Quality Payment PROGRAM

2023 Quality Payment Program (QPP) Final Rule Frequently Asked Questions (FAQs)

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Merit-based Incentive Payment System (MIPS) FAQs

General

Where can I find more information on QPP policies finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule?

We provide an overview of the major policies we finalized for QPP in our CY 2023 Physician Fee Schedule (PFS) Final Rule Resources (ZIP). In addition to this FAQ document, these resources include:

- Overview Fact Sheet (narrative highlighting major policies)
- QPP Policy Comparison table (highlighting changes from previous policy)
- MVP Policy Table (detailed look at MVP policies)

We'll also host a public webinar on November 16 that reviews the major changes in the final rule. This webinar and registration link will be announced through the QPP listserv; you can also monitor the QPP Webinar Library for information about all of our upcoming and past webinars. In addition, the Electronic Code of Federal Regulations, Subpart O, will be updated to reflect newly codified regulations. (Please note this resource frequently identifies policies by the payment year instead of the performance year; the 2025 payment year equates to the 2023 performance year.)

Are there any policies that weren't finalized?

Yes, there are 4 quality measures that weren't finalized for removal (Quality IDs 260, 261, 275, and 439) (refer to Appendix D in the 2023 QPP Final Rule Policy Comparison Tables for more information).

What are the Certified Electronic Health Record Technology (CEHRT) requirements for the 2023 performance year?

As previously finalized in the CY 2021 PFS Final Rule (85 FR 84818), clinicians must use technology certified to the 2015 Edition Cures Update certification criteria for the Promoting Interoperability performance category and to report electronic clinical quality measures (eCQMs) for the quality performance category.

We're scheduled to transition to a new EHR system during the 2023 performance year. What does this mean for our quality measure reporting and meeting the data completeness threshold?

We understand that eligible clinicians, groups, and/or their practices or hospitals may undergo a mid-year transition from one EHR system to another EHR system, which may impact a clinician or group's ability to submit a full 12 months of data for the quality performance period. We want to emphasize the 12-month performance period and 70% data completeness threshold are applicable regardless of whether an interested party undergoes an EHR transition mid-year. In this scenario, the 12-month performance period and data completeness requirements may be met by running and supplying reports in each of the EHR systems used before and after the transition and aggregating the data into a single 12-month report for submission to CMS. Please note, if you're reporting eCQMs, both the previously used EHR system(s) and the currently used EHR system(s) must be certified to the 2015 Edition Cures Update certification criteria. In instances where data for the full 12 months is unavailable (for example, if aggregation of EHR reports isn't possible), the measure score will reflect the inability to meet the 12-month performance period and data completeness threshold.

MIPS Value Pathways

What MIPS Value Pathways (MVPs) are available for reporting in 2023?

There are 12 MVPs available for voluntary reporting in 2023:

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

- Patient Safety and Support of Positive Experiences with Anesthesia
- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Patients with Episodic Neurological Conditions
- Supportive Care for Neurodegenerative Conditions
- Promoting Wellness

We expect the Explore MVPs webpage page will be updated to reflect these new and updated MVPs in January 2023. We'll also update the 2023 MVPs Implementation Guide to reflect these new and updated MVPs.

Where can I learn more about the MIPS Value Pathways (MVPs) reporting option?

Please visit the MVPs webpage.

Can we report more than one MVP?

An MVP Participant (defined as an individual clinician, single specialty group, multispecialty group, subgroup, or Alternative Payment Model (APM) Entity) can only register for and report on a single MVP. However, an individual clinician (identified by a single Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) combination) can participate in MIPS at different levels to report multiple MVPs. For example, you may report one MVP as part of a group and report a different MVP as part of a subgroup under the same TIN. You're able to change your MVP and measure selections until the registration period closes on November 30th of the performance year.

How do I register to report an MVP?

To register to report an MVP, you'll need to sign in to the QPP website and complete your MVP registration by November 30 of the performance year. Registration for the 2023 performance year will open April 3 and close November 30, 2023. You won't be able to make changes to your registration after the deadline on November 30, 2023. If you intend to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey associated with an MVP, you must complete both your MVP and CAHPS for MIPS Survey registration by June 30, 2023 to align with the CAHPS for MIPS Survey registration deadline.

At the time of MVP registration, you'll select:

- The MVP you intend to report.
- One population health measure included in the MVP.
- Any outcomes-based administrative claims measure you intend to be scored, if available within the MVP.

You'll also select if you want to report as a subgroup. For subgroup registration, you'll need to include:

- A list of Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) in the subgroup,
- A plain language name for the subgroup (which will be used for public reporting).
- A description of the composition of the subgroup, which may be selected from a list or described in a narrative.

What would happen if we registered to report an MVP, but later decided to report traditional MIPS or the APM Performance Pathway (APP)? What will happen if we register to report an MVP as a subgroup but don't end up reporting?

We'll assess and assign you a final score based on the data you submitted, whether for traditional MIPS or the APP, based on the scoring hierarchy finalized in the CY 2022 PFS Final Rule (86 FR 65537).

We **won't** assign a final score to a subgroup that registers but doesn't submit data as a subgroup.

If we participate as a subgroup, will we automatically receive the subgroup's final score?

No. The scoring hierarchy was updated in the CY 2022 PFS Final Rule (86 FR 65537) to include subgroups so that a MIPS eligible clinician will receive the highest final score that can be attributed to their Taxpayer Identification Number/National Provider Identifier (TIN/NPI) combination from any reporting option (traditional MIPS, APM Performance Pathway (APP), or MVP) and participation option (as an individual, group, subgroup, or APM Entity) with the exception of virtual groups. Clinicians that participate as a virtual group will always receive the virtual group's final score.

How do population health measures in the foundational layer differ from administrative claims measures that may be available in a specific MVP?

A population health measure is "a quality measure that indicates the quality of a population or cohort's overall health and well-being, such as, access to care, clinical outcomes, coordination of care and community services, health behaviors, preventive care and screening, health equity or utilization of health services." MVPs may include outcomes-based administrative claims measures for the quality performance category that don't meet this definition.

The scoring policies also differ in the following ways:

- Similar to our policies for administrative claims measures in traditional MIPS, **population health measures in the foundational layer** will be excluded from scoring if the measure doesn't have a benchmark or meet the case minimum requirements.

- However, if an **outcome-based administrative claims measure is available in the MVP** and selected by the MVP Participant to fulfill the outcome measure requirement, the measure will receive zero achievement points when the measure doesn't have a benchmark or meet the case minimum requirements.

How can I develop a new MVP?

Please refer to the MVP Candidate Development & Submission webpage for details on how to develop a new MVP candidate. Interested parties (including the general public) should use the MVP Development Standardized Template in the MVPs Development Resources (ZIP) to develop their proposal. The MVP Development Standardization Template includes instructions on how interested parties can submit the template for CMS's consideration. Interested parties can submit the MVP Development Standardization Template on a rolling basis through the Call for MVP process at any point throughout the year. CMS will review MVP candidate proposals. To increase public engagement in the MVP development process, we'll be posting draft versions of MVP candidates on the QPP website to solicit feedback for a 30-day period beginning in January 2023.

MVPs will be proposed and finalized through the Physician Fee Schedule (PFS) rulemaking process.

What is the MVP maintenance process and how can I participate?

The MVP maintenance process provides interested parties (including the general public) with the opportunity to recommend changes to previously finalized MVPs for CMS to consider. Interested parties can submit recommended changes to previously finalized MVPs via email, detailing the recommended changes for the MVP, by performance category. We're expanding opportunities for public participation in the MVP maintenance process by hosting an annual public webinar in addition to the rolling call for submission of potential changes to MVPs, to discuss potential MVP revisions that have been identified. Any changes that CMS decides are warranted would be made through the PFS rulemaking process.

Eligibility and Participation

How do I know if I'm eligible for MIPS in 2023?

To be eligible for MIPS, you must:

- Be a MIPS eligible clinician type (described below);
- Exceed the low-volume threshold as an individual or group; and
- Not be otherwise excluded because of your Medicare enrollment date or as a Qualifying APM Participant (QP), or as a Partial QP that has elected not to participate.

We anticipate the QPP Participation Status lookup tool will be updated with initial 2023 MIPS eligibility results in December.

MIPS Eligible Clinician Types	Low-Volume Threshold	Other Exclusions
• Physician (including doctor of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry) • Osteopathic practitioner • Chiropractor • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • Physical therapist • Occupational therapist • Clinical psychologist • Qualified speech-language pathologist • Qualified audiologist • Registered dietitian or nutrition professional • Clinical social worker • Certified nurse midwife	You exceed the low-volume threshold and are a MIPS eligible clinician if you: • Bill more than $90,000 in allowed charges for Medicare Part B covered professional services **AND** • Provide covered services to more than 200 Medicare Part B patients **AND** • Provide more than 200 covered professional services to Medicare Part B patients We evaluate individuals and groups on the low-volume threshold. We're continuing our policy that allows clinicians and groups that exceed 1 or 2 of these thresholds to **opt-in** to MIPS eligibility and participation.	You're excluded from MIPS in 2023 if you: • Enrolled as a Medicare provider on or after January 1, 2023. • Are identified as a Qualifying APM Participant (QP) or as a Partial QP that has elected not to participate. (This information is added to the QPP Participation Status lookup tool, and is tentatively scheduled for July, September and December 2023.)

Can we report traditional MIPS as a subgroup?

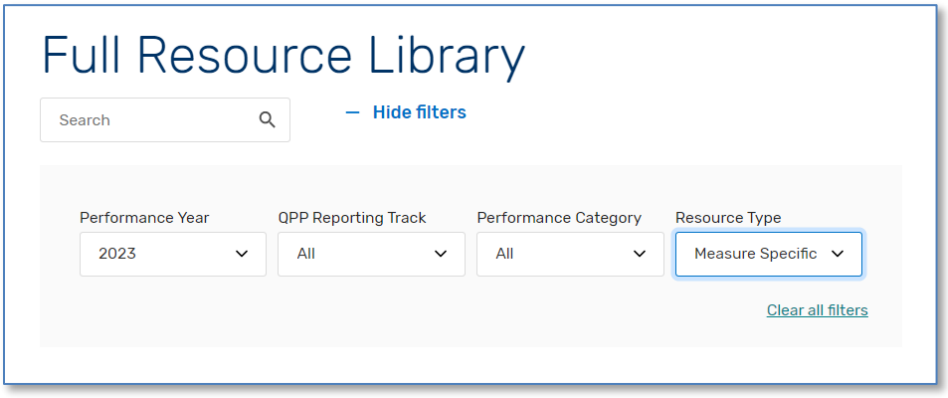
No. Clinicians can register as a subgroup to report an MVP, but subgroup participation isn't an option for traditional MIPS.

Measures and Activities

When will measure specifications/supporting documentation and activity descriptions be available for finalized measures/activities?

Measure specifications and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the QPP Resource Library before the performance period begins on January 1, 2023. We know these are critical resources for planning your participation and we'll make these resources available as soon as possible.

(When searching in the QPP Resource Library, filter by the 2023 Performance Year and choose "Measure Specifications and Benchmarks" as the Resource type.)



The Explore Measures & Activities tool will be updated for the 2023 performance period in early 2023.

When will historical quality benchmarks be available for the 2023 performance period?

We anticipate the 2023 Quality Benchmarks zip file will be posted on the QPP Resource Library in mid-January 2023, shortly after the performance year begins on January 1, 2023.

Where can I find a list of topped out quality measures for the 2023 performance period?

We identify topped out measures, including those capped at 7 points, through the benchmarking process. We anticipate the 2023 Quality Benchmarks zip file will be posted on the QPP Resource Library in in mid-January 2023, shortly after the performance year begins on January 1, 2023.

Reporting Requirements

Are there any changes to reporting requirements?

Yes, there are several changes in the Promoting Interoperability performance category that were finalized in the CY 2023 PFS Final Rule.

- We're discontinuing automatic reweighting in the Promoting Interoperability performance category for the following clinician types, beginning with this 2023 performance period:
  - Nurse practitioners
  - Physician assistants
  - Certified registered nurse anesthetists
  - Clinical nurse specialists

These clinicians must now report Promoting Interoperability data unless they qualify for reweighting due to a special status or an approved Promoting Interoperability Hardship Exception Application.

- We're requiring clinicians to report the Query of Prescription Drug Monitoring Program (PDMP) measure unless an exclusion can be claimed; this measure will no longer be optional or eligible for bonus points.
- We finalized a third option for satisfying the Health Information Exchange objective beginning with the 2023 performance period – participation in the Trusted Exchange Framework and Common Agreement – in addition to the 2 existing options.
- We're giving APM Entities the option to report Promoting Interoperability data at the APM Entity level; clinicians participating as an APM Entity will continue to have the option to report Promoting Interoperability data at the individual and group level.

Scoring and Payment Adjustments

What scoring changes were just finalized for the 2023 performance year?

We primarily focused our policies in the CY 2023 PFS Final Rule on continuing to develop new MVPs and refining the subgroup participation option. However, we did finalize changes to the total points available for individual measures in the Promoting Interoperability performance category as a result of requiring the Query of PDMP measure.

Please note there are also scoring changes that were finalized in the CY 2022 PFS Final Rule, to begin with the 2023 performance year. Refer to Appendix A of the 2023 QPP Final Rule Policy Comparison Tables for more information on these previously finalized policies.

What's the maximum negative payment adjustment for the 2023 performance year/2025 payment year?

As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year (2020 performance year) and beyond is **-9%**. The **actual** payment adjustment (positive, neutral, or negative) you'll receive for the 2025 payment year will be based on your MIPS final score from the 2023 performance year and may be subject to a scaling factor to ensure budget neutrality, as required by MACRA.

How many points do I need to avoid a negative payment adjustment for the 2023 performance year/2025 payment year?

The performance threshold is the number against which your final score is compared to determine your payment adjustment. The performance threshold for the 2023 performance year remains 75 points. See the table below for more information about the relationship between 2023 final scores and 2025 payment adjustments.

Your Final Score for the 2023 Performance Year	Payment Impact for MIPS Eligible Clinicians for the 2025 Payment Year
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (between -9% and 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) As a reminder, the 2022 performance year/2024 payment year was the last year for the additional positive payment adjustment for exceptional performance.

Public Reporting FAQs

Were any policies finalized related to public reporting?

Yes. We're adding a telehealth indicator, as applicable and technically feasible, on individual clinician profile pages for clinicians furnishing covered telehealth services. We'll also publicly report certain procedure information (utilization data) on individual clinician profile pages to aid patients in finding clinicians who may appropriately serve their needs.

Will the telehealth indicator show on both clinician and group profile pages?

No, the telehealth indicator will only show on applicable clinician profile pages. It isn't operationally feasible at this time to accurately publish telehealth information on group profile pages.

How will CMS identify telehealth services for the indicator?

We'll identify telehealth services using Place of Service (POS) Code 02, POS Code 10 or modifier 95 appended on paid physician and ancillary service claims. We will use a 6-month lookback period and refresh the information on clinician profile pages bi-monthly, as technically feasible.

Will procedural utilization data show on both clinician and group profile pages?

No, we'll only show utilization data on applicable clinician profile pages. It isn't operationally feasible at this time to accurately publish this information on group profile pages.

How will CMS select procedures?

We'll prioritize the listing on Compare of commonly performed procedures. Initial procedures listed will meet one or more of the following criteria:

- Have evidence of a positive relationship between volume and quality in the published peer reviewed clinical research.
- Are affiliated with existing MIPS measures indicating importance to CMS.
- Represent care that a patient might shop for a clinician to provide.
- Are a priority for the Department of Health and Human Services.

Consumer testing will also better ensure this information is both interpreted correctly and meaningful to patients and their caregivers when making healthcare decisions

Given the volume of procedure codes for the same or similar procedures, will CMS categorize this information for website users?

Yes. We'll use the Restructured Berenson-Eggers Type of Service (BETOS) to categorize procedures in an understandable way. For procedures in which no Restructured BETOS categories are available, we'll use procedure code sources used in MIPS, such as the procedure categories already defined for MIPS cost or quality measures. Please note that we're excluding certain non-specific procedure codes, such as evaluation and management (E&M) codes for office visits, which don't provide context about the care provided and low complexity procedures, such as basic wound care or administering a vaccine, because we determined they're too generally applicable and aren't specific enough about the services provided.

What time period will CMS use to identify the volume of procedures performed?

We'll use a 12-month lookback period, refreshed bi-monthly, as technically feasible.

Version History

Date	Change Description
11/04/2022	Updated to reflect when the historical quality benchmarks will be available for the 2023 performance period.
11/01/2022	Original posting.