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Physician Fee Schedule Final Rule for 2023 Summary Part III Medicare and Medicaid Program: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim Final Rules

[CMS-1770-F, CMS-1751-F2, CMS-1744-F2, CMS-5531-IFC]

On November 2, 2022, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule relating to the Medicare physician fee schedule (PFS) for CY 2023[1] and other revisions to Medicare Part B policies. The final rule is scheduled to be published in the November 18, 2022 issue of the *Federal Register*.

HFMA is providing a PFS summary in three parts. Part III covers the updates to the Quality Payment Program. Previously covered in Part I were sections I through III.N of the rule (except for section III.G., Medicare Shared Savings Program Requirements) and section VII, Regulatory Impact Analysis. Previously covered in Part II were the Medicare Shared Savings Program Requirements.

Part III presents finalized policies related to the Quality Payment Program, including Traditional Merit-based Incentive Payment System (MIPS), MIPS Value Pathways, and the Alternative Payment Model (APM) Incentive. Changes include updates to the MIPS Quality and Improvement Activities inventories, addition of five new MIPS Value Pathways, revising the criteria for making Advanced APM determinations, and setting the MIPS final score performance threshold at 75 points for performance year 2023/payment year 2025 (no change from prior year). Changes will take effect on January 1, 2023 unless otherwise noted.

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[1] Henceforth in this document, a year is a calendar year 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]
- Under the MIPS track, continued development of the APM Performance Pathway (APP) and MIPS Value Pathways (MVPs) 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 specified in statute: Quality, Cost, Improvement Activities (IA) and Promoting Interoperability (PI);
    - Per statute, adjustments plateaued at a maximum of ± 9 percent in performance year 2020/payment year 2022;
- Lump sum ("bonus") APM incentive payments through performance year 2022/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 for performance year 2023/payment year 2025;
- Bonus replacement per statute, beginning with performance year 2024/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.

The MIPS track consists of three reporting frameworks: Traditional MIPS, the APM Performance Pathway (APP), and the MVP. Traditional MIPS is the continuation of the original framework first implemented for QPP Year 1 by which MIPS eligible clinicians can collect and report data to MIPS. It has undergone numerous revisions but still includes the four performance categories specified in statute.[4] MIPS eligible clinicians who participate in MIPS APMs (e.g., Bundled Payments for Care Improvement, Advanced model – BPCI Advanced) also may report to MIPS through the APP.[5] Additionally, beginning with performance year 2023, all MIPS

[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, clinical social worker, certified nurse-midwife, and registered dietician /nutrition professional,.

[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. The original Resource Use category has been renamed the Cost category and the Advancing Care Information category is now the Promoting Interoperability category.

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

eligible clinicians may report to MIPS through an MVP that is relevant to their practices, if one is available.

2023 will be the QPP's seventh performance year and fifth payment year. During 2023, MIPS payment adjustments will be applied, and APM incentive payments will be made, to eligible clinicians based upon their 2021 performance data.[6] For performance year 2023, category weights will be unchanged, as shown in a table below.[7] MIPS adjustments will range from -9 to +9 percent, applied to payments for covered Part B professional services furnished during 2023. Some clinicians who met a separately specified, higher performance threshold in 2021 will be receiving an additional positive adjustment in payment year 2023 for exceptional performance. Per statute, 2022 is the final performance year for the exceptional performance bonus, and the final related payments will be made in 2024 based on 2022 data. CMS finalizes 75 points as the final 2023 performance score threshold and basis for adjustments during payment year 2025.

Budget neutrality is required within MIPS by statute. For a threshold score of 75 points, CMS estimates that positive and negative payment adjustments distributed in payment year 2025 will each total about $350 million ($698 million in aggregate). CMS projects that about 63.3 percent of engaged clinicians (i.e., those for whom data were submitted through MIPS for at least one performance category) will receive a positive or neutral MIPS adjustment. The remaining engaged clinicians are projected to receive a negative payment adjustment. CMS further estimates that the maximum possible positive payment adjustment attainable for payment year 2025 will be approximately +6.09 percent and the average will be +3.7 percent. CMS estimates an average negative payment adjustment of -1.8 percent; per statute the maximum negative adjustment is -9.0 percent.[8] CMS emphasizes that estimates may change as newer data become available, particularly since a substantial number of clinicians subject to MIPS are projected to have total performance scores clustering around the finalized MIPS performance 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, to be calculated using services furnished during 2022. Further, 2022 is the final performance year for the incentive payment, and final bonuses will be paid during payment year 2024 based on services furnished in 2023. The thresholds of payments or patients treated through APMs required to reach QP status will increase for performance year 2023/payment year 2025 and subsequent years.[9] Since the 5 percent APM bonus expires at the end of performance year 2022/payment year 2024, there will be no APM bonus expenditures from the Medicare program for performance year 2023/payment year 2025. The bonus is replaced by a conversion factor differential for performance year 2024/payment year 2026 and subsequent years.

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[6] CMS responses to the COVID-19 PHE may continue to affect some 2023 QPP data reporting and scoring policies.
[7] In section IV.H.1.c. of this summary, CMS describes a Cost performance category weight of 10 percent in the context of implementing a revised Cost category maximum improvement score. However, we note that a Cost category weight change from the currently established 30 percent was not part of the PFS proposed rule nor finalized elsewhere in this final rule.
[8] CMS makes estimates under several sets of assumptions, which produce varying results (discussed in detail in the Regulatory Impact Analysis, section VII of the rule). Most variations are small given a threshold score of 75 points.
[9] The QP thresholds will revert to levels previously specified in statute to begin with performance year 2021 but that were 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.

For the QPP overall, CMS estimates that approximately 719,500 clinicians will be MIPS eligible during the 2023 performance period, while another 476,000 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.

Performance Category Weights by Performance Year (PY)						
Performance Category	**PY 2020 *Final PHE-modified****	**PY 2021 *Final Rule***	**PY 2021 *Final PHE-modified****	**PY 2022 *Final Rule***	**PY 2023 *Proposed***	**PY 2023 Final Rule****
Quality	55%	40%	55%	30%	30%	30%
Cost	0%	20%	0%	30%	30%	30%
Improvement Activities	15%	15%	15%	15%	15%	15%
Promoting Interoperability	30%	25%	30%	25%	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 other performance categories, established reweighting policies at §414.1380(c)(ii)(2) are applicable.

** In the preamble, CMS describes a Cost performance category weight of 10 percent in the context of implementing a revised Cost category maximum improvement score. However, a Cost category weight change from the currently established 30 percent was not part of the CY 2023 PFS proposed rule nor finalized elsewhere in this final rule.

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

Changes to MIPS and Advanced APMs are described below. Under the MIPS track, changes to Traditional MIPS generally also are applicable to the MIPS Value Pathways (MVPs) and the APM Performance Pathway (APP) unless precluded by pathway-specific policies as noted below.

Changes being finalized 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,
- Discontinuing automatic reweighting of the Promoting Interoperability (PI) category to zero percent for physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists, and
- Modifying measures, objectives, and scoring within the PI category.

CMS finalizes several changes involving MVPs, including:

- Additional requirements regarding subgroup reporting,

- Revised specifications for all 7 MVPs previously finalized for implementation beginning with performance year 2023,[10]
- Adding 5 new MVPs, involving care of cancer, kidney disease, neurological conditions, and neurodegenerative diseases, as well as provision of optimal preventive care, and
- Adding opportunities for public comment on candidate MVPs prior to rulemaking.

Finalized 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 requiring 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 50-clinician limit provision of the medical home model's risk-bearing standard to be applied at the APM Entity level rather than the parent organization level.

C. Requests for Information

In section IV.A.1.c. of this final rule CMS lists Requests for Information (RFIs) involving the APM track and Traditional MIPS that were published in the CY 2023 PFS proposed rule and are shown below. CMS thanks respondents for their feedback and states that all input received will be considered during future rulemaking on these topics. (Selected additional information about these RFIs also can be found elsewhere in this summary as noted below.)

- RFI Regarding QP Determination Calculations at the Individual Eligible Clinician Level (Also see section IV.J.4. of this summary);
- RFI Regarding the Transition from APM Incentive Payments to the Enhanced PFS Conversion Factor Update for QPs (Also see section IV.J.5. of this summary);
- RFI on Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs (Also see section IV.G.4.j. of this summary);
- RFI on Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) (Also see section IV.G.4.k. of this summary); and
- RFI on Risk Indicators Within Complex Patient Bonus Formula to Continue to Align with CMS Approach to Operationalizing Health Equity (Also see section IV.G.2.b. of this summary).

D. Definitions (§414.1305)

CMS finalizes revisions to the definitions for 6 terms as proposed: 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 the context of its usage.

[10] These MVPs pertain to the following areas of clinical care: anesthesia, chronic disease management, emergency medicine, heart disease, lower extremity joint repair, rheumatology, and stroke care and prevention

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 MIPS track of 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. When estimating administrative burden associated with the QPP, CMS anticipates roughly 12 percent of clinicians participating in MIPS for performance year 2023/payment year 2025 will do so through an MVP.

CMS finalizes without modification the incorporation of public comment opportunities into the MVP development and maintenance processes, revision of MVP performance scoring, addition of 5 new MVPs, and revision of all 7 existing MVPs. All 12 finalized MVPs will 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. Proposals dealing with operational aspects of subgroup reporting are finalized as proposed (e.g., establishing a subgroup determination period). CMS also discusses an RFI addressing alignment of MVP and APM Participant Reporting.

1. MVP Development and Maintenance

a. Public Comment Opportunities

New Candidate MVP Revisions

CMS finalizes without modification a proposal to modify the established MVP development process for new MVPs by creating a formal opportunity for public comment on candidate MVPs.

Once CMS determines that a new candidate MVP is "ready for feedback" a draft version will be posted for a 30-day comment period on the QPP website (https://qpp.cms.gov). CMS will determine which if any suggested revisions are appropriate prior to proposing the revised candidate MVP for adoption into the MVP Inventory through rulemaking. Submitters of the draft candidate MVP will not be notified about revisions made by CMS prior to publication of the revised candidate MVP in the PFS proposed rule.

Commenters generally supported increased transparency of the MVP development process through the proposed public comment opportunity. Some voiced suggestions including:

- CMS should extend the public feedback period from 30 to 60 days.
- CMS should develop a standard annual timeline for MVP release, such as the annual timeline for development and maintenance of eCQMs.
- CMS should facilitate coordination among those specialty societies to whom a candidate MVP is applicable by creating an informal process for that purpose during MVP development.
- CMS should provide to the original submitters of the draft candidate MVP a period in which they can review and provide feedback to the agency prior to formal proposal of the revised candidate MVP through rulemaking by CMS.

CMS states that extending the pubic feedback period is not operationally feasible. It also states that a standard annual timeline is inconsistent with its purposeful process design to accelerate MVP development by allowing candidate MVP submission to occur on a rolling basis throughout the year. The agency believes that the MVP development process being finalized offers sufficient opportunities to draft candidate MVP submitters and other interested specialty representatives to provide feedback to CMS without creating an informal CMS-sponsored process for interspecialty coordination or a preview period for original MVP submitters prior to PFS proposed rule publication of new MVPs.

Established MVP Revisions

CMS finalizes without modification a proposal to modify the process established for maintenance of existing MVPs by creating a formal opportunity for public comment on potential revisions to those MVPs.

CMS will accept submissions of potential revisions from the public on a rolling basis throughout the year.[11] Revisions found to be feasible and appropriate by CMS will be presented for comment during a public-facing webinar hosted by the agency. Based on feedback from the webinar, CMS may make revisions and any revised MVPs would be brought forward as proposals through PFS rulemaking. Proposals for revisions would not be previewed with the submitters of the original MVP prior to proposed rulemaking.

Commenters generally supported increased public participation in the MVP maintenance process. Suggestions received included sharing all submitted potential revisions with the original MVP developer, publishing suggested revisions prior to the webinar, and sharing all feedback received as part of notice-and-comment rulemaking.

CMS does not intend to share suggested revisions with the original MVP developer prior to or separate from proposed rulemaking. The agency will investigate the operational feasibility of sharing potentially feasible and appropriate revisions in advance of the webinar. CMS will

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

publish as part of rulemaking only feedback received that the agency judges relevant to MVP revisions being proposed.

b. New and Revised MVPs

CMS finalizes adding the following 5 new MVPs to the MVP Inventory and refers readers to Appendix 3 for a complete review of the proposals and comments received. Final actions are provided below for each MVP, excerpted from Appendix 3.

- Advancing Cancer Care
  - Finalized with modification—the measure PIMSH8 *Mutation testing for lung cancer completed prior to start of targeted therapy* will not be included because the measure has been revised by its steward subsequent to proposal of this MVP.
- Optimal Care for Kidney Health
  - Finalized as proposed.
- Optimal Care for Neurological Conditions
  - Finalized as proposed.
- Supportive Care for Cognitive-Based Neurodegenerative Conditions
  - Finalized as proposed.
- Promoting Wellness
  - Finalized as proposed.

CMS finalizes revisions to 7 established MVPs listed below and refers readers to Appendix 3 for a complete review of the proposals and comments received. Revisions were proposed to align these MVPs with changes being finalized elsewhere in this rule to the MIPS Quality Measure Inventory (Appendix 1) and the MIPS Improvement Activities Inventory (Appendix 2). Final actions are provided below for each MVP, excerpted from Appendix 3.

- Advancing Rheumatology Patient Care
  - Finalized as proposed.
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
  - Finalized as proposed.
- Advancing Care for Heart Disease
  - Finalized as proposed.
- Optimizing Chronic Disease Management
  - Finalized with modification—the measure Q119 *Diabetes: Medical Attention to Nephropathy* is being removed from the MVP as it has been deleted from the MIPS Quality Inventory.
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
  - Finalized as proposed.
- Improving Care for Lower Extremity Joint Repair
  - Finalized as proposed.
- Patient Safety and Support of Positive Experiences with Anesthesia
  - Finalized as proposed.

c. MVP Reporting Requirements and Scoring Policies

Applicability of Promoting Interoperability Performance Category Changes

Each MVP is required to include the complete set of MIPS Promoting Interoperability (PI) performance category measures found in Traditional MIPS. Numerous final actions regarding Traditional MIPS PI category changes (e.g., revisions to the PI category scoring methodology) are described in detail in section IV.A.6.c.(4) of the rule and later in this summary. All changes finalized for Traditional MIPS will also be adopted into MVP PI category reporting and scoring.

Applicability of Overall MIPS Scoring Policy Changes

Scoring policies from Traditional MIPS are routinely adopted for MVP scoring unless CMS determines otherwise. Elsewhere in the rule, several changes are finalized to Traditional MIPS scoring policies listed below; the changes also are described later in this summary. The finalized policies 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.

Reporting MVPs and Team-Based Care

CMS notes that MVP reporting options for multispecialty groups will change beginning with PY 2026 and may impact multispecialty groups that practice team-based care. CMS refers readers to a discussion in the proposed rule of approaches to MVP reporting by multispecialty groups that practice team-based care (87 FR 46267) as well as to policies governing subgroup reporting that are finalized elsewhere in this rule and described later in this summary.

d. Request for Information: MVP and APM Participant Reporting

In the proposed rule, CMS requested feedback on ways to better align clinician experience between MVPs and APMs, specifically seeking input on:

- How CMS can obtain more robust reporting of primary care and specialty care performance measurement information from APM participants.
- How CMS can address the burden of specialist performance data reporting required by both certain APMs and MIPS.
- Policy ideas that would encourage the reporting of specialty services performance information in addition to the APP, such as finding a way to roll MVP quality measure performance data into the APP.
- How CMS can enhance MVP reporting as a bridge to APM participation.

CMS indicates having received responses to this RFI but does not summarize them or provide details. The agency states that the information received may be used to inform future rulemaking.

2. Subgroup Reporting

a. Definitions

CMS finalizes revisions to the definitions of single and multispecialty groups to specify that specialty types of group members will be determined by CMS using Part B claims. Specialty codes on Part B claims are assigned to clinicians by the agency's Medicare Administrative Contractors (MACs). All members of a single specialty group will share a single specialty type. A multispecialty group will include at least two members whose specialty types differ.

Many commenters questioned the accuracy of specialty assignment based on Part B claims. Others noted that a group incorrectly categorized as multispecialty based on Part B claims would unfairly be forced to subdivide to create single specialty subgroups to be able to report to MIPS via MVPs once multispecialty group MVP reporting is no longer permitted beginning with PY 2026. Some observed that clinicians of different specialty types could share a clinical focus and patient population yet be required to structure themselves as subgroups for MVP reporting (e.g., Family Medicine and Internal Medicine physicians in a single primary care practice group). Alternative approaches suggested by commenters to specialty assignment were using the specialty taxonomy followed during the National Provider Identifier (NPI) application process or allowing each clinician to self-attest as to specialty.

CMS acknowledges that Part B claims are not perfectly predictive of clinician specialty but has not identified a more accurate data source. While the NPI taxonomy is more granular than claims-based specialty assignment, clinicians are not required to update their specialty designations after their NPIs have been issued. Self-attestation would require CMS to develop a validation process, adding to operational complexity. CMS also acknowledges the administrative burden associated with transitioning from a multispecialty group structure to multiple subgroups. However, the agency has not yet set a date certain for mandatory subgroup reporting, allowing time for multispecialty groups to create and execute a multiple subgroup plan that minimizes transition burden (see potential transition timeline below).

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. 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 is unchanged by the final actions of this rule. During 2022 PFS rulemaking, CMS indicated that the end of performance year 2027 is under consideration as a potential sunset date for Traditional MIPS (86 FR 39356) but has not yet announced a firm timeline. The sunset date will be proposed through future PFS rulemaking.

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, single specialty groups, or subgroups
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 finalizes without change that each subgroup must provide a description of the composition of the subgroup and the nature of its practice at the time of subgroup registration. The description may be adapted from examples provided by CMS or be a custom narrative written by the subgroup.[12]

During registration, a subgroup must also complete the following actions:

- 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).

[12] One example narrative provided by CMS is "This subgroup represents our cardiovascular line, which includes cardiologists, cardiothoracic surgeons, and other associated professionals."

Comments were received in support of and in opposition to the new requirement. Concern was raised about added administrative burden for subgroups and their providers.

CMS states that added burden will be minimal; it anticipates that most subgroups will be able to easily create their narratives based on examples it provides. Subgroup identifiers will be assigned by CMS once all registration requirements have been satisfied.

d. Subgroup Composition

CMS finalizes its proposal to limit each clinician to membership in a single subgroup within each TIN to which the clinician belongs.

Comments were received in support of and in opposition to this limitation. Concern was raised that a single clinician could fulfill different roles within a single TIN that potentially fall into separate subgroups (e.g., a cardiologist who participates in both cardiology and primary care clinics within the TIN).

CMS acknowledges the commenters' concern but asserts that the limitation is necessary because of operational issues that would arise if a clinician could belong to multiple subgroups within a single TIN. For example, difficulties would occur with patient attribution and impair the agency's ability to match clinicians to subgroups for MIPS measures reported through Part B claims or calculated using administrative claims.

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

CMS finalizes its proposal 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. To successfully register, a subgroup will be required to include at least one clinician member who does not meet criteria for applicability of the low-volume threshold.

Clinicians meeting low-volume criteria (e.g., number of Medicare beneficiaries to whom Part B professional services are furnished) are generally excluded from MIPS participation.[13] CMS uses the MIPS determination period to identify clinicians eligible to participate in MIPS. The period has two 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.

[13] A clinician meeting one but not all low-volume criteria may opt in to MIPS participation; a clinician meeting all criteria is excluded. The criteria are: allowed Medicare 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 Medicare-covered professional services. More information is available at https://qpp.cms.gov/mips/how-eligibility-is-determined#low-volume-threshold.

CMS received supportive comments. The agency states that the finalized policy will address technical challenges it has identified while merging the finalized MVP subgroup participation framework with the existing 2-year MIPS eligibility determination process.

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

CMS finalizes without change its proposals 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. Specifically:

- 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.

A few commenters were positive but most were opposed; the latter viewed the proposal as inconsistent with the goal of more granular reporting via the subgroup mechanism. They suggested that CMS calculate scores at the subgroup and group levels and award the higher of the two scores to the subgroup.

CMS states that technical issues involving testing and attribution must be fully understood before valid subgroup calculations for cost, population health, and outcomes-based administrative claims measures can be performed. For example, questions have arisen related to the impact of subgroup size on measure case minimums and how to determine measure reliability at the subgroup level since claims do not contain subgroup identifiers. Absent a validated subgroup scoring methodology, CMS views calculating scores at two levels as suggested by commenters as an inappropriate strategy. CMS plans to pursue technical solutions to the agency's concerns that would allow future realization of the full potential value of subgroup reporting across all measures and performance categories.

g. Registered Subgroups Without Submitted Data

CMS finalizes as proposed that a final score will not be assigned to a registered subgroup that does not submit data as a subgroup within the applicable reporting period. MIPS eligible clinician members of subgroups that are registered but do not submit subgroup data will be expected to report to MIPS using other pathways.

Comments received were supportive. CMS plans to monitor subgroup participation and reporting trends and revise this policy if necessary before mandatory MVP reporting begins (date not yet finalized).

h. Subgroup Reporting Examples

CMS refers readers to a series of tables published in the proposed rule that illustrate how MIPS final scores would be calculated and awarded for clinicians in varying group and subgroup configurations (87 FR 46272 through 46275). CMS plans to provide similar material for reference purposes via the QPP website (https://qpp.cms.gov/resources/resource-library).

F. APM Performance Pathway (APP)

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.

1. Subgroup Reporting through the APP

CMS finalizes its proposal to disallow reporting through the APP by a subset of clinicians within a group, irrespective of whether the group is a single or multispecialty group (i.e., prohibit subgroup-level reporting). CMS does so by removing the reference at §414.1318(c)(2) to scoring clinician performance at the subgroup level under the APP.

CMS notes having requested in the proposed rule that commenters specify whether they preferred allowing or disallowing subgroup reporting under the APP as the best balance between reporting flexibility and administrative burden. APP subgroup reporting would require establishment of a subgroup registration process and related policies. CMS further notes that when the APP was introduced as a MIPS participation option, subgroup reporting through MVPs had not yet been established.

One comment was received in which a preference for allowing subgroup reporting under the APP was voiced. CMS concludes that allowing subgroup reporting under the APP could garner more support once MVPs become more widely adopted. The agency will consider revisiting its decision to disallow based on future experience administering the MVP subgroup framework and on additional input from interested parties. CMS states its view that subgroup reporting through the APP could serve as a step towards APM participation for clinicians who have gained experience reporting through a shared MVP.

2. Performance Category Scoring for Clinicians Reporting though the APP

a. Quality Performance Category

APP Measure Set for Performance Year 2023

The APP's Quality performance category measures are drawn from the MIPS Quality Measure Inventory (see Appendix 1 of the rule). They were reviewed by CMS earlier in this rule along with the Shared Savings Program quality standard (see section III.G.4. of the rule and section III.G.4. of this summary, which can be found in Part II of HPA's CY 2023 PFS final rule summary). The APP quality measure set for performance year 2023, shown below, is unchanged from prior years except for retitling measure Q484.

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 finalized by CMS; specifications are otherwise unchanged	

Potential New and Revised APP Quality Measures

In the proposed rule, CMS indicated that two new measures were being considered for future addition to the APP quality measure set once they are adopted into the MIPS Quality Measure Inventory: *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health*. Elsewhere in this rule, the *Screening for Social Drivers of Health* measure is finalized for addition to the Inventory and thereby could be proposed for adoption into the APP Quality measure set during future rulemaking. See Appendix 1 Item A.3 for an extensive discussion of comments received about this measure; no comments specific to adding this measure to the APP were received. The *Screen Positive Rate for Social Drivers of Health* measure has not yet been proposed for adoption into the Inventory.

In the proposed rule, CMS also indicated that consideration was being given to adding new questions to the CAHPS for MIPS Survey measure. The new questions would address health equity and healthcare price transparency. Elsewhere in this final rule, CMS indicates having received feedback in response to its RFI about these changes but provides no further information.[14] The agency indicates that comments received may be considered during future rulemaking.

[14] The outline sequencing of provisions in section IV. of the final rule is discontinuous, but the material about the CAHPS for MIPS Survey changes appears in a section numbered IV.A.10.c.

b. Improvement Activities (IA) Performance Category

Each MIPS APM has associated specified IA. 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.

In the proposed rule, CMS clarified 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 by so doing. In this final rule, CMS does not indicate having received comments or questions on this topic and simply repeats its clarification.

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 (Traditional MIPS)

1. Quality Performance Category

CMS proposed 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 finalizes its proposal to expand the definition of a high-priority measure to include health-equity related quality measures. While most commenters supported the proposal, many sought additional guidance on what would classify a measure as a health equity-related measure for purposes of the high priority designation. CMS

indicates that it is focusing on a person-centric approach and is identifying measurable interventions to close gaps in quality care and health outcomes to attain the highest level of health for all people.

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 finalizes its proposal 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 and provide for a more meaningful comparison of performance between MIPS groups.

Commenters were supportive of the proposal. CMS conducted an internal analysis of existing CAHPS for MIPS data and found that this change to the case-mix adjustment model did not have a substantial impact on scores for most groups and had a small positive impact on scores for groups with a large proportion of patients reporting speaking a language other than English at home, which suggests a slight improvement in measurement of patient experience by the survey.

In the proposed rule, CMS requested comment on potential future CAHPS for MIPS Survey measure changes to add items related to health disparities and price transparency and to create a shortened survey version that would be more applicable to care by specialists. CMS acknowledges feedback received without describing the comments then states that the input will be used to inform future rulemaking.

a. Data Completeness Criteria

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

For the 2024 and 2025 performance periods, CMS proposed increasing 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 noted that the proposal would not apply to CMS Web Interface measures which in the 2023 performance period are only available to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP).

Reaction from stakeholders was mixed. Those opposed to the proposed increase believe it would result in an unnecessary increase of reporting burden for individual MIPS clinicians, groups and virtual groups, and they believe clinicians were being held to a higher standard in MIPS compared to other quality programs. CMS disagreed with the assertion that the increase would unnecessarily increase the reporting burden, and it does not agree with the conclusion that the overall reporting burden of a CMS quality program is less than another CMS quality program merely because the one CMS quality program has a lower data completeness criteria threshold than another. CMS believes that it is critical to increase data completeness thresholds over time to more accurately assess a MIPS eligible clinician's performance on quality measures and prevent any selection bias. CMS acknowledges that the increase in the data completeness criteria threshold would impact APM Entities such as MSSP ACOs that are preparing to transition to reporting MIPS CQMs or eCQMs under the APP, and face additional considerations around the aggregation of data across ACO participant sites.

CMS finalizes its proposals without modification.

b. Selection of MIPS Quality Measures

For the 2023 performance period, CMS proposed a total of 194 quality measures and finalizes a measure set of 198 MIPS quality measures in the MIPS Quality Measure Inventory for the 2023 performance period (shown in Table Groups A through E of Appendix 1 to the final rule), including the following:[15]

- 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. (See Table Group A of Appendix 1.)
- Removal of 11 MIPS quality measures: 1 MIPS quality measure that is duplicative to a newly finalized quality measure; 4 MIPS quality measures that are duplicative to current quality measures; 3 MIPS quality measures that do not align with the Meaningful Measures Initiative (i.e., measures that are unable to produce a benchmark, have limited adoption, or describe a care standard); 2 MIPS quality measures that are under the topped-out lifecycle; and 1 MIPS quality measure that is extremely topped out. (See Table Group C of Appendix 1.)
- Partial removal of MIPS quality measures: 2 MIPS quality measures removed from traditional MIPS and retained for use in MVPs. (See Table Group DD of Appendix 1.)
- Substantive changes to 76 existing MIPS quality measures. (See Table Group D of Appendix 1.)

In the final rule, CMS notes that for the CY 2022 performance period/2024 MIPS payment year (the last year for which the CMS Web Interface is available as a collection and submission type under traditional MIPS for groups, virtual groups, and APM Entities), the CMS Web Interface benchmarks created for the APP under the Medicare Shared Savings Program would be utilized under MIPS. In the proposed rule, CMS proposed to correct the inadvertent indication that a Medicare Shared Savings Program benchmark would not be created for the Preventative Care

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

and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226). CMS believes scoring this measure would be beneficial to the overall quality performance category score for a group, virtual group, or APM Entity because (i) there would be an opportunity to earn more achievement points as an additional CMS Web Interface measure would be scored; and (ii) there would not be any additional administrative burden given that groups, virtual groups, and APM Entities are already required to report on all CMS Web Interface measures, including CMS Web Interface measures without benchmarks. See Table Group E of Appendix 1 for these quality measures.

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 outcome as well as increased healthcare utilization.[16]

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.[17]

To address DOH, CMS proposed 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.

CMS finalizes the implementation of the "Screening for Social Drivers of Health" measure as proposed (see Table Group A of Appendix 1 for the discussion of this MIPS quality measure).

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

CMS sought stakeholder input for 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.[18] It acknowledges the feedback provided, which it may take into account in future rulemaking.

[16] 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.
[17] "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/
[18] https://www.cms.gov/files/document/overview-2021-muc-list-20220308-508.pdf

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 sought feedback on a number of issues related to the development of a process measure and a composite measure. It acknowledges the feedback provided, which it may take into account in future rulemaking.

2. Cost Performance Category

CMS proposed updating 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. CMS finalizes the proposal without modification.

The current operational list is available at the MACRA Feedback page.[19] The 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.

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.[20] 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.[21]

CMS did not propose 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.

In response to comments, CMS notes that its proposal was not intended to modify the MSPB Clinician measure itself or change the way in which the measure is attributed to clinicians. It

[19] https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/GiveFeedback
[20] The measure specification documents are available on the QPP Resource Library at https://qpp.cms.gov/about/resource-library.
[21] https://www.cms.gov/Medicare/Quality-Initiative-Patient-Assessment-Instruments/Value-BasedPrograms/MACRA-MIPS-and-APMs/MACRA-Feedback.html

does not believe the new measure will add to clinician burden since it is calculated with administrative claims data. CMS clarifies that adding the MSPB Clinician measure to the operational list as a care episode group will not impact the agency's plans to continue developing episode-based cost measures for potential inclusion in the MIPS program in future years. It also notes that the MSPB Clinician measure's specifications are unchanged; thus, the measure's 35-episode case minimum that was previously finalized will continue to apply.

3. Improvement Activities Category

CMS did not propose any changes to the traditional improvement activities (IA) policies for the 2023 performance period/2025 MIPS payment year, but it did propose changes to the IA 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 proposed 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 proposed to remove six IAs to align with current clinical guidelines and to eliminate duplication. Detailed descriptions of the final decisions are provided in Appendix 2 of the rule: new IAs are found in Table A, changes to existing IAs are found in Table B; and the proposals for removal of IAs and the final decisions are found in Table C.

The four new IAs are as follows:

- 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 Achievement for Practice Staff (IA_ERP_XX).

CMS highlights one of its proposed modifications to the existing IAs: It proposed to recategorize the IA_CC_14 improvement activity (currently entitled "Practice improvements that engage community resources to support patient health goals") from the Care Coordination subcategory to the Achieving Health Equity subcategory. It also proposed renaming it to "Practice Improvements that Engage Community Resources to Address Drivers of Health." The changes were intended to re-focus the improvement activity on obtaining and acting on drivers of health data terminology, which better encompasses both SDOH and HRSN concepts. The agency also proposed to update the list of these factors in the description to reflect a more comprehensive array of drivers of health.

CMS reports that commenters were generally supportive of the changes. CMS finalizes all of its proposals as follows, including two finalized with minor modifications:

- The description of the new activity "COVID-19 Vaccine Achievement for Practice Staff" is modified so that it reads as follows: "Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff in the MIPS eligible clinician's practice staying up-to-date with COVID-19 vaccinations in accordance with the Center for Disease Control and Prevention (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified by CDC recommendations are excluded from this activity."
- For the modification to IA_PSPA_7, Use of QCDR data for ongoing practice assessment and improvements, CMS makes a technical formatting change to the activity description, changing the "or" to "OR," to make it clear that the requirements of the activity have not increased.

4. Promoting Interoperability Performance Category

a. Background

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.[22] CMS reviews the history of regulatory changes to this performance category.

b. 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 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 proposed no change to the performance periods.

c. 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).

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

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 December 31, 2022, 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 proposed 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.

d. Promoting Interoperability Performance Category Measures for MIPS Eligible Clinicians

(i) Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions. PDMPs can help identify patients who may be at risk for overdose. A measure for Query of a PDMP exists under the Electronic Prescribing objective. CMS reviews the 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 base performance on scoring of the Query of PDMP measure 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. Prior 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 recognized 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 notes that all 50 states and several localities now host PDMPs and that a number of enhancements to PDMPs are occurring across the country,

including enhancements to RxCheck, which is a free, federally supported interstate exchange hub for PDMP data.[23] The SUPPORT for Patients and Communities Act included new requirements for PDMP enhancement and integration to help reduce opioid misuse and overprescribing and to 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 proposed 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 use data from CEHRT to conduct a query of a PDMP for prescription drug history, except as prohibited and in accordance with applicable law. CMS proposed, beginning with the performance period in 2023, to require—rather than have as optional—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 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 proposed to maintain the associated points at 10 points for reporting a "yes/no" response for the Query of PDMP measure.

Comments/Responses: Several commenters supported the proposal to require the Query of PDMP measure, stating it will help combat the opioid epidemic and bring awareness to prescribers. Several others did not support the proposal, stating it would be administratively burdensome and costly for MIPS eligible clinicians facing challenges with EHR-PDMP integration, for those who lack an integrated PDMP, or those whose EHR technology remains under development. Some requested that CMS postpone the requirement for an additional year.

[23] 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.

CMS agrees that not all MIPS eligible clinicians have a fully operational statewide PDMP or a fully integrated EHR-PDMP. Without full integration, the actions required to satisfy the Query of PDMP measure could be time-consuming for clinicians and potentially cause clinical disruption. CMS modifies the final policy to allow an additional exclusion when this measure would be costly or present an excessive administrative burden for physicians.

Several commenters opposed the proposal, stating that there is limited evidence supporting the overall relationship between querying a PDMP and a reduction in opioid-related consequences. CMS responded that while the measure itself will not resolve the opioid epidemic, the measure is an important step for clinicians to gain additional awareness when prescribing Schedule II opioids, and Schedule III and IV drugs; it will also give prescribing clinicians insight into the broader clinical picture and prescribing history of their patient.

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

Final Decision: CMS is finalizing the policy with an additional exclusion that will be available only for the 2023 performance period/2025 MIPS payment year: any MIPS eligible clinician for whom querying a PDMP would impose an excessive workflow or cost burden prior to the start of the performance period they select in 2023. CMS expects that this time-limited exclusion will allow MIPS eligible clinicians time to resolve any remaining barriers to reporting the measure.

(ii). Changes to the Query of PDMP Measure to Include Schedules II, III and IV
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). Examples are shown in Table 91, reproduced below. CMS notes that PDMPs in every state currently collect data on schedules II, III and IV, and that most state PDMPs require physicians and dispensing pharmacists to review a patient's prescribing information for the past 12 months prior to prescribing or dispensing any Schedule II, III, and IV controlled substances.

TABLE 91: Controlled Substance Schedules, Descriptions, and Examples*

Schedule	Description	Examples
Schedule I	No accepted medical use, are unsafe, and hold a high potential for abuse.	Heroin and LSD
Schedule II	Accepted medical use, high potential for abuse, abuse could lead to severe psychological or physical dependence.	Hydrocodone, methadone, Demerol, OxyContin, Percocet, morphine, codeine, and amphetamine

Schedule III	Accepted medical use, less potential for abuse than schedule I or II substances, abuse may lead to moderate or low physical dependence or high psychological dependence.	Tylenol with Codeine and anabolic steroids
Schedule IV	Accepted medical use, low potential for abuse relative to schedule III substances, abuse may lead to limited physical or psychological dependence relative to schedule III substances.	Xanax, Klonopin, Valium, and Ativan
Schedule V	Accepted medical use, low potential for abuse relative to schedule IV substances, abuse may lead to limited physical or psychological dependence relative to schedule IV substances.	Cough syrups containing codeine

* GAO-21-22, Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs; 21 U.S.C. section 812, and the U.S. Drug Enforcement Administration.

The current description for the Query of PDMP measure is as follows: 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 proposed changes to the measure to include not only Schedule II opioids but also Schedule III and IV drugs, beginning with the CY 2023 performance period. CMS stated the policy will further support HHS initiatives regarding treatment of opioid and substance use disorders by expanding the types of drugs included in the Query of PDMP measure while aligning with the PDMP requirements in a majority of states. The query must occur prior to the electronic transmission of an electronic prescription for a Schedule II opioid or Schedule III or Schedule IV drug.

Comments/Responses: Several commenters supported the policy, with some saying it would actually reduce clinician, administrative, organizational and developer burden by minimizing the need to focus on one class of drugs. A few opposed the proposal, concerned about CMS simultaneously proposing to both require and expand the measure, to which CMS disagreed, restating various reasons.

Final Decision: As proposed, CMS is expanding the scope of the measure to include not only Schedule II opioids but also Schedules III and IV drugs. However, CMS notes the modification described earlier, which adds an exclusion for the Query of PDMP measure that will allow any MIPS eligible clinician for whom querying a PDMP would impose an excessive workflow or cost burden prior to the start of the performance period they select in CY 2023 to exclude the Query of PDMP measure for the CY 2023 performance period/2025 MIPS payment year.

e. Health Information Exchange (HIE) Objective: 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 (an alternative to reporting the other two measures, worth 40 points, the maximum number of points in the HIE Objective).

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.[24] 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.

[24] 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.

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. 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 proposed 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.[25]

CMS proposed that 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 cited numerous certified health IT capabilities that can support bi-directional exchange under a Framework Agreement. For example, participants may exchange information under a Framework Agreement by using technology certified to the criterion at 45 CFR 170.315(b)(1), "Care coordination—Transitions of care," to transmit care/referral summaries across a network. CMS provided several other examples. The Enabling Exchange Under TEFCA measure could offer health care providers an alternative to earn credit for the Health Information Exchange objective, without requiring clinicians to assess whether they participate in a health information exchange that meets the attributes of attestation Statement 2 under the HIE Bi-Directional Exchange measure.

Comments/Responses: Many commenters supported adding the Enabling Exchange Under TEFCA measure under the Health Information Exchange objective. Several stated the measure

[25] 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.

will minimize costly and unnecessary administrative burdens and is an important step toward fostering interoperability and nationwide data exchange, aiding to fill information gaps, and to reduce burdens placed on MIPS eligible clinicians.

CMS listed reasons why some commenters opposed the proposal, including the following:

- Some networks do not yet facilitate the live exchange of production data, so CMS should consider postponing this measure as an option, to not place additional burden on EHR vendor support staff.
- Implementation burden would limit rural MIPS eligible clinicians and small practices from participating.

CMS disagrees that the measure will create additional burden on MIPS eligible clinicians, and instead believes burden is reduced by offering an additional option to satisfy the Health Information Exchange objective (i.e., one of three options to complete the objective).

Final Decision: CMS is finalizing its proposal to add the Enabling Exchange Under TEFCA measure, beginning with the 2023 performance period, to be worth 30 points (the total amount of points available for the Health Information Exchange Objective).

f. 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 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.[26] 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 proposed to consolidate options 1 and 2 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.
- 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 believes this information on active engagement 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

[26] "Production data" refers to data generated through clinical processes involving patient care and is distinguished from "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.

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 proposed 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.

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 proposed that MIPS eligible clinicians may spend only one performance period at the Pre-production and Validation level of active engagement per measure. These clinicians must progress to the Validated Data Production level in the next performance period for which they report a particular measure or otherwise they would fail to satisfy the Public Health and Clinical Data Exchange Objective.[27]

As mentioned in the next section, among many other changes, CMS proposed 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 93 of the proposed rule).

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

Changes summarized above affect the scoring of the objectives and measures for the performance period in 2023. CMS provides several tables spanning multiple pages, including the following:

- Table 92. 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 93: 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 94: 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 95: Promoting Interoperability Performance Category Objectives and Measures and 2015 Edition Certification Criteria. For each objective, this table shows the measure and regulatory references for the 2015 Edition Certification Criteria as made by the ONC Cures Act final rule (85 FR 25667 through 25668), required beginning with the 2023 performance period.

[27] In this section of the 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.

Table 93 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 93: 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). The maximum points in this table do not include the points that will be redistributed in the event an exclusion is claimed, which is shown in Table 94 (not reproduced here).
* Signifies a final policy adopted in this 2023 PFS final rule.

As a recap, CMS is making the Query of PDMP required and retaining the 10 points associated with it and reduces the points associated with the HIE Objective measures from 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 proposed 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 proposed 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.

Comments/Responses: Several commenters supported the proposals to modify the existing scoring methodology, to make it less cumbersome, easier to understand, and more effectively highlight important objectives. One commenter stated that the scoring revision will help address the opioid crisis. Another stated support for changing the scoring methodology from optional

bonus points to an assigned 10 points, making the Electronic Prescribing objective worth a total of 20 points. CMS agrees, saying that increasing the number of points allocated to the objective by requiring the Query of PDMP measure demonstrates CMS' continued commitment to combatting the opioid epidemic.

Other commenters opposed requiring the Query of PDMP measure, with one stating that many clinicians are incapable of interconnecting their EHR technology with PDMP systems. CMS agrees that not all MIPS eligible clinicians have a fully operational statewide PDMP or a fully integrated EHR-PDMP, and that without full integration, the actions required to satisfy the Query of PDMP measure could be time-consuming for clinicians and potentially cause clinical disruption. As a result, as described earlier, CMS is adopting an additional exclusion for the Query of PDMP that will be available only for the 2023 performance period/2025 MIPS payment year.

Final Decision: CMS finalizes its proposed changes to the scoring methodology for the Promoting Interoperability performance category for the 2023 performance period.

h. Additional Considerations Regarding Non-Physician Practitioners

(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 the 2020 level of 27.5 percent. Although CMS considered a reweighting policy, CMS believes that incenting 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 proposed to discontinue the reweighting policy at §414.1380(c)(2)(i)(A)(*4*)(*ii*) of assigning 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.

Comments/Responses: Many commenters supported CMS' decision not to continue the reweighting policy for NPs, PAs, CRNAs, or CNSs, with one commenter stating that it is critical to expand health care provider participation in the Promoting Interoperability performance category so that data from NPs, PAs, CRNAs, or CNSs is included in public health reporting. One commenter requested exceptions for small practices and CRNAs in rural areas. For those in rural area, CMS said it may consider this feedback in future rulemaking; in the 2022 PFS final rule, CMS finalized a reweighting policy to assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score for MIPS eligible clinicians in small practices.

Several commenters opposed not continuing the reweighting policy, saying it is very problematic for those clinicians not reporting as a group because it makes them individually responsible for submitting data for the Promoting Interoperability performance category—an unnecessary change during the COVID-19 PHE. CMS believes that the sharing of EHI from all MIPS eligible clinicians through CEHRT will improve patient care. Moreover, MIPS eligible clinicians who do report as a group may be in small practices and eligible for reweighting under the policy at § 414.1380(c)(2)(i)(C)(*9*).

Final Decision: As proposed, CMS will end the reweighting policy at §414.1380(c)(2)(i)(A)(*4*)(*ii*) that assigns a weight of zero to the Promoting Interoperability performance category in the MIPS final score for NPs, PAs, CRNAs, or CNSs beginning with the 2023 performance period for the 2025 MIPS payment year.

(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 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 proposed to continue the existing reweighting policy for them for one more year.

Comments/Responses: The majority of commenters supported the proposal. Many expressed concerns about CMS' statement that it did not anticipate continuing the policy for additional years, that these clinician types are not eligible to participate in the Medicare and Medicaid EHR Incentive Programs and do not have the resources to adopt CEHRT. CMS may take this feedback under consideration for future rulemaking.

Final Decision: CMS is finalizing its proposal 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 (§414.1380(c)(2)(i)(A)(*4*)(*i*)).

(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 was 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 proposed 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. CMS did not receive any comments and is finalizing its proposal.

i. Request for Information (RFI): Patient Access to Health Information Measure

In the proposed rule, CMS requested comments on a measure of patient access to their health information. CMS did not summarize the comments in the final rule but will consider the information in future rulemaking.

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

This RFI appeared in the CY 2023 proposed rule and is a follow-on to an RFI that appeared in the 2022 PFS final rule (86 FR 65377 through 65382). In the first RFI, CMS announced its plan to move fully to digital quality measurement across its quality reporting and value-based purchasing programs by 2025. In the second (follow-on) RFI, CMS requested input about a

refined definition for *digital quality measure (dQM)*, data standardization, and approaches to reporting electronic clinical quality measures (eCQMs) based on FHIR standards.

In this final rule, CMS thanks respondents for their feedback but does not share any of the comments received or describe next steps towards implementing its overarching dQM strategic plan. The agency states that the input received will be considered during future rulemaking.

k. RFI: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

This RFI appeared in the CY 2023 proposed rule, at which time CMS posed questions about

- the most important use cases for different stakeholder groups that could be enabled through widespread information exchange under TEFCA;
- key ways that the capabilities of TEFCA can help to advance the goals of CMS programs;
- potential approaches available to the agency to incentivize or encourage information exchange through CMS programs under TEFCA; and
- stakeholder concerns about enabling exchange under TEFCA (e.g., provider burden, technical barriers).

In this final rule, CMS thanks respondents for their feedback but does not share any of the comments received. The agency does not describe strategic next steps towards implementing TEFCA across the Medicare program but does finalize elsewhere in this rule the adoption of a TEFCA-based measure into the MIPS Promoting Interoperability performance category. CMS does indicate that the responses received to the above questions will be considered during future rulemaking.

H. MIPS Final Score Methodology (§414.1380)

1. Policy Changes

a. Quality performance category: claims-based quality measure benchmarking

CMS finalizes its proposal without changes 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. Measures for which available claims data for a clinician do not meet case minimum or benchmark requirements will continue to be excluded from the clinician's Quality performance category score.

Most commenters were supportive of the proposed change because it decreases the time between a measure's baseline and performance periods. As a result, measure results would better reflect current clinical guidelines and care delivery patterns and provide clinicians with more actionable data. A few supported the change but urged CMS also to address benchmarking issues for other data submission types (e.g., MIPS clinical quality measures) for which current, historically-derived benchmarks include data from years during the COVID-19 PHE. Several commenters objected to the change, stating that the benchmark for a claims-based measure now will not be

available in time to allow clinicians to project their upcoming year's performance results and adjust their quality improvement plans as needed to score higher.

CMS responds that its internal analyses of 2019 and 2020 quality performance data have confirmed those data to be suitable for benchmarking purposes for measures of other submission types (86 FR 65494). CMS acknowledges that clinicians generally prefer historical baseline period benchmarking because benchmarks and performance targets for measures on which they will be scored potentially are available to them sufficiently in advance to potentially guide their performance improvement activities. However, CMS also asserts that attempts by clinicians to project their upcoming year performances on claims-based measures are of limited value as such calculations typically require data not easily accessible to clinicians.

b. Quality performance category: Topped-out quality measure scoring

CMS repeats its discussion from the proposed rule about potential interactions between its policies for scoring topped-out quality measures and truncated or suppressed quality measures. No new information is added and no comments or queries from stakeholders are addressed.

CMS identifies topped-out measures as having median performance rates of 95 percent or higher. Once topped out for 2 consecutive years, the maximum available achievement points for a 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 states 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. Measure changes that trigger suppression or truncation may change the measure substantively enough 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 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 likely no longer be valid or reliable.

c. Cost performance category: cost measure improvement scoring methodology

CMS finalizes establishing as proposed 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. As this change will cause scoring and payment changes after the start of the CY 2022 performance period (i.e., retroactively), CMS invokes section 1871(e)(1)(A) of the Act to do so, having determined that not to proceed to set a cost improvement maximum score would be contrary to the public interest.

CMS reviews in detail the sequence of statutory provisions since the QPP's inception that have affected cost category improvement scoring and associated CMS actions. CMS notes having inadvertently failed to set the maximum cost improvement score for payment year 2024 and beyond, leading to the final action taken in this rule.

Supportive comments were received, along with requests to (1) instead increase the maximum improvement to at least 5 points starting with PY 2022 and (2) delay any future increases until after the end of the COVID-19 PHE is declared.

CMS states that a 5-point or greater maximum is not warranted at this time and that any future updates to Cost category improvement scoring will occur through PFS rulemaking. CMS provides the final scoring formula along with an example cost performance score calculation.

Cost Performance Category Score = (Cost Achievement Points/Available Cost Achievement Points) + (Cost Improvement Score)

In the example presented and several other times in this section of the rule (IV.A.10.c.(1)), CMS states that the relative weight of the Cost performance category to be used during MIPS final scoring is 10 percent. However, the category weight was established at 30 percent for CY 2022 and subsequent years during CY 2022 PFS rulemaking (86 FR 65519) and is consistent with statute (section 1848(q)(5)(E)(i) of the Act). CMS does not remark on this category relative weight difference nor offer an explanation for it. The formula itself appears to be consistent with established MIPS final scoring policies.

d. Other performance categories

Elsewhere in this rule, CMS finalizes several changes to the Improvement Activities (IA) Inventory, discussed in detail in Appendix 2. Existing policies for IA scoring related to the category's contribution to MIPS final overall scoring are retained.

Similarly, CMS elsewhere finalizes several changes to the measures, objectives, and within-category scoring weights for the Promoting Interoperability (PI) performance category. Changes also are finalized regarding which clinical types are eligible for having their category scores reweighted to zero (e.g., social workers remain eligible, nurse anesthetists do not). Existing policies for PI scoring and its contribution to MIPS final overall scoring are retained.

2. Calculating the Final Score

a. Facility-based measurement

(1) Complex bonus eligibility[28] (§414.1380(c)(3))

[28] A bonus of up to 10 points (added to the total MIPS score) is available to clinicians who meet criteria for serving disproportionate numbers of patients with complex medical and/or social needs. Criteria are based on the Hierarchical Condition Category (HCC) scores and dual eligibility status of a clinician's patient population.

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

Commenters were supportive of the change and encouraged CMS to identify additional opportunities to reward care that is furnished to complex patients. CMS agrees to assess potential new opportunities.

Previously, complex bonus eligibility has required that a clinician report data for at least one measure or activity in a MIPS performance category. A clinician that is eligible for facility-based scoring and reports to MIPS as an individual is not required to submit data to MIPS for any performance category and will now be eligible to receive the complex patient bonus, if other conditions for the bonus are met. Facility-based clinicians who report to MIPS as a facility-based group are required to submit PI performance category data as a group; they have been and will remain potentially eligible for the complex patient bonus. Facility-based scoring is adapted from the scoring methodology used in the Hospital Value-Based Purchasing (HVBP) Program.

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

After receiving only supportive comments, CMS finalizes that a virtual group may be eligible for facility-based measurement if 75 percent or more of the group's MIPS eligible clinicians meet the definition of facility-based.

(3) Regulation text alignment

After receiving no comments, CMS finalizes changes as proposed that align the definition of facility-based clinician at §414.1305 with established and newly finalized facility-based measurement and scoring policies.

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

In section IV.A.1.c. of this rule CMS notes having requested information about risk indicators for potential use within the complex bonus formula that would align with agency efforts to advance health equity and the care of disadvantaged patients (87 FR 46317 through 46319). Specific questions were posed about incorporating the University of Wisconsin Area Deprivation Index into the complex patient bonus and about a potential future definition of *safety net providers* for use in the context of the complex patient bonus. CMS acknowledges receiving input that will be considered during future rulemaking. The agency does not report on or respond to comments received.

3. MIPS Payment Adjustments

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

Table 97, reproduced below from the rule, shows the MIPS final score performance thresholds previously established for payment years 2019 through 2024.

Table 97: 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

CMS finalizes its proposal to use payment year CY 2019 as the prior period on which to base the MIPS performance threshold score for performance year 2023/payment year 2025. This final action, when combined with the previously finalized decision to set the threshold as the mean rather than the median value of the final scores for all MIPS eligible clinicians for the selected prior period,[29] results in a performance threshold score of 75 points for performance year 2023/payment year 2025.

Section 1848(q)(6)(D)(i) of the Act requires the Secretary to compute annually a performance threshold for purposes of determining the adjustment factors to be applied to payments to MIPS eligible clinicians. Prior periods and their mean final score values that were available as threshold choices for payment year 2025 are shown in Table 98 of the rule, reproduced below.

Table 98: 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 received numerous comments on the proposed threshold score; they were divided between support and opposition. Support was voiced for the agency's choice of the lowest available threshold value option and the stability provided by not increasing the score from that set for performance year 2022/payment year 2024. Those opposed urged CMS to explore its authority to set a lower value. They stated that the 75-point threshold is inappropriate and will be difficult for many clinicians to meet due to factors including those listed below:

- Persistent COVID-19 PHE impacts on clinician performance and data reporting;
- Termination of several longstanding policies that generally raised clinician scores (e.g., 3-point scoring floor for quality measures);
- Large numbers of clinicians reentering MIPS after being exempted from participation by widespread application of extreme and uncontrollable circumstances policies;
- Upwardly skewed recent year performances (and associated mean final MIPS scores) because high performers were more likely to participate during years when PHE-exemptions were available;
- Predicted negative adjustments for one-third of all MIPS participating clinicians for payment year 2025 per the proposed rule's regulatory impact analysis; and
- Setting a threshold score of 75 points is a very large increase from the immediate pre-pandemic year's mean final MIPS score of 30 points (i.e., performance year 2019) rather than the "gradual and incremental" trajectory mentioned in statute.

[29] Per statute, the choice of mean or median methodology is made by the Secretary at 3-year intervals. The mean was chosen for payment years 2024 through 2026 during CY 2022 PFS rulemaking (85 FR 65527 through 65532).

CMS acknowledges that many of the concerns raised could negatively affect clinician scores for performance year 2023/payment year 2025. CMS anticipates that 2023 performance results will in fact be worse than those for recent prior years, particularly for clinicians reentering MIPS after an absence of one or more years. The updated regulatory impact analysis in this final rule still predicts that one-third of all MIPS participating clinicians will end up receiving negative payment adjustments. CMS also notes that current estimates place scores for many clinicians very near the 75-point threshold and reassures clinicians that this means that many of the negative adjustments will be "fairly small" and materially lower than the statutory maximum of -9%. The agency repeatedly emphasizes being required to set a threshold score that is compliant with statute and that its finalized choice is the lowest option that is also compliant. CMS further notes that a performance threshold for exceptional MIPS performance will not be set for payment year 2025 (performance year 2023) as funding for the exceptional performance bonus expires per statute with the end of payment year 2024 (performance year 2022).

CMS refers readers to sections VII.F.6. 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. Using payment year 2019 as finalized leads to a threshold score of 75 points, causing one-third of MIPS eligible clinicians to receive a negative payment adjustment for payment year 2025 (performance year 2023). Using payment year 2021 leads to a threshold score of 86 points causing 60 percent of MIPS eligible clinicians to receive a negative payment adjustment, while using payment year 2022 leads to a threshold score of 89 points and causes 64 percent of MIPS eligible clinicians to receive a negative payment adjustment.

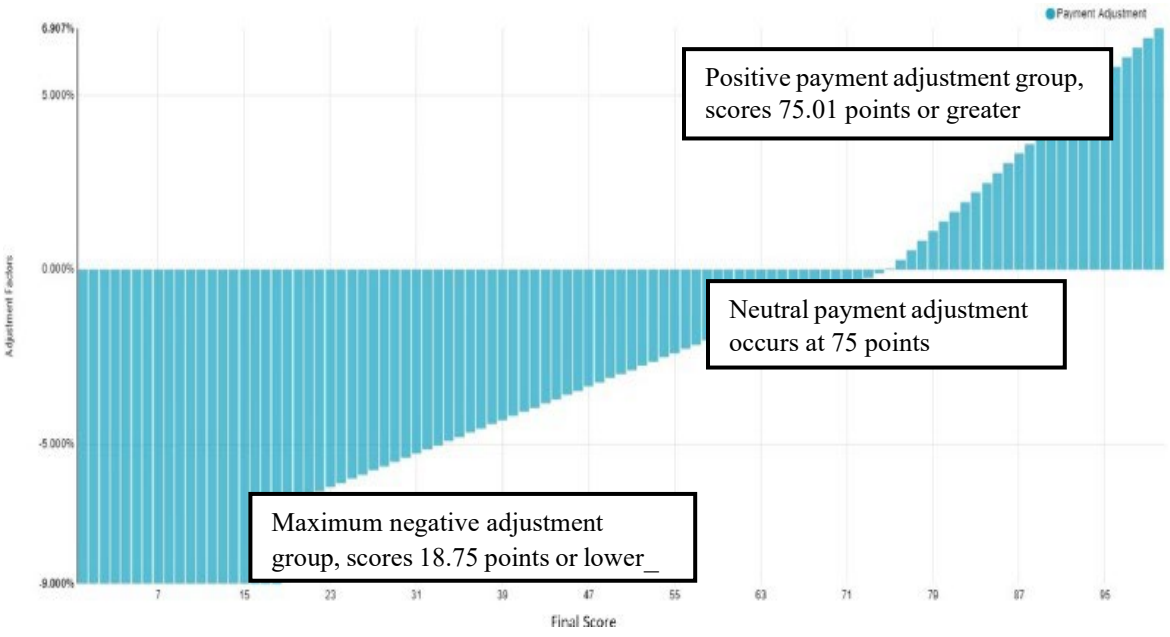
b. Example of adjustment factors

Figure 4 from the rule provides an example linking the finalized 75-point 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 also are 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%. 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 99 that links final score ranges to payment adjustments; these ranges are the same as those for use in payment year 2024.

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 once annually. The agency notes that 2021 performance feedback reports were released August 22, 2002.

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



Relationship of MIPS Final Performance Score to Proposed MIPS Payment Adjustment for Payment Year 2025/Performance Year 2023 (adapted from Table 99 of the rule)	
Final Score Points	**MIPS Adjustment**
0.0 – 18.75	Negative 9%
18.76 – 74.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
75.0	0% adjustment
75.01 – 100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale; the sliding scale ranges from 0 to positive 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 within MIPS.

I. Third Party Intermediaries General Requirements

1. General Requirements

a. Background

CMS made 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.

The proposals are finalized without modification.

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 proposed to update the definition of third party intermediary at §414.1305 to include subgroups and APM Entities and to make what it described as minor edits for technical clarity. CMS finalizes its proposal without modification.

As finalized, the term third party intermediary is defined to mean 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.

CMS notes that it finalized in the 2022 PFS rule a requirement that third party intermediaries support subgroup reporting beginning with the 2023 performance period[30] as well as requirements for subgroup registration.[31] Subgroup identifiers are established by CMS, and it clarifies that the same subgroup identifier will be used year to year, unless the composition of the group changes, in which case a new identifier will be issued.

2. Requirements Specific to QCDRs

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

CMS proposed modifications to §414.1400(b)(4)(i)(B) that were 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. CMS finalizes its proposals without modification, which were designed to limit discrepancies between the posting of CMS and QCDRs.

Section 414.1400(b)(4)(i)(B) is 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

[30] See §414.1400(a)(1) (86 FR 65544).
[31] See 86 FR 65417 and 65418.

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.

Some commenters objected to the 15-day time limit to publicly post the measure specifications. CMS believes 15 days is sufficient time to do so and notes that those specifications must be posted by January 1st of the performance period.

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 proposed 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.

CMS finalizes its proposal (without modification) 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.

Some stakeholders suggested a longer delay, such as 2 years, but CMS believes the previous delays and the one finalized in this rule will afford QCDRs sufficient time to prepare.

3. Remedial Actions and Termination of Third-Party Intermediaries

The agency proposed 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. The current CAP regulations at §414.1400(e)(1)(i)(B) include a requirement for the third party intermediary to address the impact of any noncompliance on "individual clinicians, groups, or virtual groups, regardless of whether they are participating in the program because they are MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program."

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

CMS also finalizes its proposal for a new CAP requirement under which the third party intermediary must notify the parties identified in §414.1400(e)(1)(i)(B) of the impact to these parties by developing and submitting a communication plan. This should help affected parties to understand and prepare for any operational and other challenges as needed.

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 to 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 finalizes its proposal 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 will apply beginning with the CY 2024 performance period/2026 MIPS payment year and thereafter.

A number of commenters opposed the proposal to terminate QCDRs and qualified registries that do not submit any MIPS data. They cited issues related to the COVID-19 PHE; suggested waiting under there is more traction in MVP reporting; and recommended that terminated entities be allowed to reapply for participation in the future. CMS responds that it believes there is ample time for a registry or QCDR to gather participants and submit data in the coming years, and that waiting until MVPs are more available is not appropriate because clinicians need the tools to participate in MVPs when they first become available. CMS notes that a third party intermediary that has been terminated may apply again in the future.

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 revised definition of third party intermediary finalized above, CMS proposed 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 did not receive any comments on the proposals, which it finalizes without modification.

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 sought input on flexibility in measure selection in MVPs for third party intermediaries, barriers/burdens for third party intermediaries in supporting all measures, and whether there were technical resources CMS could provide that would be helpful for these third party intermediaries. It notes that it will use the information provided in considering future rulemaking.

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.

The agency sought feedback on the value to clinicians of adding CME accreditation organizations as third party intermediaries and on the general value of adding such organizations,

as well as input on the criteria it should use in evaluating such organizations. It indicates that it will use the information provided in considering future rulemaking.

J. Public Reporting on the 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 proposed adding 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 believes 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.

Commenters supported the proposal to add a telehealth indicator to clinician and group profile pages. However, CMS does not believe it is current operationally feasible to publish telehealth indicators on group profile pages with accuracy, given clinician turnover at group practices and resulting data implications. Thus, the finalized policy only requires including the telehealth indicator on clinician profile pages.

CMS also proposed 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.

Commenters suggested the use of the newly available POS Code 10 in addition to the proposed POS Code 02 and modifier 95 appended on paid physician and ancillary service claims to identify telehealth services. CMS agrees, noting that an update was made to POS Code 02 that revised the description from "telehealth" to "telehealth provided other than in patient's home" for locations in which telehealth services were furnished. In connection with the change to POS Code 02, newly added POS Code 10, telehealth provided in patient's home was adopted by Medicare to more specifically identify the provision of telehealth in the patient's home. CMS finalizes its proposal with this modification to also require the use POS Code 10 as well as its proposals to use a 6-month lookback period and bi-monthly update frequency, as technically feasible.

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 as well as the specific procedures performed by them) and to be provided in a plain language display.

CMS proposed 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 will be used for procedures in which no Restructured BETOS categories are available. The utilization data on the Compare tool will only reflect Medicare claims data.

CMS proposed 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.

The proposals are finalized with modifications. Because of the same concerns noted above regarding current operational feasibility of reporting on group profile pages, public reporting of utilization data will only apply to clinician profile pages. CMS intends to start the reporting of utilization data on patient-facing clinician profile pages on a rolling basis (no sooner than CY 2023) and to expand the reporting of procedure categories over time.

Some commenters were concerned that patients may not understand that higher volume of procedures does not always correlate to better quality of care and successful outcomes. CMS modifies the criteria used to prioritize the publication of commonly performed procedures to better take this into account. As finalized, the procedures must meet one or more of the following criteria: (1) have evidence of a positive relationship between volume and quality in the published peer reviewed clinical research; (2) are affiliated with existing MIPS measures indicating importance to CMS; (3) represent care that a patient might shop for a clinician to provide; and/or (4) is an HHS priority. Complex, rare procedures will not be initially prioritized.

Some commenters suggested a longer look-back period, but CMS believes a 12-month time frame is appropriate. It will, however, continue conducting comprehensive and robust user testing of all utilization data, including the lookback period, to ensure appropriate interpretation of the information.

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

In the proposed rule, CMS expressed interest 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 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. It sought 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. No mention is made of any comments received on this topic in this section of the summary.

K. APM Incentive Payment Program

CMS finalizes as proposed to change the deadline by which it will accept updated contact information from QPs eligible to receive APM incentive payments. Also finalized 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 100 of the final rule, reproduced later in this section.

CMS also reviews two requests for information issued in the proposed rule 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.

The following APMs are expected to be determined to meet criteria as Advanced APMs by CMS for performance year 2023/payment year 2025:

- Bundled Payments for Care Improvement Model;
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track);
- ACO REACH Model (formerly Global and Professional Direct Contracting) Model;
- Kidney Care Choices Model (Kidney Care First; Professional Option and Global Option);
- Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program);
- Medicare Shared Savings Program (Level E of the BASIC Track and the ENHANCED Track);
- Primary Care First (PCF) Model; and,
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative).

1. Communication with Certain QPs about APM Incentive Payments

Having received no comments, CMS finalizes as proposed to change the cutoff date by which QPs may submit updated information about the TINs to which their APM incentive payments should be made from November 1 of the applicable payment year to September 1 of the

applicable payment year or 60 days from the date that CMS makes the initial round of such 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. Revising the cutoff date reflects operational factors at the agency that affect information processing and payment disbursement in accordance with the requirement at §414.1450(d) for payments to be made by December 31 of the applicable payment year.

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

Having received no comments, CMS finalizes as proposed 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.

The single measure must (1) appear in the finalized MIPS measure inventory or be endorsed by a consensus-based entity or be determined by CMS to be evidence-based, reliable, and valid; and (2) be 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 conditions 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. Parallel changes are finalized at §414.1420(c) to similarly clarify the Other Payer Advanced APM quality-based payment criterion.

b. Financial risk criterion

(1) Generally applicable nominal amount standard §414.1415(c) and §414.1420(d)

CMS finalizes as proposed to make permanent the 8 percent level of the generally applicable revenue-based nominal amount standard for use when making Advanced APM determinations beginning with performance year 2023. CMS also finalizes as proposed a permanent 8 percent standard for Other Payer Advanced APM determinations beginning with performance year 2023.

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.

Commenters were supportive of the changes. Some suggested that the 8 percent standard be reduced to levels similar to those for Medical Home and Other Payer Medical Home models. CMS declines, stating that lower levels would not represent bearing at least "nominal risk" as is required by the statutory financial risk criterion for APMs that are not medical homes.

(2) Medical Home 50-clinician limit (§§414.1415, 414.1420, 414.1440)

CMS finalizes as proposed 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, beginning with performance year 2023. CMS also finalizes as proposed that the 50-clinician limit must be satisfied on each of the three QP determination dates (known as "snapshots"). Further, CMS finalizes parallel changes for use when applying the 50-clinician limit to Other Payer Medical Homes and Medicaid Medical Homes.

CMS will use the TIN/NPIs on the APM entity's participation list for each snapshot date as the basis for the clinician count. If the count is exceeded on one or more snapshot dates, the entity will not meet the Medical Home financial risk criterion and its clinicians will not receive credit towards QP status for participating in the medical home.

Some commenters voiced support for the changes. Several suggested eliminating the 50-clinician limit entirely. CMS responds that the clinician limit is designed to ensure that the reduced risk-bearing required of medical homes is available only to organizations small enough that higher risk levels would threaten their financial viability.

3. Updated QP Threshold Score Table

CMS finalizes its proposal to amend the 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. While CMS is properly implementing the revised thresholds, the changes were inadvertently not fully and correctly described in regulation text at §414.1430(a) and (b). The correct values for all years are provided by CMS as Table 100, reproduced below.

TABLE 100: 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

Through this RFI, CMS asked whether it should continue to make QP determinations at the APM Entity level, based on the collective performance of the Entity's clinicians, or begin making all determinations at the individual clinician level to better identify and reward individual eligible clinicians with substantial engagement in Advanced APMs.

CMS reviews its current approach to making QP determinations based on the payment and patient count thresholds set in statute and regulation for services delivered by clinicians participating in Advanced APMs. Satisfying payment or patient count thresholds on any one of three QP determination "snapshot" dates annually confers QP status on all of an APM Entity's clinicians for the entire performance year who then receive QP-associated financial incentives.

CMS describes being motivated to explore this topic by the following considerations:

- Receiving reports from APM participants that to achieve higher QP threshold scores, some APM Entities have 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.

CMS states that comments were received that provided meaningful insights into how QP determination process changes could impact Advanced APM participation by clinicians. CMS does not provide details or summarize the comments and indicates that they will be considered in future rulemaking.

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

CMS views payment incentives for clinicians as part of its strategy to encourage continued movement of eligible clinicians from MIPS to Advanced APM participation in support of its overarching goal to transform Medicare from a volume-based to a value-based program. In the proposed rule, CMS issued an RFI about administrative actions that the agency might take to better balance payment incentives within the QPP beginning with performance year 2024/payment year 2026.

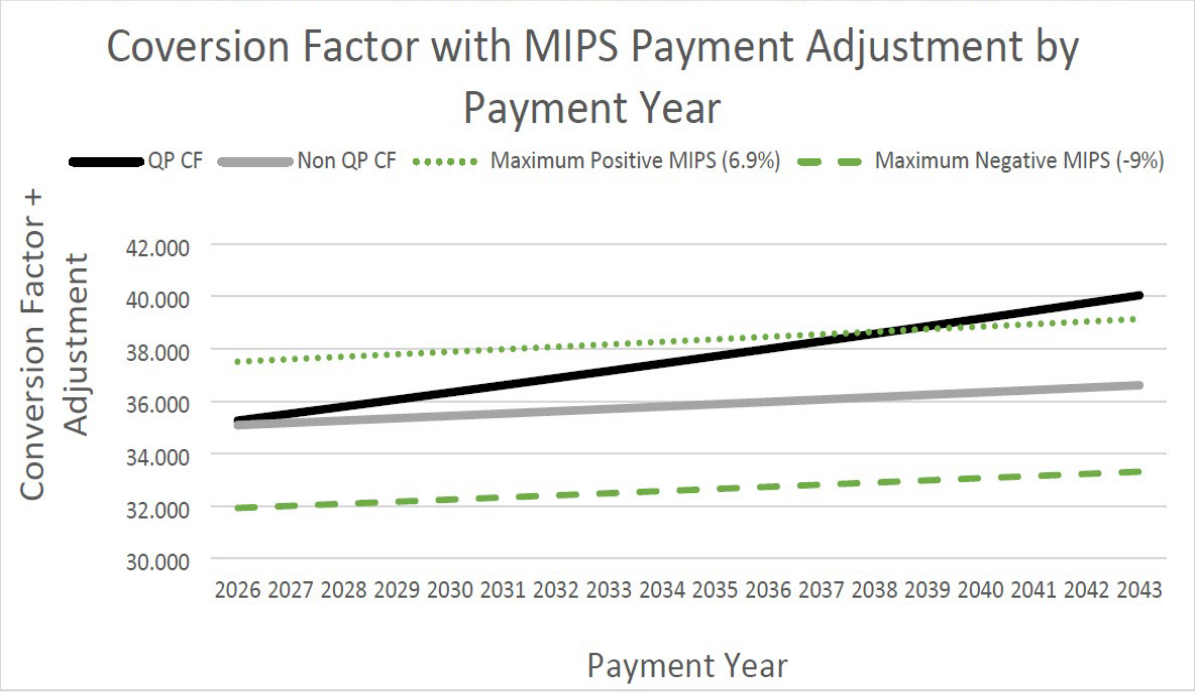
In this final rule, CMS reprises from the RFI portions of its detailed background presentation on this topic. CMS describes the impending transition from APM incentive payments in the form of lump sum bonuses (5 percent of an APM Qualifying Participant's (QP) prior year's Part B covered professional 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 payment year associated with lump sum 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.

CMS also repeats its comparison of the payment impacts of the compounding differential conversion factor with the MIPS payment adjustment structure, a structure that will remain unchanged absent statutory change. Figure 5 in the rule (reproduced below[32]) demonstrates that the maximum positive payment adjustments under MIPS will exceed those available to clinicians who reach APM Qualifying Participant (QP) status, and thereby receive the differential conversion factor, until after CY 2035.

The RFI included a series of questions exploring factors, including payment incentives, that would influence MIPS eligible clinicians to choose to participate in one of the pathways of the MIPS program (e.g., traditional MIPS, MIPS Value Pathways) or in Advanced APMs with the goal of reaching QP status. The questions are repeated in section IV.A.11.d. of the final rule. Subsequent to issuing the RFI, CMS conducted a public listening session about the issues and questions described in the RFI.

In this final rule, CMS acknowledges feedback received in response to the proposed rule and at the public listening session. CMS does not provide any details or summary of the feedback received through either channel and concludes by stating a plan to continue monitoring and public engagement about this topic.

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.

[32] In the rule, Figure 5 is incorrectly titled as showing the "Coversion" Factor rather than Conversion Factor.