals to access their health information has been tied to benefits such as improvements in access, quality of care, and health outcomes, and reductions in healthcare expenditures. In particular, access to health information has been shown to enable the discovery of medical errors, to improve medication adherence, and to promote communication between the patient and health care provider. Among other factors, health care provider encouragement is demonstrated as a facilitator of use.

In the past for the Promoting Interoperability performance category, CMS added, modified, then removed a standalone View, Download, Transmit (VDT) measure on the number of patients who actively engaged with the electronic health record. CMS says the standalone VDT measure was removed from the Promoting Interoperability performance category due to the following reasons:

- Feedback from interested parties, including physician specialty societies, cited ongoing
- concern with measures that require patient action for successful submission.
- Data analysis of VDT measure supported concerns from interested parties that barriers exist which impact a clinician's ability to meet them.
- Interested parties have indicated that success of the measure is reliant upon the patient, who may face barriers to access which are outside a clinician's control.

CMS then implemented a measure to Provide Patients Electronic Access to Their Health Information, which included a requirement for MIPS eligible clinicians to provide timely access for viewing, downloading or transmitting their health information for at least one unique patient discharged using any application of the patient's choice. This change emphasized timely electronic access of patient health information rather than requiring health care providers to be accountable for patient actions.

CMS says the current Provide Patients Electronic Access to Their Health Information measure in the Provider to Patient Exchange Objective ensures that patients have access to their health information through any application of their choice that is configured to meet the technical specifications of the Application Programing Interface (API) in the CEHRT of the MIPS eligible clinician. While CMS removed the VDT measure holding MIPS eligible clinicians responsible for patient action, CMS still requires that the technical capabilities be in place within a MIPS eligible clinician's CEHRT through the Provide Patients Electronic Access to Their Health Information measure should patients choose to access and use their health information. CMS continues to believe in the importance of taking a patient-centered approach to health information access and moving to a system in which patients have immediate access to their electronic health information and can be assured that their health information will follow them as they move throughout the health care system.

Recognizing the concerns and barriers with the previous VDT measure but acknowledging the advancements made within the health IT industry over the past few years, CMS publishes this

request for information (RFI) seeking a broad array of public comments regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the MIPS eligible clinician. CMS then poses nearly 20 questions—for example, "Do you believe the API and app ecosystem are at the point where it would be beneficial to revisit adding a measure of patient access to their health information which assesses clinicians on the degree to which their patients actively access their health information?"—and welcomes input on how it can encourage and enable patient access to and use of their health information to manage and improve their care across the care continuum.

5. APM Entity level participation for MIPS Eligible Clinicians Participating in MIPS APMs

In the 2021 PFS final rule (85 FR 84896), CMS finalized a policy to allow APM Entities to report to Traditional MIPS using any available MIPS reporting pathway, including the APM Performance Pathway (APP), Traditional MIPS and, in the future, MIPS Value Pathways (MVPs). APM Entities that do not report through the APP will continue to have the cost performance category reweighted to zero percent of their MIPS final score, but will be required to report and be scored on the three remaining MIPS performance categories—quality, improvement activities (IA), and promoting interoperability. In addition, CMS explained that the promoting interoperability performance category would continue to be scored for multi-TIN APM Entities using the promoting interoperability roll-up calculation described at §414.1317(b)(1) (85 FR 84897).

CMS cites feedback from interested parties that many of the workstream modifications, as well as data aggregation and integration tools that are likely to be used by multi-TIN APM Entities, such as use of the FHIR API or hiring vendors to complete the more complex reporting activities required for reporting APM Entity level eCQMs, could also be used to collect data and submit for the promoting interoperability performance category at the APM Entity level. CMS also understands that it is possible for an APM Entity to represent only a single practice site or specialty within a larger multi-specialty TIN. In these circumstances, the APM Entity may have both the ability and desire to report on the promoting interoperability performance category at the APM Entity level, thereby excluding data generated by the rest of the larger TIN, in cases where the APM Entity itself performed above average relative to the rest of that TIN.

Therefore, CMS is proposing to introduce a voluntary reporting option for APM Entities to report the promoting interoperability performance category at the APM Entity level beginning with the 2023 performance period. Multi-TIN APM Entities that do not choose this proposed new reporting option would continue to be scored using the roll -up calculation described at §414.1317(b)(1). **CMS seeks comment on this proposal.**

H. MIPS Final Score Methodology

1. Proposed Policy Changes

a. Claims-based quality measure benchmarking

CMS proposes to amend the current benchmarking policy to score administrative claims measures in the quality performance category using a benchmark calculated from performance period data rather from a specified historical baseline period (§414.1380(b)(1)(ii)(D)). Measures for which available claims data for a clinician do not meet case minimum or benchmark requirements would continue to be excluded from the clinician's Quality performance category score.

CMS expects that reducing the lag time from the baseline to the performance period will produce measure results that will better reflect recent clinical care as well as provide more timely and actionable feedback for providers and more useful data for analytic purposes. CMS notes that claims-based measures require no action by the clinician as the data are extracted by CMS from its data repository so no clinician burden is imposed. CMS states a belief that clinicians prefer historical baseline period benchmarking because benchmarks and performance targets for measures on which they will be scored are available to them sufficiently in advance to guide their performance improvement activities but does not comment further on clinician preferences.

b. Topped-out quality measure scoring

CMS reviews potential interactions between its policies for scoring topped-out measures and truncated or suppressed quality measures. CMS identifies topped-out measures as having median performance rates of 95 percent or higher, leaving little room for improvement by most clinicians. Once a measure is topped out for 2 consecutive years, the maximum available achievement points for the measure are reduced from 10 to 7 points. Separately, a measure may be suppressed entirely from scoring or may have its performance period truncated whenever CMS determines that revised clinical guidelines, measure specifications, or codes (e.g., ICD-10 diagnosis codes that define measure numerators or denominators) may lead to misleading measure results or interfere with accurate data submission.

CMS believes that confusion may occur when the two sets of policies interact. For example, suppression or truncation of a measure may interrupt what would otherwise be two consecutive topped-out measure years and impact an impending reduction in maximum measure points. Alternatively, measure changes that trigger suppression or truncation may change the measure sufficiently that subsequent performance is no longer topped-out. To add clarity, CMS states that when a measure has been suppressed or had its performance period truncated because of a substantive change (e.g., codes, specifications) or a change in relevant clinical guidelines, the topped-out measure process resets entirely beginning with the year following the change, as the measure's previously established historical benchmark will no longer be applicable.

c. Cost measure improvement scoring methodology

CMS proposes to establish a maximum Cost performance category improvement score of 1 percentage point out of the 100 percentage points available beginning with the CY 2022 performance period/2024 MIPS payment year.

CMS reviews in detail the sequence of statutory provisions since the QPP's inception that have impacted the application of improvement scoring to the Cost performance category score and the

series of regulatory changes made by CMS to comply with applicable statute as it evolved. CMS notes having inadvertently failed to set the maximum cost improvement score for payment year 2024 and beyond. CMS proposes a value of 1 percentage point as it is close to the zero points that have been in force for several recent years yet begins to implement opportunities for scoring adjustments based on improvement in the cost category. CMS believes setting a higher value would be inappropriate since clinicians are still accruing experience with being scored on cost measures and care delivery is still being affected by the COVID-19 PHE.

Because the proposal would result in scoring and payment changes after the start of the applicable performance period (CY 2022), CMS cites section 1871(e)(1)(A) of the Act in proposing to make the retroactive change, having determined that not to proceed to set a cost improvement maximum score would be contrary to the public interest.

d. Promoting Interoperability Performance Category Scoring

CMS refers readers to section IV.A.10.c.(4)(1) where proposed measure, scoring, and policy modifications are discussed holistically (also see section IV.G.4. of this summary). Proposed changes include redistribution of potential total points across the category's four Objectives; ending the period of reweighting this category to 0 percent of the MIPS total score for physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists; and allowing APM entities to report data for this category at the entity level, in addition to existing group and individual level options.

2. Calculating the Final Score

a. Facility-based measurement

(1) Complex bonus eligibility (§414.1380(c)(3)).

Beginning with performance year 2023/payment year 2025, CMS proposes to make facility-based clinicians eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category.

The complex patient bonus was implemented beginning with performance year 2018/payment year 2020 and has undergone multiple policy revisions subsequently. The bonus is designed to recognize clinicians who serve disproportionate numbers of patients with complex medical and/or social needs and is applied by adding up to 10 points to a clinician's total MIPS score. To be eligible for the bonus, a clinician must report on at least one measure or activity in a MIPS performance category. The bonus amount is determined by the Hierarchical Condition Category (HCC) scores and dual eligibility status of a clinician's patient population.

Facility-based clinicians are eligible for facility-based scoring. Their quality and cost category scores are derived from those of the facilities in which they predominately practice (i.e., based on the facility's Hospital Value-Based Purchasing Program score). Because individual facility-based clinicians are not required to submit any MIPS performance category data, they have not been

eligible for the complex patient bonus.[22] CMS proposes to make these clinicians bonus-eligible by dropping the requirement for the clinician to submit data to CMS for at least one MIPS performance category (§414.1380((c)(3)).

(2) Virtual group eligibility for facility-based measurement (§414.1380(e)(2)).

CMS proposes that a virtual group may be eligible for facility-based measurement if 75 percent or more of the groups MIPS eligible clinicians meet the definition of facility-based.

CMS states having intended previously to extend facility-based eligibility to virtual groups but has not previously made a formal proposal to do so.

(3) Regulation text alignment

CMS proposes to align the definition of *Facility-based MIPS eligible clinician* at §414.1305 with the facility-based eligibility determination requirements at §414.1380(3)(2). A mismatch currently exists as the definition was not updated when determination requirements were changed during CY 2019 PFS rulemaking.

b. RFI: Complex patient bonus risk indicators and health equity

CMS believes that the intent of the complex patient bonus, recognizing clinicians who serve disproportionate numbers of patients with complex medical and/or social needs, aligns fully with the agency's overarching initiative to advance health equity and reduce care disparities through its quality programs. The bonus methodology currently incorporates dual eligibility status and HCC score as indicators of increased medical risk and health-related social needs.

CMS first asks about the potential utility of risk indicators other than HCC score and dual eligibility status in the context of the complex patient bonus**. In addition to the questions listed below, CMS specifically asks about incorporating the University of Wisconsin Area Deprivation Index into the complex patient bonus.**

- What additional risk indicators should CMS consider incorporating within the complex patient bonus formula?
- How should CMS incorporate those additional risk indicators into the complex patient bonus formula?
- What additional data sources should CMS consider that would allow for CMS to calculate the complex patient bonus in both a feasible and timely manner?
- What additional measures or indicators are already developed which may capture the social determinants of health?

CMS also requests input and information about a potential future definition of *safety net providers* for use in the context of the complex patient bonus. CMS refers to the definition

[22] An individual facility-based clinician's quality and cost scores rely on hospital scores that are available to CMS from the hospital, and the clinician is not required to submit improvement activities or promoting interoperability measure data.

of *essential community provider* (ECP) as found in 45 CFR 156.235 – shown below -- and asks the questions that follow the ECP definition.

> **Definition**. *An **essential community provider** is a provider that serves predominantly low-income, medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act.*

- Does the definition of "essential community providers" adequately function as a potential definition for safety net providers and could it include all MIPS eligible clinicians who may receive the complex patient bonus? What (if any) concerns would health care providers or health care professionals have regarding the use of this definition?
- What recommendations for alternate definitions should CMS consider as a definition of "safety net provider" that would be inclusive of all MIPS eligible clinicians who may receive the complex patient bonus?
- When considering the "safety net provider" definition, how would commenters suggest CMS consider differences related to location or facilities that might qualify as "safety net providers" versus individual health care professionals who might also qualify as "safety net providers"? What would commenters identify as key determinations when considering allocation, site-based, or facility-based definition or an individual health care professional based definition of "safety net provider" in the context of MIPS eligible clinicians who may receive the complex patient bonus?

3. MIPS Payment Adjustments

a. Performance threshold setting for performance year 2023/payment year 2025

Section 1848(q)(6)(D)(i) of the Act requires the Secretary to annually compute a performance threshold for purposes of determining the MIPS payment adjustment factors. Beginning with payment year 2024, statute also requires the that the threshold is either the mean or median of the final scores for all MIPS eligible clinicians for a prior period as specified by the Secretary. The threshold methodology, mean or median, may be reassessed by the Secretary every 3 years. Table 89, reproduced below shows the performance thresholds established for payment years 2019 through 2024.

Table 89: Finalized MIPS Performance Thresholds by Payment Year Through 2024

2019	2020	2021	2022	2023	2024
3 points	15 points	30 points	45 points	60 points	75 points

For payment years 2024, 2025, and 2026, the Secretary has selected the mean as the threshold methodology and intends to reassess that choice for payment years 2027, 2028, and 2029 during future rulemaking. For payment year 2024 (performance year 2022), the Secretary selected payment year 2019 as the prior period for use in threshold setting, resulting in a threshold score of 75 points for that year. For payment year 2025 (performance year 2023) the mean methodology will be used but the prior period has not yet been established. Table 90, reproduced

below, shows the mean value choices from prior periods. The mean final score for payment year 2025 (performance year 2023) was not available in time for inclusion in this rule.

CMS proposes to again use payment year 2019 (performance year 2017) as the prior period for threshold score setting for payment year 2025 (performance year 2023). CMS bases this choice on considerations including: an expectation that the mean final MIPS across all clinicians for payment year 2025 (2023 performance period) will fall below those for payment years 2020 through 2022; downstream consequences of having applied extreme and uncontrollable circumstances policies in response to the COVID-19 PHE; performance category reweighting for fewer clinicians during performance year 2023 than the preceding year; and continuing effects of the ongoing PHE on care delivery that affect clinician performance and data reporting.

CMS notes that a performance threshold for exceptional MIPS performance will not be set for payment year 2025 (performance period 2023) as funding for the exceptional performance bonus expires per statute with the end of payment year 2024 (performance year 2022).

Table 90: Possible Values for Payment Year 2025 Threshold

Performance Year	2019	2020	2021	2022
Mean	74.65 points	87 points	85.61 points	89.47 points

CMS refers readers to sections VII.E.16.d(4) and VII.F.7. of this rule's regulatory impact analysis wherein CMS discusses the impact of selecting a prior period other than payment year 2019 to set the payment year 2025 MIPS final score threshold. If using payment year 2019 for threshold setting is finalized (i.e., the threshold is set at 75 points), CMS estimates that one-third of MIPS eligible clinicians will receive a negative payment adjustment for payment year 2025 (performance year 2023). However, CMS cautions readers that this estimate may change as final scores for many MIPS eligible clinicians are projected to be quite close to the proposed 75-point threshold. Modeling using performance means from payment years 2021 and 2022 results in 82 percent and 89 percent of clinicians receiving negative MIPS payment adjustments for those years, respectively. Finally, CMS intends to reevaluate in future rulemaking its choice of payment year 2019 as the prior period for payment year MIPS final score threshold setting.

CMS requests comments on use of an alternative prior period (i.e., other than payment year 2019) to set the 2025 payment year threshold.

b. Example of adjustment factors

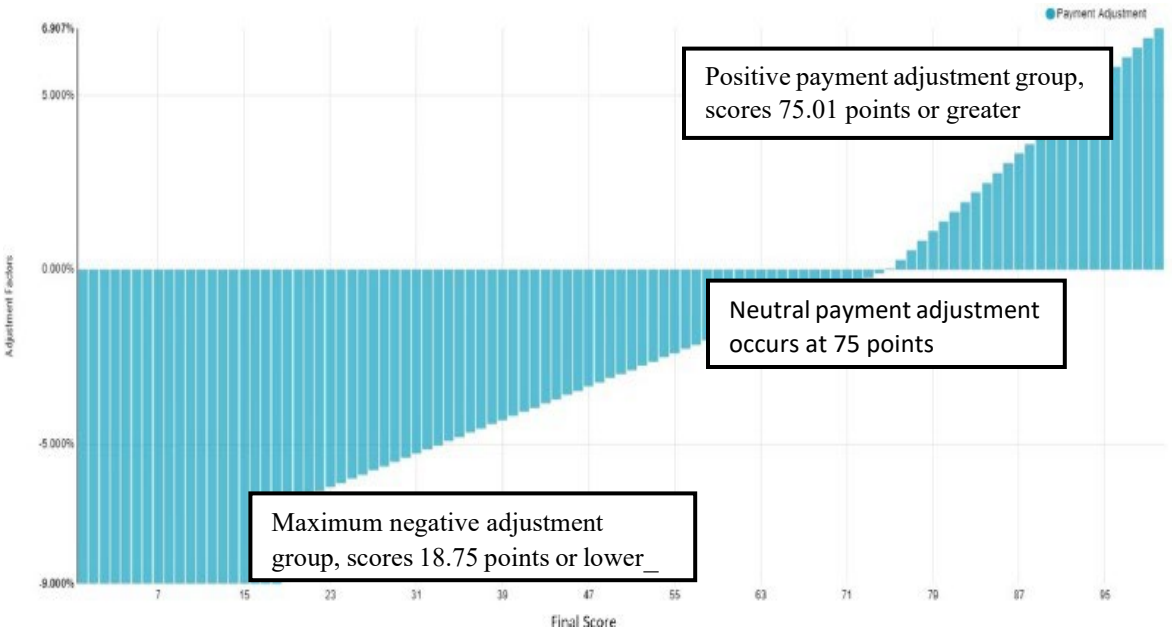
Figure 4 from the rule provides an example linking the proposed performance threshold to actual payment adjustment factors for payment year 2025 (performance year 2023) and is reproduced at the end of this section. CMS notes that per statute payments are also adjusted such that clinicians whose final scores fall between zero and one-fourth of the threshold receive the lowest possible MIPS payment adjustment of -9 percent. Further, a scaling factor greater than 0 but no higher than 3 is applied as needed to render MIPS payments budget neutral as required by statute (i.e., positive payment adjustment amounts in aggregate must equal negative adjustment amounts). Figure 4 reflects the latter two statutory requirements along with the proposed MIPS threshold

score of 75 points. Also reproduced below in part is Table 91 that links the final score points to the payment adjustments.

c. Performance feedback

CMS is required by statute to provide timely performance feedback to clinicians about their Quality and Cost category scores, and is given discretion to provide feedback about Improvement Activities and Promoting Interoperability category performances. To date, CMS has provided feedback on approximately an annual basis. The agency estimates that the next feedback reports, covering 2021 performances, will be made available to clinicians on or around July 1, 2022 but notes the potential for delay.

Figure 4: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold for the 2025 MIPS Payment Year



The actual payment adjustments may vary based on the distribution of final scores for MIPS eligible clinicians.

Relationship of MIPS Final Performance Score to Proposed MIPS Payment Adjustment for Payment Year 2025/Performance Year 2023 (from Table 91 of the rule)	
Final Score Points	**MIPS Adjustment**
0.0 – 18.75	Negative 9%
18.76 – 74.99	Negative MIPS payment adjustment > negative 9% and < 0% on a linear sliding scale

Relationship of MIPS Final Performance Score to Proposed MIPS Payment Adjustment for Payment Year 2025/Performance Year 2023 (from Table 91 of the rule)	
Final Score Points	**MIPS Adjustment**
75.0	0% adjustment
75.01 – 100	Positive MIPS payment adjustment > 0% on a linear sliding scale; the sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than 0 but not exceeding 3.0 to preserve budget neutrality.

I. Third Party Intermediaries General Requirements

1. General Requirements

a. Background

CMS makes the following proposals with respect to third party intermediaries which are described in greater detail below:

- To update the definition of third party intermediary consistent with existing policies;
- To revise QCDR measure self-nomination and measure approval requirements, including proposing to delay the QCDR measure testing requirement for Traditional MIPS by an additional year, until the CY 2024 performance period/2026 MIPS payment year; and
- To revise remedial action and termination policies.

Two requests for information are also included.

b. Definition of Third Party Intermediary (§414.1305)

In the 2022 PSF final rule, CMS added an APM Entity to the list of data reporters on whose behalf third-party intermediaries may report to MIPS. Additionally, QCDRs, qualified registries, health IT vendors, and CAHPS for MIPS survey vendors are permitted to support subgroup reporting. CMS proposes to make what it describes as an update to the definition of third party intermediary at §414.1305 which would read as follows:

Third party intermediary means an entity that CMS has approved under §414.1400 to submit data on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity for one or more of the quality, improvement activities, and Promoting Interoperability performance categories.

2. Requirements Specific to QCDRs

a. QCDR Measure Self-Nomination Requirements (§414.1400(b)(4)(i)(B))

CMS proposes modifications to §414.1400(b)(4)(i)(B) that are intended to clarify that a QCDR, as part of the QCDR measure self-nomination, must publicly post measure specifications no later

than 15 calendar days following CMS's posting of approved QCDR measure specifications on a CMS website. Additionally, the QCDR would have to confirm that the measure specifications they post align with the measure specifications posted by CMS. These proposals are designed to limit discrepancies between the posting of CMS and QCDRs.

Section 414.1400(b)(4)(i)(B) would be revised to state that, for a QCDR measure, the entity must submit for CMS approval measure specifications including the Name/title of measure, National Quality Forum (NQF) number (if NQF- endorsed), descriptions of the denominator, numerator, and when applicable, denominator exceptions, denominator exclusions, risk adjustment variables, and risk adjustment algorithms.
Additionally, no later than 15 calendar days following CMS posting of all approved specifications for a QCDR measure, the entity must publicly post the CMS-approved measure specifications for the QCDR measure (including the CMS- assigned QCDR measure ID) and provide CMS with a link to where this information is posted.

b. QCDR Measure Approval Criteria (§414.1400(b)(4)(iii))

CMS previously finalized requirements for QCDR measure testing, including a requirement that all QCDR measures must be fully developed and tested with complete testing results at the clinician level beginning with the CY 2021 performance period/ 2023 MIPS payment year. Because of the COVID-19 PHE, full testing for QCDR measures was delayed until the CY 2023 performance year.

CMS proposes another one-year delay for the requirement for a QCDR measure to be fully developed and tested with complete testing results at the clinician level until the CY 2024 performance year. As proposed, a QCDR measure approved for the CY 2023 performance year or earlier would not need to be fully developed and tested until the CY 2024 performance year. A new QCDR measure proposed for the CY 2024 performance year would be required to meet face validity.

Specifically, CMS proposes to amend §414.1400(b)(4)(iii)(A)(3) to state that beginning with the CY 2022 performance period/2024 MIPS payment year, CMS may approve a QCDR measure only if the QCDR measure meets face validity. Beginning with the CY 2024 performance period/2026 MIPS payment year, a QCDR measure approved for a previous performance year must be fully developed and tested, with complete testing results at the clinician level, prior to self-nomination. **CMS seeks comment on this proposal.**

3. Remedial Actions and Termination of Third-Party Intermediaries

The agency proposes changes to the regulations on remedial actions and terminations related to corrective action plans and terminations of certain QCDRs and Qualified Registries that continue to fail to submit performance data.

a. Revised Corrective Action Plan (CAP) Requirements (§414.1400(e)(1)(i))

CMS may require a third party intermediary to submit a corrective action plan (CAP) to correct noncompliance with requirements. A CAP must address a number of issues, including the impact any noncompliance on clinicians and groups and has the potential to implicate substantial program dollars. The current CAP requirements at §414.1400(e)(1)(i)(B) requires the third party intermediary to address the impact of the noncompliance on "individual clinicians, groups, or virtual groups, regardless of whether they are participating in the program because they are MIPS eligible, voluntary participating, or opting in to participating in the MIPS program."

CMS proposes to expand the requirement to identify impacts beyond clinicians to also include impacts on any QCDRs under certain circumstances. Specifically, where QCDRs were granted licenses to the measures of another QCDR upon which a CAP has been imposed, the CAP for the affected QCRD must also identify impacts to any QCDRs that were granted licenses to the measures of the affected QCDR.

Additionally, a new CAP requirement is proposed to require the third party intermediary to notify the parties identified in proposed §414.1400(e)(1)(i)(B) of the impact to these parties by developing and submitting a communication plan. This would help affected parties to understand and prepare for any operational and other challenges as needed. **CMS seeks comment on the proposals.**

b. Termination of Approved QCDRs and Qualified Registries That Have Not Submitted Performance Data (§414.1400(e)(5))

Approved QCDRs and qualified registries that have not submitted performance data are required to submit a participation plan as part of their self-nomination process. CMS previously finalized a policy to require a QCDR or qualified registry that was approved but did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan in order for it to be approved for the CY 2024 performance period/2026 MIPS payment year or for a future performance period/payment year (§414.1400(b)(3)(viii)).

CMS proposes to add a new ground for termination at §414.1400(e)(5) for a QCDR or qualified registry that submits a participation plan as required under §414.1400(b)(3)(viii), but does not submit MIPS data for the applicable performance period for which they self-nominated under §414.1400(b)(3)(viii). This would apply beginning with the CY 2024 performance period/2026 MIPS payment year and thereafter. **CMS seeks comment on the proposals.**

4. Auditing of Entities Submitting MIPS Data

Third party entities are required under §414.1400(f)(1) to provide CMS the contact information of each MIPS eligible clinician or group on behalf of whom it submits data. Consistent with its proposed revised definition of third party intermediary described above, CMS proposes to update §414.1400(f)(1) to require that the entity must make available to CMS the contact information of each MIPS eligible clinician, group, virtual group, subgroup, or APM Entity on behalf of whom it submits data. The contact information must include, at a minimum, the MIPS eligible clinician, group, virtual group, subgroup, or APM Entity phone number, address, and, if available, email. CMS invites comments on this proposal.

5. Requests for Information

a. Third Party Intermediary Support of MVPs

While CMS believes it is important to allow third party intermediaries to support the MIPS Value Pathways (MVPs), some third party intermediaries have expressed concern about the requirement to support all measures within an MVP due to operational limitations. CMS is concerned that allowing the support of only specific measures within an MVP would create undue burden on the MVP participant and limit clinician choice of measures. CMS seeks input on the following three questions:

- Should third party intermediaries have the flexibility to choose which measures they will support within an MVP?
- What are the barriers/burdens that third party intermediaries face to supporting all measures within an MVP?
- What type of technical educational resources would be helpful for QCDRs, qualified registries, and Health IT vendors to support all measures within an MVP?

b. National Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities

The agency's current third party intermediary policies do not allow third party intermediaries to submit data solely for the improvement activities performance category. However, CMS is considering whether national continuing medical education (CME) accreditation organizations that certify CME could be established as a new type of third party intermediary to submit data for clinicians seeking credit for improvement activities performance category credit IA_PSPA_28, "Completion of an Accredited Safety or Quality Improvement Program," and IA_PSPA_2, "Participation in MOC Part IV." These are both medium-weighted improvement activities, so that clinicians would not need to attest to completion of the improvement activities through the QPP web portal. The agency is also considering how to include information from national CME accreditation organizations in MIPS. **CMS seeks comment whether a new type of third party intermediary for this purpose would be valuable to clinicians.**

If the agency decided to establish this new type of third party intermediary, it would only consider national CME accreditation organizations to reduce potential clinician confusion and program complexity. CMS notes that all requirements that apply to third party intermediaries would also have to apply to CME Accreditation Organizations. CMS is interested in feedback on the following:

- The types of organizations that should be considered and criteria for selection.
- A review process to evaluate vendor application forms.
- Requirements for yearly vendor training and additional training.
- Quality Assurance Plans (QAPs) regarding the data submitted.
- Policies about the public posting of information submitted.
- Benefits and barriers to the CME accreditation organizations if CMS established a different type of third party intermediary.

The preamble includes detailed questions on these issues.

J. Public Reporting on Compare Tools Hosted by HHS

1. Telehealth Indicator

Noting the increase in telehealth services that were covered and furnished during the COVID-19 PHE, CMS proposes to add a telehealth indicator to the clinician and group profile pages on the Compare tool. Because the Compare tool may inform how beneficiaries access care, knowing whether a clinician offers services via telehealth is helpful and would fill a gap in information currently provided. CMS believe it may also further health equity goals. The telehealth indicator would include a statement on the profile page warning, in a user-friendly way, that the clinician or group only provides some, not all, services via telehealth.

CMS proposes to identify clinicians who perform telehealth services using Place of Service Code 02 (indicating telehealth) on paid physician and ancillary service (i.e., carrier) claims, or modifier 95 appended on paid claims. To ensure up-to-date information, it would use a 6-month lookback period and refresh the telehealth indicator on clinician profile pages bi-monthly.

CMS seeks comment on all aspects of the proposal.

2. Publicly Reporting Utilization Data on Profile Pages

CMS notes that its current method of making utilization data available on the Compare tool is presented in a technical manner which, while useful to the healthcare industry and researchers, is not helpful or user friendly for patients who do not understand medical procedure coding. CMS would like reporting of utilization data on patient-facing clinician profile pages to allow for more granular clinician searches (i.e., searches for specific types of clinicians AND the specific procedures performed by them) and to be provided in a plain language display.

CMS proposes to collapse HCPCS codes using the Restructured Berenson-Eggers Type of Service (BETOS) Codes Classification System into procedural categories. BETOS is a taxonomy that allows for the grouping of health care services codes for Medicare Part B into clinically meaningful categories and subcategories. It would exclude non-specific procedure codes (e.g., E&M codes for office visits which do not provide context about the care provided) and low complexity procedures (e.g., basic wound care or administering a vaccine) because these codes encompass many types of care and are not specific enough about the services covered. Procedure code sources used in MIPS would be used for procedures in which no Restructured BETOS categories are available. The utilization data on the Compare tool would only reflect Medicare claims data.

CMS proposes to conduct user testing with patients and caregivers to determine which procedures are of most importance, how best to display the information, and the plain language utilization data to be used on profile pages. It would begin publicly reporting procedural utilization data no earlier than 2023 and would use a 12-month lookback period and bi-monthly data refresh frequency, as technically feasible.

CMS seeks comment on all aspects of the proposal.

3. Incorporating Health Equity into Public Reporting: Request for Information

CMS is interested in information on ways to incorporate health equity into public reporting on doctor and clinician profile pages with the goal of ensuring that all patients and caregivers can easily access meaningful information to assist with their healthcare decisions. It believes empowering all patients with information that enables them to select high quality, high value clinicians will be one facet that helps improve outcomes and close disparity gaps across social risk factors, race, and ethnicity.

The agency has considered adding information to the Compare tools, such as whether the clinician or group has language services available, speaks other languages besides English, and whether they accept insurance outside of traditional Medicare Fee-for-Service, such as Medicaid, Medigap, Medicare Advantage, and other commercial insurance. **CMS seeks comment on what additional information should be publicly reported on the Compare tool as well as readily available, centralized data sources from which information may be gathered.**

K. APM Incentive Payment Program

CMS proposes to change the deadline by which it will accept updated contact information from QPs eligible to receive APM incentive payments. Also proposed are revisions to two of the three criteria used in making Advanced APM determinations: quality linkage to payment and financial risk standards. An updated table of threshold payment amounts and patient counts for reaching QP and partial QP status is provided in Table 92 of the proposed rule, reproduced later in this section.

CMS also issues two requests for information related to APM incentive payments. The first explores making future determinations of QP and partial QP status at the individual clinician level rather than at the APM Entity level as is currently done. The second raises questions about administrative actions that CMS might take during the transition from the current 5 percent bonus APM incentive payments to differential conversion factor updates for QPs and non-QPs set in statute to begin with performance year 2024/payment year 2026.

1. Communication with Certain QPs about APM Incentive Payments

CMS proposes to change the cutoff date by which certain QPs may submit updated information about the TINs to which their APM incentive payments should be made. Currently CMS uses a deadline of November 1 of the payment year or 60 days from the date that CMS makes the initial round of payments, whichever is later. CMS proposes to advance the deadline to September 1 of the payment year, or 60 days from the date that CMS makes the initial round of payments, whichever is later.

Each year a subset of QPs is identified on whose behalf CMS has insufficient information to identify the TINs to whom payments should be sent. CMS attempts to contact those QPs through its usual provider communication channels (e.g., QPP listserv) and through a Federal Register

notice. The proposal to move the cutoff date forward takes into account that (1) operational adjustments made by CMS now allow the initial round of incentive payments to be made earlier in the payment year, and (2) the November cutoff date does not allow sufficient time between receipt of updated payment information by CMS for the agency to satisfy the requirement at §414.1450(d) for payments to be made no later than 1 year after the incentive payment base period (i.e., by December 31 of the payment year, which is the year following the base period).

CMS notes that the following current policies would continue without change:

- After the cutoff date, CMS no longer accepts updated information from QPs or their representatives.
- After the cutoff date, a QP who has not provided updated information about the TIN to which payment should be made will forfeit any claim to the incentive payment that would otherwise have been made.

2. Revisions of Advanced APM Criteria

Based on sections 1833(z)(3)(C) and (D) of the Act, the defining criteria for an Advanced APM are described in §414.1415(a) through (c). The Advanced APM must:

- Require its participants to use CEHRT,
- Provide for payment for covered professional services based on quality measures comparable to MIPS Quality performance category measures, and
- Require its participating APM Entities to bear financial risk or monetary losses in excess of a nominal amount, or be a Medical Home model expanded under section 1115A(c) of the Act.

a. Quality-based payment criterion

CMS proposes regulation text changes at §414.1415(b) to clarify that the Advanced APM requirement for payment to be based on quality measures can be satisfied through use of a single quality measure that both (1) appears in the finalized MIPS measure inventory or is endorsed by a consensus-based entity or is determined by CMS to be evidence-based, reliable, and valid; and (2) is an outcome measure, unless there are no available or applicable outcome measures when the Advanced APM's first QP performance period begins. If a single measure that satisfies both criteria is not available and applicable to the Advanced APM, then 2 measures that together satisfy the two-part requirement must be used to meet the quality-based payment criterion.

b. Financial risk criterion

(1) Generally applicable nominal amount standard

CMS proposes to make permanent the generally applicable revenue-based nominal amount standard that has been repeatedly adopted for use during sequential PFS rulemaking cycles and is currently applicable through performance year 2024. CMS also proposes to make permanent the analogous 8 percent standard that has been applied to Other Payer Advanced APM determinations since that category of Advanced APMs was established beginning with performance year 2021 (§414.1420(d)(3)(i)). CMS believes these proposals would provide

policy continuity within the APM incentive payment program and states that operational experiences with the 8 percent standards have been satisfactory.

CMS notes that the standard as applied to Medicare-sponsored Advanced APMs is based on 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities. For Other Payer Advanced APMs, the standard is based on the APM's total combined revenues from the payer to providers and other entities covered under the Other Payer payment arrangement.

(2) Medical Home 50-clinician limit (§§414.1415 and 414.1440)

Beginning with performance year 2023, CMS proposes to apply the 50-clinician limit on the number of clinicians in an organization that participates in a Medicare-sponsored Advanced APM under a Medical Home model at the level of the medical home's APM Entity rather than at its parent organization level as is currently done. CMS would use the TIN/NPIs on the entity's participation list on each of the three QP determination dates (known as "snapshots") as the basis for the MIPS eligible clinician count. CMS further proposes that the clinician count must satisfy the 50-clinician limit on each of the snapshot dates or the entity will not meet the financial risk criterion for a Medical Home Advanced APM and its clinicians would not receive credit towards QP status for participating in the medical home. Analogous changes also are proposed for application to Aligned Other Payer medical homes and Medicaid medical homes.

CMS acknowledges having repeated difficulties in consistently applying the 50-clinician limit at the parent organization level because of the diverse nature of relationships between parent organizations, APM Entities, TINs, and individual clinicians. Conversely, CMS states that it has gained confidence in its ability to understand how individual APM Entities in medical homes manage financial risk. CMS notes that the proposal to require that the limit be met on all three snapshot dates should serve to discourage gaming of the clinician count by entities who otherwise might time addition or subtraction of clinicians to leverage the overall clinician count to comply with the limit if it were measured only on a single snapshot date.

3. Updated QP Threshold Score Table

CMS proposes to amend the applicable regulation text describing payment amounts and patient count thresholds required of clinicians to achieve QP or partial QP status to fully conform to provisions of section 114(a) of Subtitle B of Title I of Division CC as enacted in CAA, 2021. The CAA froze the payment amounts and patient count thresholds for payment years 2023 and 2024 at 2021 and 2022 levels. For payment year 2025 and thereafter, however, the thresholds revert to the payment amounts and patient counts as were previously described in statute and regulations.

CMS indicates that policies were finalized to implement the revised thresholds but the new policies were not fully and correctly described in regulation text at §414.1430(a) and (b). CMS proposes regulation text changes to correct the errors. The correct values for all years are provided by CMS as Table 92, reproduced below.

TABLE 92: QP Threshold Score Updates

Medicare Option - Payment Amount Method						
Performance year / Payment Year	2021/2023 (Percent)		2022/2024 (Percent)		2023/2025 and later (Percent)	
QP Payment Amount Threshold	50		50		75	
Partial QP Payment Amount Threshold	40		40		50	
Medicare Option - Patient Count Method						
Performance year / Payment Year	2021/2023 (Percent)		2022/2024 (Percent)		2023/2025 and later (Percent)	
QP Patient Count Threshold	35		35		50	
Partial QP Patient Count Threshold	25		25		35	
All-Payer Combination Option - Payment Amount Method						
Performance year / Payment Year	2021/2023 (Percent)		2022/2024 (Percent)		2023/2025 and later (Percent)	
QP Payment Amount Threshold	50	25	50	25	75	25
Partial QP Payment Amount Threshold	40	20	40	20	50	20
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum
All-Payer Combination Option - Patient Count Method						
Performance year / Payment Year	2021/2023 (Percent)		2022/2024 (Percent)		2023/2025 and later (Percent)	
QP Patient Count Threshold	35	20	35	20	50	20
Partial QP Patient Count Threshold	25	10	25	10	35	10
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

4. RFI: Potential Transition to Individual QP Determinations Only

CMS reviews its current approach to determining whether clinicians who are participating in the QPP through Advanced APMs meet the criteria to become APM Qualifying Participants (QPs) and to receive payment incentives available only to QPs. The criteria are expressed as thresholds for which the metrics are payments or patient counts for services delivered through Advanced APMs. By design, CMS makes nearly all QP determinations for a performance year at the APM Entity level such that QP status is awarded at that level based on the collective performance of clinicians found on the APM's Participant List on one or more of three "snapshot" dates during the performance year (March 31, June 30, August 31). Satisfying payment or patient count thresholds on any one of the three snapshot dates confers QP status on the entity's clinicians for the entire performance year. QP status is awarded either to all or none of the entity's clinicians.

CMS asks whether an individual level QP determination approach is an avenue that CMS should continue exploring in future years to better identify and reward individual eligible clinicians with substantial engagement in Advanced APMs. CMS indicates being motivated to broach this topic by the following considerations:

- Receiving reports from APM participants that to achieve higher QP threshold scores, some APM Entities haven taken steps to exclude from their APM Entity groups (and their APM Participation Lists) clinicians who furnish proportionally fewer services that lead to

attribution of patients or payment amounts to the APM Entity and that the excluded clinicians are predominantly specialists;
    - Manipulation of Participation Lists could also exacerbate care disparities;
- Recognizing that some individual clinicians who are very engaged with their Advanced APMs (e.g., furnish services to large numbers of patients through the APM) fail to reach QP status even though as individuals they would satisfy QP threshold criteria;
    - Their APM Entity includes less engaged clinicians who would not meet QP thresholds as individuals and who drag down the entity's collective QP threshold scores;
- Observing that less engaged clinicians who achieve QP status largely through high engagement levels by other clinicians in an APM Entity may earn large APM incentive bonus payments because those payments are based on total professional services delivered in the preceding year not solely on services delivered through the APM;
    - CMS terms these large bonuses as "windfall" payments; and
- Concluding that some undesirable consequences of the current policy to make most QP determinations at the APM Entity level may have an aggregate effect of discouraging Advanced APM participation, which is counter to the agency's plan for transitioning Medicare to a value-based program in which beneficiaries are cared for through accountable care relationships.

5. RFI: Quality Program Payment Incentives Beginning in Performance Year 2023

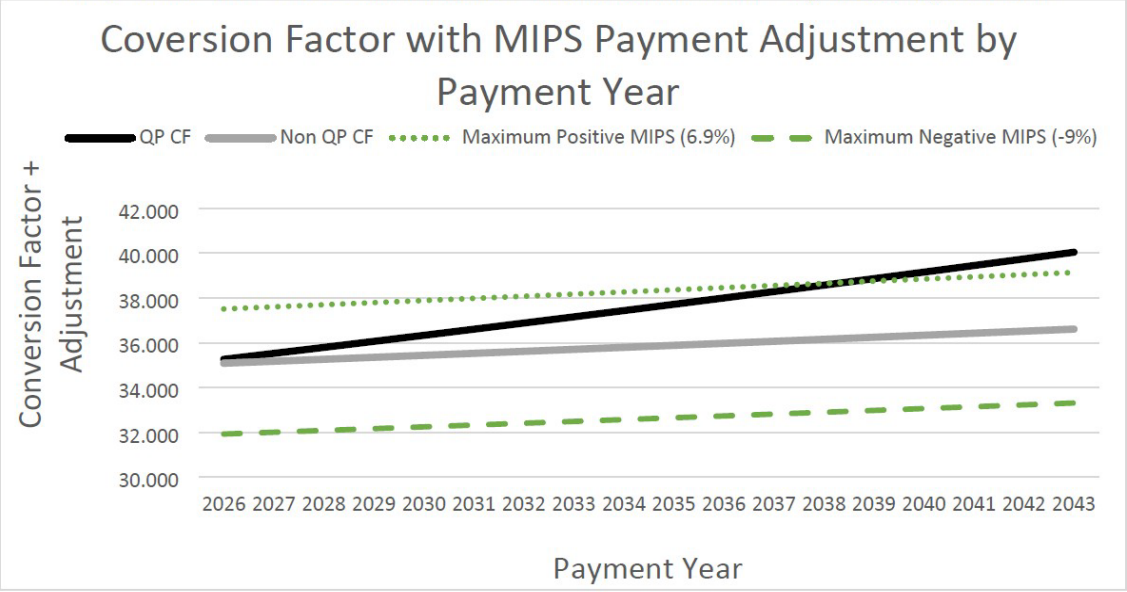
CMS reviews the impending transition from APM incentive payments in the form of lump sum bonuses (5 percent of a QP's prior Part B covered professional services) to the form of a higher annual PFS conversion factor for QPs versus non-QPs (0.75 percent and 0.25 percent, respectively). CY 2022 is the final performance year and CY 2024 will be the final year associated with lump sum incentive payments. Statute does not provide for any form of APM incentive payment for performance year 2023/payment year 2025. Statute does provide for the differential conversion factors to begin with performance year 2024/payment year 2026, and no end date is specified. The effects of the differential factors are allowed to compound over time for QPs who continue to maintain QP status in consecutive years.

CMS also notes that QP threshold criteria will increase to higher levels beginning with performance year 2023/payment year 2025 and remain at those levels for subsequent years. CMS believes that the higher required percentages of payments and patient counts required to reach QP status are likely to result in a lower number of QPs than in prior years.

During the APM incentive payment transition, the MIPS payment adjustment structure remains unchanged from that established in statute and regulation beginning with performance year 2023/payment year 2025. The payment adjustments will continue to range between -9 percent and +9 percent. The adjustment structure remains redistributive: In aggregate, payment adjustments must still be budget neutral (i.e., total positive payments must equal total negative payments). CY 2024 will be the final payment year for additional positive adjustments for exceptional performance as measured by higher MIPS total final scores.

CMS provides Figure 5, reproduced below, that illustrates the effects on the PFS conversion factor of the conversion factor differential (assuming compounding) compared to sequential years of MIPS adjustments at the highest and lowest possible percentages. The QP conversion factor is not expected to equate to the anticipated maximum positive payment adjustment under MIPS until after CY 2038. CMS notes that the distribution of MIPS final scores among clinicians subject to MIPS may be changed by the shift of clinicians who are now participating in Advanced APMs into the MIPS program (i.e., leaving Advanced APMs since QPs are not permitted to simultaneously participate in MIPS). These clinicians are anticipated to be high-performers under MIPS who would skew the MIPS final score distribution towards higher scores and thereby would reduce the average and maximum positive MIPS payment adjustments available because of the application of the MIPS budget neutrality scaling factor (the scaling factor was discussed earlier in the rule and this summary in the context of MIPS final scoring).

FIGURE 5: PFS Conversion Factors vs. Maximum MIPS Payment Adjustments*



*This graph depicts the PFS conversion factors that would apply for each year given the annual updates as specified in current statute, and does not otherwise depict an estimate of PFS payment rates for future years.

CMS voices serious concerns about the trends illustrated in Figure 5 and their implications for moving the Medicare program to one that is value-based and which most beneficiaries are in relationships with clinicians who are accountable for quality and total cost of care. However, CMS concludes from its analysis that it would be prudent for the agency to forgo administrative actions for performance year 2023/payment year 2025 intended to mitigate the illustrated effects. Instead, the agency seeks public input into its considerations for options for administrative actions for permeance year 2024/payment year 2026 and potentially beyond.

Specific questions posed by CMS for feedback are framed as queries to clinicians who are subject to the QPP, as follows where "you" is the clinician:

- What are your primary considerations going forward as you choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments? What factors are the most important as you make this decision?
- If you are participating in an Advanced APM now and have been or could be a QP for a year, will the end of the 5 percent lump-sum APM Incentive Payments beginning in the 2025 payment year (associated with the 2023 QP Performance Period) cause you to consider dropping your participation in the Advanced APM, which would mean forgoing QP determinations, thereby ensuring you are subject to MIPS reporting requirements and payment adjustments?
- Going forward, attaining QP status for a year through sufficient participation in one or more Advanced APMs will enable an eligible clinician to, for a year: (1) continue receiving any financial incentive payments available under the Advanced APM(s) in which they participate, subject to the terms and conditions applicable to the specific Advanced APM(s); (2) be paid under the PFS in the payment year using the a higher QP conversion factor (0.75 percent rather than 0.25 percent) beginning in payment year 2026; and (3) not be subject to MIPS reporting requirements or payment adjustments. Do these three conditions provide sufficient incentives for you to participate in an Advanced APM, or would you instead decide to be subject to Misreporting requirements and payment adjustments?
- Are there other advantages of MIPS participation that might lead a clinician to prefer MIPS over participation in an Advanced APM, such as: (1) quality measurement that may be specific to a particular practice area or specialty area; or (2) the desire for more precise accountability through public reporting of quality measure performance in the future?

CMS reminds commenters that any administrative actions or policy options are subject to the following statutory constraints:

- CMS is required to make QP determinations for eligible clinicians participating in Advanced APMs;
- Advanced APMs are defined as APMs that require CEHRT use, set payment based on MIPS-comparable quality measures, and require assumption of more than nominal financial risk (described at §414.1415); and
- QPs are specifically excluded from being MIPS eligible clinicians.