Physician Fee Schedule Proposed Rule for 2024
Summary Part III

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [CMS-1784-P]

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2024[1] and other revisions to Medicare Part B policies. The proposed rule is scheduled to be published in the August 7, 2023 issue of the *Federal Register*. If finalized, policies in the proposed rule generally would take effect on January 1, 2024. **The 60-day comment period ends at close of business on September 11, 2023.**

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

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

TABLE OF CONTENTS

[1] Henceforth in this document, a year is a calendar year (CY) unless otherwise indicated, a reference to "the Act" is a reference to the Social Security Act, and a reference to a regulatory section is a reference to that section in title 42, CFR.

IV. Quality Payment Program

A. Executive Summary: Background, Overview and Summary of Major Provisions

1. Background[2]

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). There are two payment tracks under the QPP: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs).[3]

a. MIPS Payment Track

For the MIPS payment track, MIPS eligible clinicians are subject to a MIPS payment adjustment (positive, negative, or neutral) that is applied to payment for their Medicare part B-covered services. The adjustment is based on their performance on measures and activities in 4 performance categories: (i) quality, (ii) cost, (iii) improvement activities (IA), and (iv) promoting interoperability (PI). Each MIPS eligible clinician's total performance is assessed during a performance period according to established performance standards with respect to the applicable measures and activities reported by the clinician in the performance categories to compute a final composite performance score. Different weights are assigned to each performance category for determining the clinicians' final composite performance score. For the 2024 performance period (PP)/2026 MIPS payment year (MIPS PY), the scoring weights are: 30 percent for the quality performance category, 30 percent for the cost performance category, 15 percent for the IA performance category, and 25 percent for the PI performance category.[4] Each MIPS eligible clinician's final score is compared to the performance threshold determined by CMS for the performance period to calculate the payment adjustment factor. The payment adjustment factor is determined such that a MIPS eligible clinician will receive a positive adjustment if their score is higher than the threshold, no adjustment if their score meets the threshold, and a negative adjustment if their score is below the threshold.

There are 3 reporting options for MIPS eligible clinicians under the MIPS payment track: Traditional MIPS, the Alternative Payment Model (APM) Performance Pathway (APP), and the MIPS Value Pathways (MVPs). Under the Traditional MIPS pathway, the clinicians select quality measures and IA from the inventories finalized from MIPS and report on them and report on the complete PI measure set. CMS collects and calculates data for the clinicians for the cost performance category. The APP is an option for MIPS eligible clinicians participating in a MIPS APM. Unlike under traditional MIPS, performance is measured across 3 areas (quality, IA, and

[2] More information about all aspects of the QPP is available for download at https://qpp.cms.gov/resources/resource-library.
[3] QPP participants include the following practitioner types: physician (as defined in section 1861(r) of the Act), physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, physical therapist, occupational therapist, clinical psychologist, qualified speech-language pathologist, qualified audiologist, and registered dietician and nutrition professional, clinical social workers, and certified nurse-midwives.
[4] These weights are subject to certain exceptions specified in section 1848(q)(5) of the Act.

PI), and clinicians under the APP report on a predetermined set of quality measures (in addition to the same complete PI measure set) and currently receive full credit for the IA category. The weights for the performance categories under the APP are as follows: (i) Quality, 50 percent; (ii) Cost, 0 percent; (iii) IA, 20 percent, (iv) PI, 30 percent.[5] The MVPs are the newest reporting pathway and allow clinicians to choose and report on a subset of quality measures and IAs that are specific to a specialty or medical condition. As with the other options, clinicians must report on the same complete traditional MIPS PI measure set. CMS collects and calculates data for the cost performance category.

b. Advanced APM Track

If an eligible clinician participates in an Advanced APM and is a qualifying APM participant (QP) or a partial qualifying APM participant (partial QP), the MIPS reporting requirements and payment adjustment do not apply to the clinician.[6] For the 2023 PP/2025 MIPS PY, QPs receive a 3.5 percent APM Incentive payment. Beginning with the 2024 PP/MIPS PY 2026, QPs will receive a higher alternative PFS payment rate (through a higher qualifying PFS conversion factor) than non-QPs.

2. Overview

CMS describes that the QPP proposals in the rule and the implementation of MVPs align the QPP with broader CMS initiatives such as the Universal Foundation[7] and the CMS National Quality Strategy.[8] Consistent with that goal, CMS describes that it is exploring the expansion of the APP reported in the Shared Savings Program and for Advanced APMs to include the primary care universal measure set in the future, will implement a health equity adjustment to reward ACOs that provide high quality care and serve underserved populations, is proposing to align the IP category measures and objectives required under the Shared Savings program with those required under MIPS, is proposing to modify the CEHRT use criterion for Advanced APMs, and is proposing to expand the MVPs available for the 2024 PP/2026 MIPS PY.

In 2024, this will be the QPP's eighth performance year and sixth payment year. During 2024, MIPS payment adjustments will be applied, and APM incentive payments will be made, to eligible clinicians based upon their 2022 performance data. For performance year 2024, category weights will be unchanged. MIPS adjustments will range from -9 to +9 percent, applied to payments for covered Part B professional services furnished during 2024. Some clinicians who met a separately specified, higher performance threshold in 2022 will be receiving an additional positive adjustment in payment year 2024 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 proposes 82 points as the proposed 2024 performance score threshold and basis for adjustments during payment year 2026.

---

[5] CMS may assign a different scoring weight to the quality or PI categories and reweight in accordance with §414.1367(d)(2).
[6] Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment.
[7] See https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.
[8] See https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/cms-quality-strategy.

Budget neutrality is required within MIPS by statute. For a proposed threshold score of 82 points, CMS estimates that positive and negative payment adjustments distributed in payment year 2026 will each total about $445 million ($890 million in aggregate). CMS projects that about 45.7 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 2026 will be approximately +8.82 percent and the average will be +3.4 percent. CMS estimates an average negative payment adjustment of -2.4 percent; per statute the maximum negative adjustment is -9.0 percent.[9] 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 82 points for performance year 2024/payment year 2026.

The 2024 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. 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 2024/payment year 2026. The bonus is replaced by a conversion factor differential for performance year 2024/payment year 2026 and subsequent years. Specifically, the update to the PFS conversion factor for services that are furnished by clinicians who achieve QP status for a year will be 0.75 percent, otherwise it will be 0.25 percent.

For the QPP overall, CMS estimates that approximately 820,047 clinicians will be MIPS eligible during the 2024 performance period, while another 480,071 would be potentially MIPS eligible but not required to participate. CMS further estimates that between 187,000 and 241,000 eligible clinicians will become QPs and thereby excluded from MIPS.

CMS generally requests comments on the QPP proposals.

3. Summary of Major Provisions

a. Transforming the QPP

CMS describes how it is implementing MVPs to allow clinicians to report on measures that are directly relevant to their clinical practice, engage more specialists in performance measurement, and reduce barriers to APM participation.

[9] CMS notes that the performance threshold is the critical factor affecting the distribution of payment adjustments. In its analysis of the alternative performance threshold of 86, CMS found that 67.2 percent of MIPS eligible clinicians who submitted data would receive a negative payment adjustment.

b. Major MIPS Provisions

CMS requests comment on how the QPP can facilitate continuous improvement of Medicare beneficiaries' health care and build on existing CMMI model policies and Medicare programs (such as the Shared Savings Program). Specifically, it seeks feedback on how its policies, requirements, and performance standards could be modified to encourage clinicians to improve the quality of care, particularly for those with little room for improvement in MIPS.

MVP-Specific Proposals. CMS proposes:

- 5 new MVPs related to: (i) women's health; (ii) infectious disease, including Hepatitis C and HIV; (iii) mental health (MH) and substance use disorder (SUD); (iv) quality care for ear, nose, and throat (ENT); and (v) rehabilitative support for musculoskeletal care;
- MVP maintenance updates that are in alignment with the MVP development criteria; and
- Regarding subgroups: (i) to codify previously finalized subgroup policies; to update the subgroup reporting policy for reweighting of MVP performance categories, to update the facility-based scoring and the complex patient bonus for subgroups, and to add subgroups to the targeted review regulation text.

Quality Performance Category Proposals. CMs proposes to establish a measure set inventory of 200 MIPS quality measures and to make several modifications to the quality performance category, including:

- Expand collection type options to include Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs);
- Establish data submission criteria for eCQMs to require utilization of CEHRT;
- Require the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey in the Spanish translation; and
- Maintain the at least 75 percent data completeness criteria for the 2026 PP/2028 MIPS PY, and change it to at least 80 percent for the 2027 PP/ 2029 MIPS PY.

Cost Performance Category Proposals. CMS proposes, beginning with the 2024 PP/ 2026 MIPS PY: (i) to add 5 episode-based measures (Depression, Emergency Medicine, Heart Failure Low Back Pain, and Psychoses and Related conditions), and to use a 20-episode case minimum for each; and (ii) to remove the Simple Pneumonia with Hospitalization episode-based measure.

Improvement Activities (IA) Performance Category Proposals. CMS proposes to add five IAs, modify one IA, and remove three IAs.

PI Performance Category Proposals. CMS proposes 5 modifications: (i) lengthen the performance period from 90 days to 180 days; (ii) modify one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure; (iii) provide a technical update to the e-Prescribing measure's description; (iv) modify the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completing self-assessment of their safety practices implementation; and (v) continue to reweight this category at zero percent for clinical social workers for the 2024 PP/2026 MIPS PY.

MIPS Final Scoring Methodology Proposals. CMS proposes to update the criteria it uses to assess the scoring impacts of coding changes, apply its scoring flexibilities, and require eCQM measure specifications to be able to be shortened to a 9-month performance period. It proposes to change cost improvement scoring from measure-level to category-level and to remove the statistical significance requirement. It also proposes that the maximum cost improvement score be 0 percentage points for the 2018-2022 PPs/2020-2024 MIPS PYs and 1 percentage point beginning with the 2023 PP/ 2025 MIPS PY.

MIPS Payment Adjustments Proposals. Beginning with the 2024PP/2026 MIPS PY, CMS proposes to define the "prior period" by which the performance threshold is determined as 3 performance periods instead of a single performance period. For the PY 2024/MIPS payment year 2026, it would use performance periods 2017 through 2019 as the prior period, which would establish the performance threshold as 82 points.

MIPS Targeted Review. CMS proposes (i) virtual groups and subgroups be eligible to submit a request for targeted review; (ii) to change the submission period for requests for targeted review to begin on the day it makes the MIPS final score available and end 30 days after publication of the MIPS payment adjustment factors; and (iii) to require additional information requested by CMS under the process to be received by it by 15 days after receipt of the request.

Third Party Intermediaries. CMS proposes several changes to the third party intermediaries (TPI) policies, some of which are to: (i) require TPIs to obtain documentation of their authority to submit on behalf of MIPS eligible clinicians; (ii) specify the use of a simplified self-nomination process for existing qualified clinical data registries (QCDRs) and qualified registries; (iii) add requirements for QCDRs and qualified registries to attest that the information in the qualified posting about them is correct; (iv) modify requirements for QCDRs and qualified registries to support MVP reporting; (v) specify requirements for data validation audits, requirements for a transition plan for QCDRs and qualified registries withdrawing from the program, and criteria for audits; (vi) add criteria for rejecting QCDR measures; (vii) require QCDR measure specifications to be displayed throughout the performance period and data submission period; (viii) eliminate the Health IT vendor category; and (ix) with respect to remedial and corrective actions, revise corrective action plan requirements, add failure to maintain updated contact information as criteria for remedial action, and specify the process for publicly posting remedial action.

Public Reporting on Compare Tools. CMS proposes to (i) revise the telehealth indicator by using the most recent coding policies at the time information is updated on Care Compare; and (ii) update utilization data to allow it to have more procedure code grouping flexibility. It also solicits feedback through an RFI on ways to publicly report data submitted on measures under the MIPS cost performance category on the Compare tool.

c. Major APM Provisions

APM Performance Pathway. CMS proposes to include the Medicare CQM for ACOs participating in the Shared Savings Program in the APP measure set.

APM Incentive. CMS proposes (i) to end APM entity-level QP determinations and make all QP determinations at the individual eligible clinician level, (ii) in the definition of "attribution-eligible beneficiary," for purposes of making QP determinations, to include any beneficiary who has received a covered professional service furnished by a clinician identified by the National Provider Identifier (NPI), (iii) and regulatory amendments to reflect the statutory changes made by the CAA, 2023, as well as to adjust the targeted review period to address operational challenges before the required transition for the MIPS PY from the APM Incentive Payment to the higher PFS payment rate for QPs.

Advanced APMs. CMS proposes, beginning with the 2024 PP, to not apply the 75 percent CEHRT use minimum and instead specify that the Advanced APM must require all APM participants to use CEHRT.

B. Definitions[10]

CMS proposes at §414.1305, to revise the definitions of (1) Attribution-eligible beneficiary; (2) Certified Electronic Health Record Technology (CEHRT); (3) Collection type; and (4) Qualified posting. The terms and definitions are discussed in detail below and in the relevant sections of the rule (the first section IV.A.4.n.(3), the second IV.A.4.n.(3), and IV.A.4.k.(3)(b)(v), respectively).

C. Transforming the QPP[11]

1. Advancing CMS National Quality Strategy Goals

CMS describes its National Quality Strategy, which aims to "advance toward a more equitable, safe, and outcomes-based health care system for all individuals." It describes the Universal Foundation as part of this strategy. The agency has identified adult and pediatric measures for the Universal Foundation to be used across CMS programs, including the QPP. The QPP measure inventory already includes measures in the adult core set from the Universal Foundation. CMS proposes to combine the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single consolidated primary care MVP that would align with the adult Universal Core set.[12]

CMS reviews its continuing steps to advance health equity, including the CMS Framework for Health Equity[13] released by its Office of Minority Health and the Health Equity Adjustment (HEA) that will apply beginning in the 2023 performance year in the Shared Savings Program to an ACO's MIPS quality performance category score.[14]

---

[10] These proposals were included as IV.A.2. in the rule.
[11] This was included as IV.A.3. in the rule.
[12] Section IV.A.4.b. of the proposed rule and Appendix 3: MVP Inventory, Table B.11 in the rule provide details on the proposed updates to these MVPs.
[13] CMS Equity Plan for Improving Quality in Medicare. *https://www.cms.gov/about-cms/agency-information/omh/omh_dwnld-cms_equityplanformedicare_090615.pdf*.
[14] 87 FR 69838 through 69857.

Lastly, CMS describes the transition to a digital and data driven health care system as one of its National Quality Strategy goals, including through the development of digital quality measures. It refers to the proposals described in section III.G.2.h. of the rule, which would require Shared Savings Program ACO clinicians to report the measures in the MIPS PI performance category and would modify use of CEHRT requirements for AAPMs to increase flexibility.

2. QPP Vision and Goals

CMS describes that the QPP was designed to promote value-based, patient-centered care through its 2 tracks of MIPS and Advanced APMs, and through its ongoing alignment of the Shared Savings Program and QPP. It is implementing MVPs in MIPS to allow clinicians to report on measures that are directly relevant to their practice by allowing them to select an MVP and report on measures contained in that MVP that are a more targeted set of cohesive measures and activities relevant to their specialty or applicable clinical condition, as compared to the large inventory of measures under traditional MIPS.

3. Request for Information (RFI): Promoting Continuous Improvement in MIPS

CMS seeks comment on how it could modify its QPP policies to encourage clinicians' continuous performance improvement, including through more rigorous performance standards, emphasizing year-to-year improvement, or requiring clinicians to report on different measures or activities than the ones on which they have shown consistently high performance. Specifically, CMS seeks comment on the following questions:

- What potential policies in the MIPS program would provide opportunities for clinicians to continuously improve care?
- Should it consider in future rulemaking policy changes to assess performance to encourage continuous performance improvement, such as increasing the reporting requirements or requiring that specific measures are reported once MVPs are mandatory?
- Should it consider creating additional incentives to join APMs to foster continuous improvement, and if so, what incentives?
- What changes to policies should CMS consider to assess continuous performance improvement and clinicians interested in transitioning from MIPS to APMs?
- How should it balance consideration of reporting burden with creating continuous opportunities for performance improvement?
- What are ways to mitigate unintended consequences (such as the increasing challenge for some clinicians to meet the performance threshold) of implementing such policies, requirements, and performance standards?

D. MVP Development, Maintenance, Scoring, and Subgroups[15]

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

[15] These proposals were included as section IV.A.4. of the rule.

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. There are currently 12 MVPs, the first 7 of which were adopted in the 2022 PFS final rule.[16]

1. Development of New MVPs

CMS proposes 5 new MVPs (shown in the table below). Details on these MVPs, including the specific measures included for each, are in Appendix 3: MVP Inventory, in the proposed rule. The below table summarizes information included in the rule on the 5 proposed MVPs, showing for each a description of the clinician/condition focus and a synopsis of the quality measures, IAs, and cost measures proposed for inclusion.

MVPs Proposed for Addition

MVP (Name)	Focus/Applicability	Quality Measures	IAs	Cost Measures
Focusing on Women's Health	Treatment and management of women's health; most applicable to clinicians who treat patients within the practices of gynecology, obstetrics, and urogynecology	18 MIPS quality measures and one QCDR measure, including 14 measures focused on women's health and 5 relevant, more broadly applicable measures	14 IAs from the IA inventory	2 MIPS cost measures: Medicare Spending Per Beneficiary (MSPB) Clinician, and Total Per Capita Cost (TPCC)
Prevention and Treatment of Infectious Disease Including Hepatitis C and HIV	Providing care for patients with infectious disorders; most applicable to clinicians who treat patients within the practice of infectious disease and immunology	14 MIPS quality measures, including 8 that are focused on the prevention and treatment of infectious diseases, and 6 relevant, more broadly applicable measures	14 IAs from the IA inventory	1 MIPS cost measure: Total Per Capita Cost (TPCC)
Quality Care in Mental Health and Substance Use Disorder	Providing care related to behavioral health, including mental health and substance use disorders; most applicable to clinicians who treat patients within the practices of mental/behavioral health and psychiatry	12 MIPS quality measures and 3 QCDR measures, including 13 that are focused on the behavioral health, and 2 relevant, more broadly applicable measures	18 IAs from the IA inventory	3 MIPS cost measures: Medicare Spending Per Beneficiary (MSPB) Clinician, Total Per Capita Cost (TPCC), and Psychoses and Related Conditions
Quality Care for Ear, Nose, and Throat (ENT)	Providing care for patients with ENT conditions, such as otologic conditions, chronic rhinosinusitis (CRS), age-related hearing loss (ARHL), and otitis media; most applicable to clinicians who treat patients within the practice	8 MIPS quality measures and 4 QCDR measures, including 9 measures that are focused on treating patients with ENT conditions, and 3 relevant, more broadly applicable measures	11 IAs from the IA inventory	1 MIPS cost measure: Medicare Spending Per Beneficiary (MSPB) Clinician

[16] 86 FR 65998 through 66031.

MVP (Name)	Focus/Applicability	Quality Measures	IAs	Cost Measures
	of otolaryngology (ENT specialists)			
Rehabilitative Support for Musculoskeletal Care	Most applicable to clinicians who provide rehabilitative support for musculoskeletal care, such as chiropractic, physiatry, physical therapy, and occupational therapy	10 MIPS quality measures, including 7 that are focused on rehabilitative support for musculoskeletal care, and 3 relevant, more broadly applicable measures	17 IAs from the IA inventory	1 MIPS cost measure: Low Back Pain

2. MVP Maintenance on Previously Finalized MVPs

The current set of 12 MVPs available for reporting beginning with the 2023 PP/2025 MIPS PY are the following:[17]

- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Neurological Conditions
- Supportive Care for Cognitive-Based Neurological Conditions
- Promoting Wellness
- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support of Positive Experiences with Anesthesia

3. Scoring MVP Performance

CMS refers readers to several proposed policies later in section IV.A.4. of the rule relating to scoring MVP performance. MIPS performance category proposals, final score methodology proposals, and payment adjustments are further discussed in sections IV.F, IV.G, and 4.H below, respectively.

4. Subgroup Reporting

Beginning in the PY2023/MIPS payment year 2025, clinicians have the option to participate in subgroups for reporting MVPs.[18]

a. Subgroup Reweighting Proposal

Currently, under §414.1365(e)(2)(ii), for an MVP participant that is a subgroup, any reweighting applied to its affiliated group is applied to the subgroup. A subgroup may receive reweighting if

[17] Details on measures and activities (including any proposed modification on measures and activities) within each of the current MVPs can be found in Group B of Appendix 3 in the Proposed Rule.
[18] See details in the CY 2022 PFS final rule (86 FR 65392 through 65394) and at §§414.1318 and 414.1365.

reweighting is not applied to the affiliated group and if either (A) the subgroup demonstrates that it was subject to extreme and uncontrollable circumstances, or (B) CMS determines that data for the subgroup are inaccurate, unusable, or otherwise compromised because of circumstances outside of the control of the subgroup.[19] If a subgroup reports data for a performance category that was reweighted, the subgroup data will void the reweighting applied to the performance category. CMS is now concerned that where a subgroup and affiliated group each submit a reweighting request the subgroup will not know its reweighting status until CMS makes a determination regarding the group's request (since the group's reweighting would apply to the subgroup). The time it takes to adjudicate reconsideration requests may prevent the subgroup from knowing of its reweighting status for a good portion of the performance period involved.

CMS therefore proposes to revise §414.1365(e)(2)(ii) to limit the application of the policy allowing for the separate subgroup reweighting under the specified circumstances to only the 2023 PP/ 2025 MIPS PY.

b. Subgroup Scoring Proposals

Facility-Based Scoring. At §414.1380(e) CMS calculates a MIPS eligible clinician's final facility-based score using the clinician's performance in another VBP. In the 2022 PFS final rule (86 FR 65425), CMS added a paragraph (3) to §414.1380(e) providing that a facility-based score will also be calculated under that section in that same way for an MVP participant that is not an APM entity, but that is eligible for facility-based scoring. CMS now notes that it inadvertently failed to exclude MVP participants that are subgroups from facility-based scoring, and that it was not its intent to calculate such a score at the subgroup level. CMS explains that if a facility-based clinician participates in an MVP, a facility-based score would be calculated as part of traditional MIPS and not as part of MVP reporting. Subgroup reporting is limited to MVPs and not available for traditional MIPs.

CMS proposes, therefore, to revise that new paragraph (3) to clarify that the MVP participant could not be an APM entity or a subgroup to be eligible for the facility-based score calculated under §414.1380(e).

Complex Patient Bonus for Subgroups. A complex patient bonus is added to the final score of certain MIPS eligible clinicians that submit data on at least one performance category during a performance period (§414.1380(c)(3)(i)). The bonus is calculated on the basis of the average Hierarchical Condition Category (HCC) risk score and the dual eligible ratio for beneficiaries seen by clinicians and groups. In the CY 2022 PFS final rule (86 FR 65425), CMS finalized a policy that a complex patient bonus will also be added to the final score for an MVP participant, and a policy that permits subgroups to receive the complex patient bonus. However, the agency has found that it is unable to identify the beneficiaries seen by clinicians in a subgroup and cannot calculate the average HCC score and dual eligible ratio scores at the subgroup level for applying the bonus for subgroups.

CMS proposes to retroactively modify the previously established policy for the 2023 PP/ 2025 MIPS PY to correct for the fact it cannot calculate the complex patient bonus at the subgroup

[19] This policy was finalized in the CY 2022 PFS final rule (86 FR 65425 through 65426).

level and to specify that for subgroups, the affiliated group's bonus will be added to the final score.

c. Other Subgroup Proposals

Targeted Review for Subgroups. At §414.1385(a) a clinician or group may request a targeted review of their MIPS payment adjustment factor calculation and, if applicable, the additional MIPS payment adjustment factor calculation. Beginning with the 2023 PP/2025 MIPS PY, MIPS eligible clinicians who participate in MVP reporting and are scored as a subgroup may request a targeted review. CMS never reflected the availability of targeted review for subgroups in §414.1385(a), and now proposes to revise such section to do so.

Codification of previously finalized policies. CMS proposes to codify several previously finalized policies and make regulatory changes to remedy inconsistencies between the finalized policies and regulatory provisions that had not been updated to reflect those policies. It believes it is necessary for the proposed changes to the policies to be effective with the 2023 PP/2025 MIPS PY in order for the MVPs to operate, and therefore justifies the retroactive application.[20] These regulatory changes include:

- At §414.1305: Revising the definition of "attestation" so that subgroups are referenced in the definition along with clinicians and groups as those submitting required data for the PI or IA performance categories. Also, revising the definition of "submitter type" to include a reference to subgroups.
- At §414.1360(a): Revising the data submission criteria in the IA performance category to specify that subgroups, in addition to clinicians and groups, must submit data on MIPS IAs.[21]

E. APM Performance Pathway (AAP)[22]

The APP is established at §414.1367 as a MIPS reporting option. ACOs under the Shared Savings Program are required to report quality data through the APP. Specifically, through the 2024 PP/2026 MIPS PY, those ACOs must report the 10 CMS Web Interface measures or the 3 eCQMs/MIPS CQMs, in addition to the CAHPS for MIPS survey, and beginning with the 2025 PP/2027 MIPS PY, those ACOs would no longer have the option to report the CMS Web Interface measures.

In section III.F.2.b.(2) of the proposed rule, CMS proposes, beginning with the 2024 PP/2026 MIPS PY, the addition of the Medicare CQMs collection type in the APP measure set, which would be available to only ACOs participating in the Shared Savings Program. Under the Medicare CQM option, ACOs would report on only their Medicare FFS beneficiaries who meet the definition (proposed under such section) of a beneficiary eligible for Medicare CQMs, in contrast to having to report on their all payer/all patient population under the eCQM/MIPS CQM

[20] Section 1871(e)(1)(A)(ii) of the Act provides for retroactive application of a substantive change if the Secretary determines the failure to do so would be contrary to public interest.
[21] The CY 2022 PFS final rule (86 FR 65462) allows subgroups to perform and attest to their improvement activities separately and to apply the 50 percent threshold within their subgroup.
[22] These proposals were included under section IV.A.4.e. of the rule.

option. The Medicare CQMs collection type is proposed to be a temporary transition collection type, available as determined by CMS.

F. MIPS Performance Category, Measures and Activities[23]

1. Quality Performance Category

Each MIPS eligible clinicians' final total performance score is required by statute to take into account the quality performance category, based on performance on the applicable measures included in such category.[24] CMS makes the following policy proposals related to the quality performance category.

a. Revision to the Definition of Collection Type

CMS proposes to amend the definition of collection type at §414.1305 to include the proposed Medicare CQMs as an available collection type in MIPS.

b. Quality Data Submission Criteria for Quality Measures

CMS proposes:

- To make technical amendments to the data submission criteria to account for expanding MIPS participation from including only MIPS eligible clinicians and groups to also including virtual groups (beginning with PY 2018), APM entities (beginning PY 2021), and subgroups (beginning PY 2023).
- To amend the data submission criteria to clarify in §414.1335(a)(1) that the data submission of MIPS quality measures specific to eCQMs must be submitted through CEHRT, regardless of the sunset of the end-to-end electronic reporting bonus points.
- To amend the definition of CEHRT in §414.1305(2)(ii) to broaden the applicability of health IT certification criteria that are necessary to report objectives and measures specified under MIPS so that the criteria would be applicable for any MIPS performance category (not only the PI performance category). At a minimum, a MIPS eligible clinician, group, virtual group, subgroup, or APM entity would need to use technology certified to the criteria at 45 CFR 170.315(c)(1) through (3) to report on eCQMs.
- To establish data submission criteria for the proposed Medicare CQMs.

c. Quality Data Submission Criteria for CAHPS for MIPS Survey

The survey measures 10 dimensions of patient experience of care. It is optional for groups, virtual groups, subgroups, and APM entities of 2 or more eligible clinicians reporting through traditional MIPS or MVPS, and is required for Shared Savings Program ACOs reporting through the APP. There are official translations of the survey in 7 languages, but use of the translations is generally voluntary.[25] Those electing to administer the survey must contract with a CMS-

[23] These proposals were included as section IV.A.4.f. of the rule.
[24] See section 1848(q)(2)(A)(i) of the Act.
[25] In addition to the required administration in English, the translations are available in Spanish, Cantonese, Korean, Mandarin, Portuguese, Russian, and Vietnamese. The Spanish translation is required for patients in Puerto Rico.

approved survey vendor, and if they want to provide a translation must request such translation for the vendor to administer.

CMS proposes to require the administration of the CAHPS for MIPS Survey in the Spanish translation for patients preferring such translation, and recommends that the survey be administered in other available translations based on the language preferences of patients. **CMS seeks information** on whether organizations that administer the CAHPS for MIPS Survey request administration of the survey in any translation based on the language preferences of patients, and on factors that affect the administration of survey translations.

d. Data Completeness Criteria

For Quality Measures Other than Medicare CQMs. CMS describes how it has incrementally increased the data completeness threshold. For the 2024 and 2025 PPs/2026 and 2027 MIPS PYs, the threshold is at least 75 percent. CMS proposes to maintain this threshold for the 2026 PP/2028 MIPS PY, and increase the threshold to at least 80 percent for the 2027 PP/2029 MIPS PY. These thresholds apply with respect to QCDR measures, MIPS CQMs, and eCQMs, as well as with respect to quality data on Medicare part B claims measures. CMS encourages the use of EHRs and eCQMs to reduce burden associated with meeting the higher data completeness standards.

For Medicare CQMs. CMS proposes the following data completeness thresholds with respect to the proposed Medicare CQMs: (i) for the 2024-2026 PPs/2026-2028 MIPS PYs, quality data would need to be submitted on at least 75 percent of the APM entity's applicable beneficiaries eligible for the Medicare CQM who meet the applicable measure's denominator criteria, and (ii) for the 2027 PP/2029MIPS PY, that threshold would increase to at least 80 percent.

e. Selection of MIPS Quality Measures

For the 2024 PP/2026 MIPS PY, CMS proposes a total of 200 quality measures.[26] Specifically, CMS proposes:

- The addition of 14 new MIPS quality measures, including 1 composite measure and 7 high priority measures, of which 4 are patient-reported outcome measures. Table Group A of Appendix 1 of the rule lists the proposed quality measures.
- Modifications to existing specialty sets and new specialty sets listed in Table Group B of Appendix 1 of the rule.
- Removal of 12 MIPS quality measures and partial removal of 3 quality measures that are proposed for removal from traditional MIPS but for retention for use in MVPs. Table Group C of Appendix 1 of the rule lists the quality measures and the rationale for the measure removal. Table Group DD lists the measures proposed for retention in the MVP.
    - The MIPS measures proposed for removal include 2 measures that are duplicative of a proposed new measure; 3 measures duplicative of current measures; 5 measures that are under the topped-out lifecycle; 1 measure that is extremely

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

topped out, and 1 that is constructed in such a manner as to make it difficult to attribute action to the clinician, which creates burden.

- Substantive changes to 59 existing MIPS quality measures (Table Group D) including 3 quality measures proposed for retention for the purposes of utilization under MVP (Table Group DD). CMS reviews the established MIPs quality measure inventory on an annual basis to consider updates.
- Substantive changes to CMS Web Interface measures for MSSP ACOs meeting reporting requirements under the APP; Table Group E of Appendix 1 lists these proposals.

2. Cost Performance Category[27]

Beginning with the 2024 PP/2026 MIPS PY, CMS proposes to:

- Add 5 new episode-based measures: 3 which are chronic condition episode types (Depression, Heart Failure, and Low Back Pain); 1 which is a care setting episode type (Emergency Medicine); and 1 which is an acute inpatient medical condition episode type (Psychoses and Related Conditions);
- Remove the Simple Pneumonia with Hospitalization episode-based measure; and
- Add those 5 measures and remove that 1 measure from the operational list of care episode and patient condition groups and codes.

a. Proposed Addition of Episode-Based Measures

Background. For the 2023 PP/2025 MIPS PY, there are 25 cost measures in the cost performance category, including 23 episode-based measures and 2 population-based measures. Episode-based measures are intended to compare clinicians on the cost to Medicare and beneficiaries of care furnished during an episode. Generally, for all episode-based measures, CMS (i) applies a risk adjustment model, and (ii) excludes episodes where costs cannot be fairly compared to the costs for the whole cohort in the measure.

CMS describes that the 5 episode-based measures proposed for addition would fill identified gaps in cost measures for clinicians who have limited or no applicable cost measures, and would therefore support the transition to MVPs. All 5 were included on the 2022 Measures Under Consideration (MUC) list. The MAP provided conditional support for the 5 measures for rulemaking, pending endorsement of the measures by a consensus-based entity (CBE). Concerns were raised related to the inclusion of Medicare Part D covered drugs in certain measures, potential unintended consequences of assessing costs related to mental health care, appropriateness of the attribution methodology, and a request for additional detail on testing into adjusting for social determinants of health.[28] However, CMS believes the concerns have been addressed during measure development and the MAP meetings.

Proposed Chronic Condition Measures. The 3 chronic condition measures would attribute episodes to the clinician group that renders services that constitute a trigger event, identified by two claims with a diagnosis code indicating the same chronic condition (the first of which must

[27] Policies for the cost performance category are under §414.1350.

[28] The MAP recommendations document may be found at *https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&itemID=98102*.

be an E/M code for outpatient services) billed in close proximity by the same clinician group. The trigger event starts a year-long attribution window from the initial E/M outpatient service, which could be extended if there's evidence that the clinician relationship is ongoing (i.e., another E/M or condition-related procedure code). CMS would attribute episodes to each individual MIPS eligible clinician within an attributed clinician group that renders at least 30 percent of trigger or reaffirming codes on part B claim lines during the episode.

Other Proposed Measures. The preamble includes the following details on the 2 episode-based measures which are not chronic condition measures:[29]

- *Psychoses and Related Conditions Measure*. This measure focuses on assessing the cost of care specifically for patients hospitalized for schizophrenia, delusional disorders, brief psychotic disorder, schizoaffective disorder, manic episode with psychotic symptoms, bipolar disorder with psychotic symptoms, major depressive disorder with psychotic symptoms, or unspecific psychosis. In response to concerns raised during the measure development cycle, the following 3 refinements were made: (i) reduced the episode window to 45 days to better ensure clinicians can be held accountable for post-discharge care; (ii) excluded episodes with involuntary holds at admission and episodes which were transfers to state hospitals; and (ii) risk adjusted for facility type to account for differences in payment policies.
- *Emergency Medicine Measure*. This measure assesses the cost of care clinically related to the treatment of a patient during an ED visit. Attribution is triggered by a CPT/HCPCS code indicating a clinician has furnished care in the ED. The trigger opens a 14-day episode window during which the attributed clinician is responsible for costs related to all Medicare parts A and B services furnished that are clinically related to the episode. The measure stratifies care into 28 ED visit types to ensure clinical comparability. These visit types are further stratified by whether or not the ED visit resulted in subsequent observation care or inpatient admission.

Reliability and Case Minimum. CMS proposes a 20-episode case minimum for each of the 5 proposed measures.[30] The agency also clarifies that the case minimum criteria specified in §414.1350(c)(4) through (6) for each type of episode-based measures (acute inpatient medical condition, chronic condition, and procedural) applies to all episode-based measures of the same type adopted (current and future) unless specified otherwise in rulemaking.

b. Removal of Simple Pneumonia with Hospitalization Measure.

CMS proposes to remove this episode-based measure from the cost performance category beginning with the 2024 PP/2026 MIPS PY. The measure was adopted beginning with the 2019 PP, but the cost performance category was assigned a zero percent weight during the 2020 and 2021 PPs, and the measure itself was suppressed for the 2022 PP because of the COVID-19 public health emergency. The measure was suppressed for the 2022 PP specifically because of

[29] The proposed specifications for all 5 episode-based measures are available at About Cost Measures | CMS.
[30] CMS considers a mean reliability of 0.4 as representing the balance of moderate reliability. It tested the mean reliability of each proposed measure at the 20-episode case minimum. Table 44 in the rule shows the mean reliability of all measures exceeded 0.4 for groups and clinicians.

coding changes related to COVID-19, which resulted in the measure no longer being able to capture many pneumonia episodes. Based on the coding changes leading to misleading or inaccurate results in calculating the measure's score, CMS proposes its removal. CMS is looking into substantive changes to the measure's triggering methodology to take into account the coding changes.

c. Proposed Revisions to Operational List of Care Episode and Patient Condition Groups and Codes.

Section 1848(r)(2) of the Act requires the development of care episode and patient coding groups (and classification codes for such groups).[31] The operational list of such care episodes, groups, and codes is required to be annually updated.

CMS proposes to revise the operational list beginning with the 2024 PP/2026 MIPS PY to include Emergency Medicine and Psychoses and Related Conditions as care episode groups and Heart Failure, Low Back Pain, and Depression as patient condition groups, and to remove the Simple Pneumonia with Hospitalization care episode group.

3. Improvement Activities (IA) Performance Category

a. IA Inventory.

IAs are activities identified as improving clinical practice or delivery that the Secretary determines are likely to result in improved outcomes. CMS describes the formal annual call for activities process used for adding possible new IAs and possible modifications to IAs in the inventory.[32] CMS establishes IAs through rulemaking.[33]

Beginning for the 2024 PP/2026 MIPS PY, CMS proposes:

- To add the following five IAs (according to subcategory named) to fill gaps identified in the inventory:
    - Practice Management subcategory: The Improving Practice Capacity for HIV Prevention Services IA, which provides credit for establishing policies to improve capacity to increase HIV prevention screening, education, and resources, and reduce disparities in pre-exposure prophylaxis uptake;
    - Practice Management subcategory: The Decision Support Improves Adherence to Cervical Cancer Screening and Management Guidelines IA, which provides credit for incorporating cervical cancer clinical decision support within the EHR system;
    - Behavioral and Mental Health subcategory: The Behavioral/Mental Health and Substance Use Screening and Referral for Pregnant and Postpartum Women IA, which provides credit for screening and referring to treatment or social services

[31] The current operational list and prior operational lists are available at https://www.cms.gov/Medicare/Quality-Payment-Program/Cost-Measures.
[32] A nomination form available at www.qpp.cms.gov must be submitted during the Annual Call to submit a request for a new activity or modification.
[33] A complete list of current IAs may be found at Explore Measures & Activities (cms.gov).

for perinatal mood and anxiety disorders and substance use disorder in pregnant and postpartum women;
    - Behavioral and Mental Health subcategory: The Behavioral/Mental Health and Substance Use Screening and Referral for Older Adults IA, which provides credit for screening and referring to treatment or social services for mental health and substance use disorder in older adults; and
    - MVP focused: The Practice-wide quality improvement in MVP IA, which would require a clinician to complete a model for quality improvement linked to at least 3 measures in the specific MVP.
- To modify the description of the IA titled "Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs," and its validation criteria, to promote the use of clinical decision support.
- To remove 3 IAs ((i) Implementation of co-location PCP and MH services, (ii) Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder, and (iii) Consulting Appropriate Use Criteria Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging) so that the inventory reflects current clinical practice.

Tables A, B, and C of Appendix 2 of the proposed rule provide further details.

b. IA Reporting Policies.

While CMS is not revising any group reporting policies, it clarifies that under §414.1360 if a subgroup consists of 50 percent or more of the clinicians in the affiliated group and the subgroup attests to completing an activity, then the group receives credit for the IA.

4. Promoting Interoperability (PI) Performance Category

This category measures the meaningful use of certified electronic health record technology (CEHRT).

a. Performance Period

For the 2024 MIPS PY and subsequent payment years, the performance period for the PI category is a minimum of any continuous 90-day period during the year occurring 2 years before the applicable MIPS PY (up to the full year). Beginning with the 2026 MIPS PY, CMS proposes to replace the 90-day minimum period with a 180-day minimum period.

b. CEHRT Requirements

In the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing proposed rule (88 FR 23758), the Office for the National Coordinator (ONC) proposes to maintain a single set of ONC Certification Criteria for Health IT. CMS proposes to modify the CEHRT definition for the QPP to incorporate any changes made by ONC to its definition of Base EHR and its certification criteria.

c. PI Performance Category Measures

Changes to Query of Prescription Drug Monitoring Program (PDMP) Measure under the E-Prescribing Objective. In the 2023 PFS final rule, beginning with the 2023 PP, this measure became required and worth 10 points. CMS provided for 2 exclusions: (i) for clinicians who are unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs, and (ii) for clinicians who write fewer than 100 permissible prescriptions.

CMS proposes to modify the second exclusion to clarify that a clinician who is unable to prescribe opioids or drugs as described in the first exclusion may also claim the second exclusion.

Changes to Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure. ONC developed several SAFER Guides for organizations to use to self-assess the safety and use of EHRs. Under the SAFER Guides measure, clinicians are required to attest (yes/no) whether they have conducted an annual self-assessment using the High Priority Practices Safer Guide at any point during the year in which the performance period occurs. There is no consequence if "no" is the attestation. Beginning with the 2024 PP/2026 MIPS PY, CMS proposes that only a "yes" response will count for completion of the measure and "no" would result in a score of zero.

d. Requirements for the PI Performance Category for the 2024 PP

To show the requirements for the PI performance category for the 2024 PP, CMS provides several tables spanning multiple pages, including the following:

- Table 45: Objectives and Measures for the Promoting Interoperability Performance Category for the 2024 Performance Period. For each measure (including as proposed to be revised in the rule and as described above), this table shows the objective, numerator and denominator (if measure is not Y/N), and any exclusions.
- Table 46: Scoring Methodology for the 2024 Performance Period. For each measure, this table shows the objective, maximum points, and whether the measure is optional or required.
- Table 47: Exclusion Redistribution for the 2024 Performance Period. For each measure, this table shows the objective and the redistribution policy if an exclusion is claimed.
- Table 48: Promoting Interoperability Performance Category Objectives and Measures and 2015 Edition Certification Criteria. For each measure, this table shows the objective and the 2015 edition certification criteria.

Table 46 is reproduced below.

Table 46: Scoring Methodology for the 2024 Performance Period

Objective	Measure	Maximum Points	Required/ Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
	Support Electronic Referral Loops by Sending Health Information	15 points	

Objective	Measure	Maximum Points	Required/ Optional
Health Information Exchange	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	Required (MIPS eligible clinician's choice of one of the three reporting options)
	-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).

e. Clinical Social Workers

Clinical social workers (CSWs) were included in the definition of MIPS eligible clinicians beginning with the 2022 PP/2024 MIPS PY.[34] They were assigned a weight of zero for the PI performance category since CMS believed there would not be sufficient PI measures available that were applicable to CSWs. However, if a CSW submits any data for any of the PI measures then the category would be reweighted and the CSW would be scored on the category as part of their final composite performance score. Since CMS does not yet have data on whether there are sufficient measures for CSWs, it proposes to continue this existing policy for the 2024 PP/2026 MIPS PY.

5. APM Improvement Activities Performance Category Score

A MIPS eligible clinician who is in an APM for a performance period earns a minimum score of 50 percent of the highest potential score for the IA performance category.[35]

CMS proposes revisions to §414.1380 to clarify that this baseline minimum score of at least 50 percent is limited to the purpose of the MIPS final scoring. The revisions would require that to trigger the baseline score the clinician or group participating in an APM must submit data for the quality and PI performance categories or attest to having completed an IA. A baseline score would not be applied if CMS also approved a request for category reweighting or a hardship exception affecting the IA category.

[34] Clinical social workers were added to the definition at §414.1305 in the 2022 PFS final rule (86 FR 65387 through 65389).

[35] Section 1848(q)(5)(C)(ii) of the Act.

G. MIPS Final Score Methodology[36]

1. Performance Category Scores

For the 2024 PP/2026 MIPS PY, CMS proposes (i) a technical update to §414.1380(a)(1)(i) and (b)(1)(v)(A) to make the provisions consistent with the removal of bonus points for reporting additional high priority measures and using end to end electronic reporting,[37] (ii) revisions to the criteria for assessing ICD-10 coding impacts under its scoring flexibilities policy, and (iii) updates to policies on improvement scoring for the cost performance category.

a. Scoring Flexibility for Changes that Impact Quality Measures During the Performance Period.

Currently, under CMS' scoring flexibility policy, if it determines that a quality measure is significantly impacted by a change to or errors in clinical guidelines, measure specifications, or codes (i.e., changes or errors affecting clinicians' ability to submit information on the measures or lead to potentially misleading results), it may shorten the performance period for the measure from 12 to 9 months. If 9 months of data is not available, it may suppress the measure by reducing the total available measure achievement points for the measure in the quality performance category by 10 points. A measure is determined to be significantly impacted by a change or error based on these factors: (i) a more than 10 percent change in ICD-10 codes in the measure numerator, denominator, exclusions, and exceptions; (ii) clinical guideline changes or new items or procedures reflected in the changes; and (iii) feedback from measure developers and stewards.

CMS proposes to (i) replace the 10 percent threshold factor and instead assess the overall impact of changes to ICD-10 codes on the measure numerator, denominator, exclusions, and exceptions that could produce misleading or harmful results or change the scope or intent of the measure; (ii) assess according to measure collection type (eCQM, MIPS CQM, Medicare part B claims) the impacts of the changes and corresponding decision (shorten performance period to 9 months, keep 12 months, or suppress); and (iii) specify that the performance period for eCQMs may be shortened to 9 months (since currently a 12-month reporting period is specified).

b. Cost Performance Category Score: Improvement Scoring Methodology

Beginning with the 2022 PP/2024 MIPS PY, CMS' scoring methodology must take into account a clinician's improvement in the cost performance category if sufficient data are available to measure such improvement.[38] The cost improvement score is to be greater than 0 but not more than 1 percentage point, and is determined at the measure level and not the category level by comparing the number of cost measures with significant improvement in performance and the number of cost measures with significant declines for a clinician or group, measured between 2

[36] These proposals were included as section IV.A.4.g. in the rule.
[37] The bonus points ended beginning with the 2022 PP per 86 FR 65504 through 65507.
[38] See section 1848(q)(5)(D)(i) and (iii) of the Act. The overall cost performance category score is the performance score plus improvement score.

consecutive performance periods.[39] Significant improvement or decline in performance between performance periods would be determined by a statistical significance requirement using the t-test, which compares how significant differences are between group means.

CMS has discovered that use of the t-test is not workable with the underlying data because the t-test compares aggregate values and cannot compare how significant the differences are between single values. The use of a t-test makes the scoring methodology mathematically infeasible because the agency's methodology requires comparing a clinician's scores for an individual cost measure. The agency also identified 3 additional issues with applying the score at the individual measure level: (1) The growing number of cost measures raises questions of operational feasibility, (2) Improvement scoring for the quality performance category is at the category level and inconsistency between the 2 categories would increase implementation cost and complexity and cause clinician confusion; and (3) It may be unfair to score at the measure level since it would be difficult for clinicians to demonstrate improvement across all measures (for example, they may not meet minimum cases threshold for some).

Therefore, beginning with the 2023 PP/2025 MIPS PY, CMS proposes to revise the cost improvement scoring policy so that the score will be at the category level instead of the measure level, to remove the statistical significance requirement, and to begin the improvement scoring for the 2025 MIPS PY instead of the 2024 MIPS PY. The score would be calculated as follows:

- (The change between current and previous year performance scores / previous year performance score)/100

To show how the cost improvement score would be calculated, as proposed, CMS provides the example of a clinician using the same identifier for 2 consecutive performance periods and who has a cost performance category score of 52.0 percent for the first period and 63.71 percent in the second (current) period. The score would be calculated as follows:

- ((63.71 percent - 52.0 percent)/52.0 percent)/100 = 0.23 percentage points
- Based on current policy for determining the overall cost performance category score, the overall score would be 63.71 percent + 0.23 percent = 63.94 percent (i.e., the current year performance score + improvement score).
- Based on current policy for determining the points contributed to the final score, the clinician would have 63.94 percent x 30 percent x 100 = 19.18 points from the performance category contributed to the final performance score (i.e., the current year cost performance category score x the weight of the cost performance category x 100).

H. MIPS Payment Adjustments[40]

1. Background

The MIPS payment adjustment factor is a percentage determined by comparing the MIPS eligible clinician's final score for the year involved to the performance threshold established for that year. The threshold is computed as the mean or median (as selected by the Secretary) of the

[39] The calculation is described in 82 FR 53750 through 53752). The cost improvement scoring policies are codified at § 414.1380(b)(2)(iv).

[40] Note that details on this proposal appear in the preamble labeled as a second f. following a g. under section IV.A.4. on page 991 of the display copy.

final scores for all MIPS eligible clinicians with respect to a prior period specified by the Secretary. The threshold methodology, mean or median, may be reassessed by the Secretary every 3 years. Adjustment factors specified for a year must result in differential payments such that clinicians with final scores above the threshold receive a positive adjustments factor, at the threshold receive a neutral adjustment factor, and below the threshold receive a negative adjustment factor.

2. Performance Threshold

For MIPS PYs 2024, 2025, and 2026, the Secretary has selected the mean as the threshold methodology. For each of MIPS PYs 2024 and 2025 (performance periods 2022 and 2023), the Secretary selected a single respective performance period as the "prior period".

The table below is based on table 50 in the rule, which shows the performance thresholds established for performance periods 2017 through 2023/ MIPS payment years 2019 through 2025.

Table 50: Performance Thresholds for the 2017 through 2023 Performance Periods						
2017 PP	**2018 PP**	**2019**	**2020**	**2021**	**2022**	**2023**
3 points	15 points	30 points	45 points	60 points	75 points	75 points

CMS proposes, beginning with the 2024 PP/2026 MIPS PY, that the "prior period" used to identify the threshold for the payment year would be a span of 3 performance periods, which would control for unusual fluctuations in performance in a single period. Specifically, CMS proposes to use the 2017-2019 PPs/2019-2021 MIPS PYs as the prior period (which would result in the mean of 82.06 (rounded to 82) points) applied as the threshold.

The table below, based on Table 51 in the rule, shows possible values for the 2024 PP/2026 MIPS PY performance threshold, ranging from 74.65 points to 89.47 points.

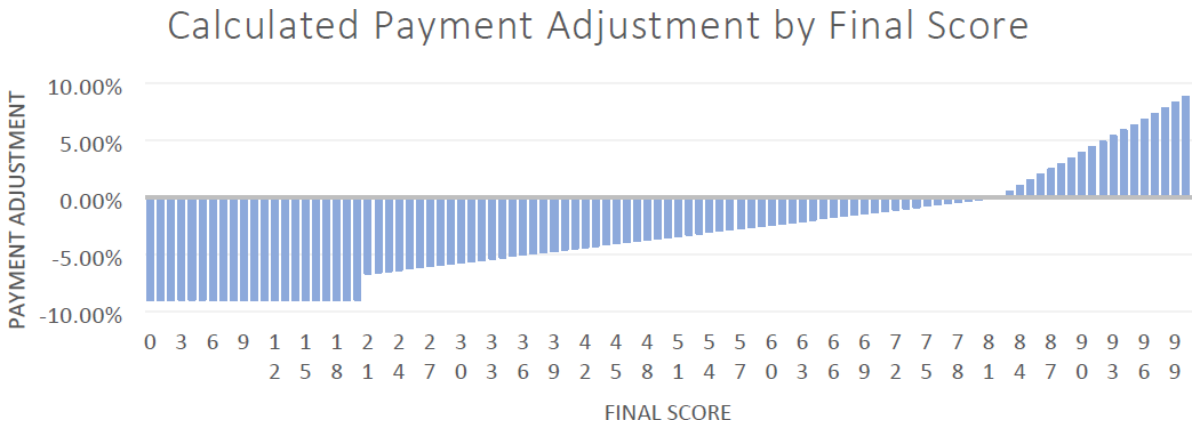
Table 51: Possible Values for 2024 PP/2026 MIPS PY Threshold						
Performance Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2017-2019**
Mean	74.65 points	87 points	85.61 points	89.47 points	89.22 points	82.06 points

CMS estimates in the Regulatory Impact Analysis (RIA) in section VII.E.23.d.(4) of the rule that approximately 46 percent of MIPS eligible clinicians would receive a negative payment adjustment for the 2024 PP/2026 MIPS PY if the proposed policies for the QPP, including this proposed threshold were finalized.

CMS requests comments on this proposal, specifically on whether it should use the means of final scores from alternative years, which is discussed in the RIA in section VII.F.4. of the rule.

3. Example of Adjustment Factors

The adjustment factor is determined on a linear sliding scale from 0 to 100, with 0 being the lowest possible score and resulting in the lowest payment adjustment, and 100 being the highest possible score and resulting in the highest payment adjustment.[41] CMS notes the following 2 deviations from that sliding scale, required per statute: (1) payments are also adjusted such that all clinicians whose final scores fall between zero and one-fourth of the threshold (which would be between 0 and 20.5 points based on a threshold of 82, as proposed) receive the lowest possible MIPS payment adjustment of -9 percent; and (2) a scaling factor greater than 0 but no higher than 3 is applied as needed to render MIPS payments budget neutral (i.e., positive payment adjustment amounts in aggregate must equal negative adjustment amounts). Figure 1 from the rule (reproduced below) illustrates payment adjustment factors for MIPS PY 2026 (performance period 2024), that would reflect the statutory requirements described above along with the proposed MIPS threshold score of 82 points.



Reproduced below in part is Table 52 in the proposed rule, which links the final score points to the payment adjustments.

Relationship of MIPS Final Performance Score to Proposed MIPS Payment Adjustment for 2024 PP/ 2026 MIPS PY (from Table 52 of the rule)	
Final Score Points	**MIPS Adjustment**
0.0 – 20.5	Negative 9%
20.51 – 81.99	Negative MIPS payment adjustment > negative 9% and < 0% on a linear sliding scale
82.0	0% adjustment
82.01 – 100	Positive MIPS payment adjustment > 0% on a linear sliding scale; the sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than 0 but not exceeding 3.0 to preserve budget neutrality.

[41] See section 1848(q)(6) of the Act.

I. Review and Correction of MIPS Final Score[42]

CMS is statutorily required to provide MIPS eligible clinicians with timely confidential feedback on their performance on the quality and cost performance categories and may provide such feedback on the IA and PI categories.[43] CMS provides such reports for the quality and costs categories annually, and for the IA and PI categories if technically feasible. The agency aims to provide feedback for the 2022 PP/2024 MIPS payment year on or around July 1, 2023.[44]

J. Targeted Review[45]

MIPS eligible clinicians, groups, and APM entities may request and receive targeted review of the calculation of their MIPS adjustment factor.[46] There is a 60-day submission period for requests, beginning on the day CMS makes available the adjustment factors for the MIPS PY, and this period may be extended. Beginning with the 2024 PP/2026 MIPS PY, eligible clinicians who are qualifying APM participants (QPs) will receive an alternative differentially higher PFS conversion factor of 0.75, as compared to the 0.25 percent for non-QPs.[47] CMS describes the challenges that the target review request submission period presents in the context of implementing the alternative conversion factor for QPs. A significant amount of targeted review requests are for resolving whether an eligible clinician should be designated as a QP. The process therefore provides important information for identifying an accurate list of QPs. This list would be needed to submit to Medicare Administrative Contractors by October 1 preceding a payment year in order to implement the alternative conversion factor for that payment year, but the information based on the targeted review request timeframe would not be available until the December preceding the payment year.

Therefore, CMS proposes to change the period for submission of requests for targeted review to begin on the date it makes the MIPS final scores available and end 30 days after publication of the MIPS payment adjustment factors for the MIPS payment year. This would still provide for an approximately 60-day period (around 30 days before publication of the adjustment factors and 30 days after). In addition, CMS proposes to shorten the period under the targeted review process during which a clinician must provide additional information if requested by CMS to 15 days (from the current 30 days) after receipt of the request. Figure 2 in the proposed rule illustrates a comparison of the current versus proposed timing.

CMS also proposes to add subgroups and virtual groups as being eligible to submit a request for targeted review under the process.

---

[42] Note that this policy is included as a "g." under section IV.A.4. of the proposed rule, on page 1004 of the display copy.
[43] Section 1848(q)(12)(A)(i) of the Act.
[44] See qpp.cms.gov for further information.
[45] Note that this policy is included as a "K." under section IV.A.4. of the proposed rule, on page 1005 of the display copy.
[46] The targeted review process and requirements are codified at §414.1385(a).
[47] Section 1848(d)(1)(A) of the Act requires the differentially higher PFS conversion factor starting with the 2026 MIPS PY.

K. Third Party Intermediaries General Requirements

Many of the policies that apply to third party intermediaries (TPIs) were finalized through prior rulemaking but not codified in the CFR, which has caused confusion. CMS says it has reviewed previously finalized language and policies that should be codified and proposes to do so in this rule. In addition, CMS makes a number of new or clarifying proposals for the TPI regulations.

1. General Requirements

a. Requirement to Obtain Documentation (§414.1400(b)(3)(xii) and (xiii))

CMS proposes to codify its policies for QCDRs and qualified registries to get signed documentation from clinicians and groups about their authority to handle and submit data on behalf of those clinicians and groups. For MIPS eligible clinicians, this requires a HIPAA-compliant Business Associate Agreement. Records must be kept for 6 years after the performance period ends.

b. Requirement to Report in Form and Manner Specified (§414.1400(a)(2)(i)(C))

Pursuant to §414.1400(a)(2)(i)(C), all data submitted by a TPI must be submitted in the form and manner specified by CMS. In the preamble, CMS specifies 10 specific criteria for data submissions required of functioning QCDRs and qualified registries. However, the specific criteria themselves are not proposed to be added to the regulations.

Additionally, CMS proposes to codify (at §414.1400(a)(3)(ii)(A)) the previously established requirement that data submitted by TPIs must include data on all of the MIPS eligible clinician's patients regardless of payer unless otherwise specified by the collection type. This change is proposed in conjunction with the earlier proposal to allow Shared Savings Program ACOs meeting the reporting requirements under the APP to report on a subset of patients "that is partially defined by having the payer of Medicare."

2. Requirements for QCDRs and Qualified Registries

Self-Nomination and Program Requirements. The requirement that TPIs must support subgroup reporting beginning with the 2023 performance period/2025 MIPS payment year would be codified at §414.1400(b)(1)(iii).

Simplified Self-Nomination Process for Existing QCDRs and Qualified Registries in Good Standing. A simplified self-nomination form was established to reduce the self-nomination burden for TPIs in good standing by allowing them to self-nominate with a mostly pre-populated self-nomination form, permitting them to attest to no change in certain sections of the application. Some TPIs interpreted this as permitting them to attest that their previously approved self-nomination form is still accurate, thereby obviating the need to submit a new form. CMS proposes to revise §414.1400(b)(2) to clarify that TPIs must submit their self-nomination form even if they use the simplified self-nomination process and even if no changes are made from the previously approved submission.

Measure Numbers and Identifiers and Titles for the Improvement Activity Performance Category, the PIP Category, and MVPs. CMS proposes to codify (at §414.1400(b)(3)(ix)) existing policy that, during the self-nomination period, a QCDR or a qualified registry must submit to CMS quality measure numbers, Promoting Interoperability identifiers, improvement activity identifiers and MVP titles.

Quality Measures. The current requirement for a QCDR or a qualified registry to be able to submit to CMS data for at least six quality measures including at least one outcome measure would be codified at §414.1400(b)(3)(ix). If no outcome measure is available, a QCDR or qualified registry must be able to submit results for at least one other high priority measure.

Qualified Posting Attestation. CMS proposes to align requirements related to qualified postings. First, CMS proposes to define the term "qualified posting" to mean the document made available by CMS that lists QCDRs or qualified registries available for use by MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities. Then, at §414.1400(b)(3)(xiv) it would require QCDRs and qualified registries to attest that the information on the qualified posting is correct.

Data Access Capabilities. Current policy requiring QCDRs and qualified registries to comply with any request by CMS to review data submitted by a TPI for purposes of MIPS would be codified at §414.1400(b)(3)(xv).

Attestation of Data Access Capabilities. CMS proposes to add two new requirements at §414.1400(b)(3)(xvi) for TPIs to attest to their capabilities. First, a QCDR or a qualified registry would have to attest that it has required each MIPS eligible clinician on whose behalf it reports to provide the QCDR or qualified registry with all documentation necessary to verify the accuracy of the data on quality measures that the eligible clinician submitted. Next, a QCDR or a qualified registry would have to attest that it has required each MIPS eligible clinician to allow the QCDR or qualified registry to provide the information described above to CMS upon request to ensure that data can be accessed by the TPI for auditing purposes.

TPI Support of MVP Reporting. In the 2022 rulemaking cycle, CMS required, beginning with the 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries to support MVPs applicable to the MVP participants on whose behalf they submit MIPS data. QCDRs and qualified registries could also support the APP. Because this policy could impact measures reported by clinicians across multiple specialties, some of whom might be outside the QCDR's or qualified registry's intended customer base, CMS proposes to revise its policy. It would provide two exceptions to the established policy. First, if an MVP includes several specialties, then a QCDR or a qualified registry would only be expected to support the measures that are pertinent to the specialty of their clinicians. Second, QCDR measures would only have to be reported by the QCDR measure owner. If a QCDR does not own the QCDR measures in the MVP, the QCDR may only support the QCDR measures if they have permission to do so.

Readiness to Accept Data. The current requirement that a QCDR or a qualified registry must be able to accept and retain data by January 1 of the applicable performance period would be codified at §414.1400(b)(3)(xvii).

Duration of Services Provided. Currently, TPIs are required to provide services throughout the entire performance period and applicable data submission period; CMS proposes to change this requirement to state that the TPIs are to provide services throughout the entire performance period and applicable data submission period.

Transition Plan Requirements. CMS proposes to specify requirements for transition plans required of QCRDs and qualified registries where their services would be discontinued for any MIPS eligible clinician, group, virtual group, subgroup, or APM Entity during a performance period. Generally, the TPI must support the transition of duties for the measures involved to another TPI. CMS proposes to specify (at §414.1400(a)(3)(iv)) the following five specific requirements for the transition plans:

A. The plan describes the issues that contributed to the withdrawal or discontinuation of services mid-performance period.
B. The plan lists the impacted entities, meaning:
    (1) The number of clinicians, groups, virtual groups, subgroups or APM entities (including MIPS eligible, opt-in and voluntary participants) that must find another way to report.
    (2) Any QCDRs that were granted licenses to QCDR measures which would no longer be available for reporting due to the transition.
C. The plan describes the steps the TPI will take to ensure that the clinicians, etc., are notified of the transition in a timely manner, and successfully transitioned to an alternate TPI, submitter type, or, for any measure or activity on which data has been collected, collection type, as applicable.
D. The plan includes a detailed timeline that outlines timing for communications, the start of the transition, and completion of the transition of these clinicians, etc.
E. The TPI must notify CMS that the transition was completed by the date included in the detailed timeline.

Submission Requirements. First, the current policy requiring qualified registries to submit risk-adjusted measure results for those measures that are risk-adjusted would be codified at §414.1400(b)(3)(xi).

CMS established requirements for TPI annual data validation audits, and some stakeholders are confused by references to "TIN/NPI" in the context of sample size and how they map to individual MIPS eligible clinicians, groups, virtual groups, subgroups or APM Entities. CMS proposes to remove the reference to TIN/NPI in §414.1400(b)(3)(v)(E)(*1*) and (*2*) and instead refer to "a combination of individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM Entities." The proposed text would read as follows:

"(E) The QCDR or qualified registry must conduct each data validation audit using a sampling methodology that meets the following requirements:

"(1) Uses a sample size of at least 3 percent of a combination of the individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM entities for which the QCDR or qualified registry will submit data to CMS, except that the sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups and APM entities, no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM entities.
"(2) Uses a sample that includes at least 25 percent of the patients of each individual clinician, group, virtual group, subgroup or APM entity in the sample, except that the sample for each individual clinician, group, virtual group, subgroup or APM entity must include a minimum of 5 patients and need not include more than 50 patients."

3. Requirements Specific to QCDRs

New QCDR Measures May Not be Submitted After Self-nomination. CMS intends for the self-nomination document to be comprehensive in terms of which QCDR measures would be submitted for consideration, and it proposes to clarify that new QCDR measures may not be added after the end of the QCDR self-nomination process for the performance year. It proposes to add that a measure was submitted after self-nomination to its list of reasons for rejecting a QCDR measure at §414.1400(b)(4)(iv)(O).

Limitations on Number of QCDR Measures Submitted for Self-nomination. CMS would propose to add (at §414.1400(b)(4)(iv)(P)) another factor to the list of reasons for rejecting a QCDR measure. The agency reports that there have been occasions where a single QCDR has submitted a large number of QCDR measures for consideration. CMS would add that a QCDR measure may be rejected if the QCDR submits more than 30 quality measures not in the annual list of MIPS quality measures for CMS consideration.

Requirements for Previous Data on QCDR Measures. The policy requiring QCDRs to provide data from years before the start of the performance period for non-MIPS measures, if available, would be codified at §414.1400(b)(4)(i)(C).

Requirement for QCDR Measure Specifications to Be Displayed Throughout the Performance Period and Data Submission Period. CMS proposes to amend §414.1400(b)(4)(i)(B) to require approved QCDR measure specifications to remain published throughout the performance period and data submission period. The agency thought its intent on this issue was clear, however, the proposal would remove any doubt or misinterpretation and would improve transparency.

4. Health IT Vendors

A health IT vendor is defined as an entity that supports the health IT requirements on behalf of a MIPS eligible clinician (including obtaining data from a MIPS eligible clinician's CEHRT). Program safeguards for data validation audits and targeted audit requirements apply to QCDRs and qualified registries but not to health IT vendors, and the agency notes that health IT vendors have submitted inaccurate and unusable data. CMS considered adding a self-nomination requirement or data validation audit requirements to health IT vendors, but it concluded doing so would eliminate the difference between a health IT vendor and a qualified registry. Thus, it

proposes to eliminate the health IT vendor TPI category beginning with the 2025 performance period.

CMS notes that health IT vendors would still be able to provide their technology for clinicians to directly report under MIPS; however, they would no longer be able to do so as a TPI.

5. Remedial Action and Termination of TPIs

a. Additional Basis for Remedial Action (§414.1400(e)(2)(v))

CMS proposes to add a new cause for immediate termination, with or without notice, of a QCDR or qualified registry for failure to maintain current contact information for correspondence. The agency acknowledges that personnel change over time in an organization, but such a change does not relieve the QCDR or qualified registry of its obligations to maintain up-to-date contact information under these rules.

Remedial action includes placing TPIs on probation for failure to meet requirements for the current performance period and possibly the following performance period. For periods of probation lasting through the end of the second year, the TPI is disqualified for the following performance year. CMS proposes to add a new cause for termination for TPIs that are placed on remedial action (e.g., corrective action plans) for 2 consecutive years.

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

CMS may require a TPI to submit a corrective action plan (CAP) to correct noncompliance with requirements. A CAP must address a number of issues, including the impact of any noncompliance on clinicians and groups and whether the deficiency has the potential to implicate substantial program dollars. CMS adopted a policy in the 2023 PFS final rule to require TPIs to provide a plan for communicating the impact to the parties identified within the corrective action plan (87 FR 70107).

CMS acknowledges there is a gap in its ability to determine if certain elements of the CAP have been completed in the time and manner specified within the plan. It proposes to add a new requirement for a TPI under a CAP to communicate the final resolution to CMS once the resolution is complete, and to provide an update, if any, to the monitoring plan provided.

c. Public Posting of Deficiencies (§414.1400(e)(1)(ii)(B))

Currently, if a QCDR or qualified registry had data inaccuracies that affected more than 3 percent but less than 5 percent of the total number of MIPS eligible clinicians, CMS posts this information on its website until the data error rate falls below 3 percent. CMS proposes, beginning with the 2025 performance period/2027 MIPS payment year, to disclose on its website that it took remedial action against or terminated the TPI. It clarifies that the public disclosure would be limited to the presence of the CAP and would not include any proprietary information from the QCDR or qualified registry. Concurrently, it proposes to sunset the current practice of

publicly disclosing the TPI's data error rate on the CMS website until the data error rate falls below 3 percent starting with the 2025 performance period/2027 MIPS payment year.

d. Considering Past Performance in Approving TPIs

CMS considers past data errors when deciding whether to approve TPIs. Noting that it continues to experience issues related to data errors from TPIs and that these errors often extend over multiple years, CMS proposes to clarify that past errors may be taken into account when determining a remedial action or probation for current or future program years.

e. Terms of Audits

TPIs submitting MIPS data must comply with auditing procedures under §414.1400(f). CMS conducts random and targeted compliance audits though the reasons are not set down in regulation. The agency proposes to revise this section of the regulations to indicate that TPIs may be selected for an audit randomly or based on certain criteria, which would be referred to as areas of concern. The regulation text would include examples of areas of concern, including high data errors, support call absences, delinquent deliverables, remedial action status, clinician concerns regarding the TPI, and other concerns.

6. Regulatory Impact

CMS proposes to add two new ICRs (for QCDRs and qualified registries) to represent the estimated burden for the TPIs submitting applications for the simplified self-nomination process. Other proposals, such as the elimination of the health IT vendor category and the codification of policies previously established in guidance or the preamble of previous rulemaking would not have any impact on the estimated burden for the self-nomination process. Tables 60 through 67 show the estimated burden for various aspects of the self-nomination process for TPIs.

CMS projects that most proposals relating to TPI audits would not result in a change to previous burden estimates. The agency is unable to estimate the burden associated with its proposal to specify requirements for transition plans due to the potential wide variety of effort required based on the circumstances of each QCDR or qualified registry audit involved. Tables 68 through 70 show the estimated burden for proposals relating to TPI audits.

L. Public Reporting on Compare Tool

The Affordable Care Act (ACA) provided for the development of a Physician Compare Internet Website ("Physician Compare") with information on physicians and other eligible professionals enrolled in Medicare who participate in the Physician Quality Reporting Initiative (PQRI).

MACRA aligned Physician Compare with the newly established Merit-Based Incentive Payment System (MIPS) by requiring the public reporting of MIPS performance information for MIPS eligible professionals through Physician Compare. CMS points to a number of prior rules for a full history, as well as the Care Compare: Doctors and Clinicians Initiative web page. While current regulations at §414.1305 define "Physician Compare," CMS also refers to it as the Compare tool.

1. Telehealth Indicator

In the 2023 PFS rule, CMS finalized adding an indicator to the profile pages of clinicians furnishing telehealth services, based on specific codes used on the claims (e.g., POS 02, POS 10, modifier 95), which continue to be updated. To stay current with all types of coding changes occurring during the year—that is, to ensure that codes used to inform the telehealth indicator are not incomplete or outdated, resulting in users of the Compare tool receiving incorrect information—CMS proposes to update its policy for identifying clinicians furnishing telehealth services outside of the annual PFS rulemaking cycle.

CMS proposes that—instead of only using POS code 02, 10, or modifier 95—to identify telehealth services furnished for the telehealth indicator, it would use the most recent codes at the time the data are refreshed that identify a clinician as furnishing services via telehealth. The agency would publish the details of which codes are used through education and outreach, such as via a fact sheet and on the Care Compare: Doctors and Clinicians Initiative page.

2. Publicly Reporting Utilization Data on Profile Pages

Beginning in 2015, MACRA required CMS to annually publish, in an easily understandable format, information on the items and services furnished to Medicare beneficiaries by physicians and, as appropriate, other eligible professionals, including the number of services provided. MACRA also required this data to be integrated into the Compare tool. Until 2023, this utilization data for certain services and procedures from physician/supplier Medicare Part B non-institutional claims was only available in the Physician and Other Supplier Data Public Use File (PUF), which is not easily accessible or usable by patients.

The 2023 PFS rule established a policy for publicly reporting procedure information on clinician profile pages in an understandable format no *earlier* than 2023, with specific criteria for establishing priority procedures for public reporting. Among other requirements, this data would be based on a 12-month lookback period, with data refreshes updated bi-monthly (as technically feasible), reflecting only Medicare Fee-for-Service (FFS) claims data. Since then, CMS' consumer testing has confirmed that publicly reporting utilization data on patient-facing clinician profile pages and using plain language is helpful for patients and caregivers to make informed healthcare decisions, since it allows them to find clinicians who have performed specific types of procedures.[48]

a. Updating the Provider Data Catalog (PDC) Utilization Data Policy

CMS publishes a PDC file that is a subset of the most commonly performed procedures in the PUF. With the upcoming release of the initial procedural utilization data, CMS will publish a second utilization file in the PDC that will reflect the procedure category information on clinician profile pages.

To avoid confusion with multiple PDC files, CMS proposes to have the single downloadable dataset reflect the same procedure utilization data that would appear on clinician profile pages.

[48] CMS says it is targeting to release procedure data based on FFS claims on clinician profile pages later this year, beginning with 13 priority procedure categories identified for public reporting.

The full CMS PUF of FFS data is still available on https://data.cms.gov for those interested in the full set of Medicare procedure information at the individual procedure code level.

b. Procedure Grouping Policy for Publicly Reporting Utilization Data

The 2023 PFS rule finalized using Restructured BETOS—and using procedure code sources used in MIPS when no Restructured BETOS categories are available. Since finalizing this policy, some commonly sought procedures, such as hysterectomy, have been identified that do not have a procedure category in Restructured BETOS or a relevant code set in any MIPS quality or cost measures. A few comments on the 2023 PFS proposed rule stated that some of the Restructured BETOS categories may be too broad and acknowledged that there is no other existing standard, systematic way to group procedures by HCPCS codes, but offered no suggestions for alternative sources.

CMS proposes to define meaningful categories using subject matter expert (e.g., clinician) input to create new, clinically meaningful, and well-understood procedure categories when :

- A procedure category is unavailable under the Restructured BETOS or MIPS measures,
- A code category exists but is not suitable for public reporting, or
- A procedure category does not exist.

Specifically, CMS proposes that it may use alternative sources (that is, other than the Restructured BETOS or MIPS measures) to create clinically meaningful and appropriate procedural categories, particularly when no relevant grouping exists. CMS would engage subject matter experts and interested parties through periodic requests for feedback using methods outside of rulemaking, such as listserv emails, listening sessions, and focus groups to solicit feedback on specific procedure categories planned for future releases of utilization data, as appropriate and technically feasible.

CMS seeks comment on all aspects of the proposal to modify existing procedural categorization policy, to use alternate sources to create clinically meaningful and appropriate procedural categories, and to engage with subject matter experts in developing procedure categories.

c. Incorporating Medicare Advantage (MA) Data into Public Reporting

For the initial 13 priority procedures identified in the 2023 PFS rule, approximately half of clinician-procedure combinations fall into the low volume category (less than 10), which would mean CMS could only publish an indicator that a clinician has experience with the procedure rather than specific counts. This is partly due to not including data for patients with MA plans or other payers. This limitation may get worse as CMS identifies more priority procedures for public reporting.

Several comments on the 2023 PFS proposed rule expressed concern about the understandability of the data and that limiting procedure data counts to Medicare FFS claims does not reflect the full scope of clinician practice. Consumer testing findings have also shown that patients and caregivers would like procedure information to reflect all procedures performed, as a better representation of clinicians' experience. While CMS agreed, it was unable to finalize the possibility of using other payer data as appropriate and technically feasible at that time. Since then, CMS has determined through analysis of MA encounter data that it would be technically feasible to integrate MA encounter data into procedure category counts and that adding such data

adds to the representation of some clinicians' scope of care. For example, adding MA encounter data to the initial set of publicly reported procedure categories would reduce the low volume clinician-procedure counts by approximately 12 percent, adding 10,689 unique clinicians with such information on their profile pages.

CMS proposes to publicly report aggregated counts of procedures performed by providers based on MA encounter data in addition to Medicare FFS utilization data, given that it has determined it is appropriate and technically feasible. The agency reviews how its authority under this MACRA provision is fairly broad—for items and services furnished to "Medicare beneficiaries under Medicare by physicians and certain other professionals"—thus potentially including MA enrollees. CMS also cites its statutory authority for Physician Compare under the ACA as being even broader—not only Medicare but also, to the extent practicable, other payers—so that the inclusion of MA encounter data is consistent with the statutory provisions for Care Compare disclosures, as well.

CMS points to existing MA regulations regarding the collection of this data, but also proposes a technical amendment to permit the release of the MA encounter data on the timeframe(s) used for disclosure and release of the data on the Care Compare website. Under current regulations, only in specified circumstances may CMS release MA encounter data before the applicable payment year's reconciliation has been completed. Because CMS would use information from the MA encounter data over a 12-month rolling period, while risk adjustment reconciliation occurs no sooner than 13 months after the end of the year that services were provided, the timing of the proposed release of the MA encounter data is not within the scope of the timing requirements in §422.310(f)(3). Thus, CMS proposes an additional exception—if CMS determines that releasing aggregated data (that is, not at the beneficiary level) before reconciliation is necessary and appropriate to support activities or authorized uses for activities to support the administration of the Medicare program.

3. RFI: Publicly Reporting Cost Measures

The statute requires CMS to publicly report MIPS eligible clinicians' final scores and performance category scores. It authorizes, but does not require, CMS to publicly report those clinicians' performance on each measure or activity. CMS publicly reports certain MIPS performance information on clinician, group, and ACO profile pages of the Compare tool. The agency also established a policy to publicly report performance on measures, activities and attestations from the MIPS quality, cost, Promoting Interoperability (previously called Advancing Care Information), and improvement activities performance categories that meet established public reporting standards codified at §414.1395(b). Those standards require that data included on Physician Compare be statistically valid, reliable and accurate, comparable across collection types, meet the reliability threshold, and, to be included on the public facing profile pages, "must also resonate with website users, as determined by CMS."

At this time, data from the CY 2021 performance period/2023 MIPS payment year regarding MIPS eligible clinicians' performance in the quality, improvement activities, and Promoting Interoperability performance categories that meet public reporting standards are publicly available on Compare tool profile pages and in the PDC. However, cost measure information from the cost performance category has never been publicly reported, for two primary reasons:

- The 2019 PFS final rule established a policy to delay publicly reporting any new quality and cost measures for the first two years providers are in MIPS, to allow them to gain experience with the new measure—after which time, CMS could reevaluate the measures.
- CMS has not had cost measures available for public reporting due to PHE, when CMS reweighted the cost performance category to zero percent for the 2019 performance period/2021 MIPS payment year.

CMS is now evaluating ways to publicly report cost performance on clinician and group profile pages beginning with data from the 2024 performance period/2026 MIPS payment year—publicly reported in 2026. A total of 25 cost measures could be available for public reporting in 2026—23 Episode-Based Cost Measures (EBCMs), Medicare Spending Per Beneficiary (MSPB), and Total Per Capita Cost (TPCC).

In future rulemaking, CMS intends to propose publicly reporting MIPS cost measures, beginning with data from the 2024 performance period/2026 MIPS payment year in 2026 on Compare tool clinician and group profile pages and in the PDC. In this Request for Information (RFI), CMS is seeking comment on a number of aspects of how to best establish publicly reporting cost measures. The RFI's primary issues are listed below; the preamble has significantly more detailed discussions on each.

- Potential approaches to reporting MIPS cost measures, including whether it is more meaningful to only report aggregated episodes or include component-level cost information for the EBCMs; and
- Benchmarking and possible comparators, as well as how to best present this information to provide frames of reference for the cost performance information—for example, while higher than expected costs may be driven by adverse outcomes, overall cost is comprised of care components that consumers could perceive as higher quality (follow-up visits) as well as lower quality (re-hospitalizations).

The RFI also poses a number of questions:

- How can CMS present MIPS cost measures information in a way that reflects meaningful outcomes to patients and their caregivers and the value of care, rather than cost alone?
- What are the considerations for publicly reporting the total episodic cost, component-level costs, or both?
    - Do the component costs provide adequate context for patients and their caregivers to make informed healthcare decision?
    - What other specific information about MIPS cost measures, including the context of quality measures and MIPS Value Pathways (MVPs), should CMS consider including on the Compare tool?
- What are the considerations for publicly reporting the national average cost, ratio of cost to the national average cost, and/or the dollar cost per episode as possible benchmarks for comparison? What other benchmarks or comparator approaches should CMS consider?
- Are there any considerations for evaluating cost measures for public reporting in 2026 beginning with cost measure data from 2024 performance period/2026 MIPS payment year?

- What other factors, such as those related to health equity, should be taken into consideration?
- Is there any additional information that the agency may not have considered or discussed in the rule about publicly reporting MIPS cost measures, as well as any unintended impacts and/or positive outcomes that could result from making this information publicly available on the Compare tool?

M. Overview of QP Determinations and the APM Incentive

1. Background

The Quality Payment Program provides incentives for clinicians to engage in value-based, patient-centered care under Medicare Part B via MIPS and Advanced APMs. The Secretary has also adopted the closely related goal of having all people with Traditional Medicare in an accountable care relationship with their health care provider by 2030. CMS seeks to develop, propose and implement policies that encourage broad clinician participation in Advanced APMs. For example, in this section, CMS is proposing to calculate Qualifying APM Participant (QP) determinations at the individual level for each unique NPI associated with an eligible clinician participating in an Advanced APM, which it says will provide a more accurate measure of the actual engagement of individual clinicians participating in Advanced APMs.

CMS reviews the history of its development of Qualifying APM Participant (QP) determinations in §414.1425. Of note:

- An eligible clinician must be present on the Participation List of an APM Entity in an Advanced APM on any one of the "snapshot dates" (March 31, June 30, or August 31) for the QP Performance Period.
- For eligible clinicians who appear on a Participation List for more than one APM Entity but do not achieve QP status based on any APM *Entity*-level determinations, CMS makes QP determinations at the *individual* level.
- For eligible clinicians on an Affiliated Practitioner[49] List for an Advanced APM, CMS makes QP determinations at the *individual* level at each of the three QP determination snapshot dates.

2. Individual QP Determination

Since most eligible clinicians participating in Advanced APMs receive their QP determinations at the APM Entity level, this could lead to some eligible clinicians becoming QPs when they would not have met the QP Threshold individually (a "freerider" scenario). On the other hand, some eligible clinicians may not become QPs when they might have qualified individually (a dilution scenario). Although CMS previously believed that the benefits of performing QP determinations for the APM Entity as a group outweighed these potential scenarios, it now believes otherwise, for a number of reasons described in the preamble. For example, the policy to conduct most QP determinations at the APM Entity level may have inadvertently discouraged some APM Entities from including certain types of eligible clinicians, particularly in multi-

[49] Per §414.1305, an affiliated practitioner is not participant in an APM entity but is on a CMS-maintained list and has a contractual relationship with the APM Entity for the purposes of supporting the APM Entity's quality or cost goals under the Advanced APM.

specialty APM entities such as ACOs, leading those clinicians (particularly specialists) to be excluded from participation in Advanced APMs.

CMS notes that while it has the authority to identify a clinician for QP purposes under a group, it is not required to do so. If APM Entities are removing or otherwise not including eligible clinicians who may technically contribute less to the APM Entity-level Threshold Score, this may impede other worthy goals of the Advanced APM (such as increased care coordination directly among providers caring for a patient), undermining the larger positive change CMS seeks. Conversely, CMS is concerned about "windfall financial rewards" when Threshold Scores use the aggregate of payment amounts or patient counts by *all* the eligible clinicians in the APM Entity, even when an individual eligible clinician furnished only a few such services.

CMS proposes to amend §414.1425(b) so that, beginning with the QP Performance Period for CY 2024, all QP determinations would be at the individual level—for each unique NPI associated with an eligible clinician participating in an Advanced APM.[50] Specifically, CMS would calculate a Threshold Score for each NPI based on all covered professional services furnished across all Tax Identification Numbers (TINs) to which the eligible clinician has reassigned their billing rights.

3. Payment Amount and Patient Count Methods

CMS reviews in greater depth how Threshold Scores are calculated for QP determinations using the payment amount method and the patient count method (§414.1435(a) and (b), respectively). If the Threshold Score (using either the payment amount or patient count method) for the eligible clinician or APM Entity, as applicable, meets or exceeds the relevant QP threshold (§414.1430(a)), those clinicians attain QP status for that year.

- The *payment amount method* is based on payments for Medicare Part B covered professional services, including certain supplemental service payments.
- The *patient count method* is based on numbers of patients.
- *Threshold Scores* are percentages (during the QP performance period) of the ratio of:
    - The payment amounts or patient counts for *Attributed beneficiaries* to
    - The payment amounts or patient counts for *Attribution-eligible beneficiaries*.
- *Attributed beneficiaries* are those attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of Attributed beneficiaries at the time of a QP determination.
- *Attribution-eligible beneficiaries* generally are those who, during the QP Performance Period, could be eligible for the Advanced APM by meeting the following six criteria (§414.1305):
    - Is not enrolled in Medicare Advantage or a Medicare cost plan;
    - Does not have Medicare as a secondary payer;
    - Is enrolled in both Medicare Parts A and B;
    - Is at least 18 years of age;
    - Is a United States resident; and

[50] CMS reiterates that Threshold Scores are currently calculated at the individual level for eligible clinicians only on an Affiliated Practitioner List (§414.1425(b)(2)) and when the eligible clinician participates in multiple Advanced APMs and does not achieve QP status at the APM Entity level (§414.1425(c)(4)). The proposal would not change the policy for these determinations, but for all other eligible clinicians.

- Has a minimum of one claim for evaluation and management (E/M) (office visit) services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period.

The sixth criterion also has an alternative—for an Advanced APM that does *not* base attribution on E/M services (and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least one claim for E/M services furnished by an eligible clinician who is in the APM Entity), the attribution basis determined by CMS based on the methodology the Advanced APM uses for attribution, which may include a combination of E/M and/or other services. This alternative applies to 4 Advanced APMs:

- Bundled Payments for Care Improvement Advanced Model,
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track),
- Comprehensive ESRD Care Model (LDO arrangement and Non LDO Two-Sided Risk Arrangement), and
- Maryland Total Cost of Care Model (Care Redesign Program).

Regarding the sixth criterion, CMS acknowledges that over time, as it has implemented the APM track of the Quality Payment Program, by affording sufficient flexibility within the program, it can both foster innovation in Advanced APMs and simplify execution of the program. By having a more narrowly defined default approach to beneficiary attribution (relying on E/M services), the agency frequently needed to exercise the flexibility to determine an appropriate attribution methodology for an Advanced APM that falls into the exception, which meant identifying several individually tailored ways of performing the attribution methodology for each specific Advanced APM.

CMS has come to believe that application of its current regulations may result in increased complexity over time, particularly as Advanced APMs continue to evolve and use novel approaches to value-based care that emphasize a broader range of covered professional services. In addition, primary care practitioners generally furnish a higher proportion of E/M services than specialists, so that the emphasis on E/M services in the beneficiary attribution policy may have inadvertently encouraged APM Entities to exclude specialists from their Participation Lists.

CMS proposes to change the definition of "Attribution-eligible beneficiary" at §414.1305 so that a single definition using covered professional services will be applied regardless of the Advanced APMs in which the eligible clinician participates. Specifically, the sixth criterion would be simplified to include any beneficiary who has received a covered professional service furnished by the eligible clinician (NPI). By no longer specifying E/M services as the default attribution basis in the sixth criterion, CMS is eliminating the need for flexibility to use a different attribution basis that ties attribution eligibility to a specific Advanced APM's attribution methodology. This would simplify and streamline QP determinations and address the challenges to Advanced APM participation faced by specialists who are less likely than primary care practitioners to provide E/M services.

CMS seeks comment on its proposal to modify the sixth criterion in the definition of "Attribution-eligible beneficiary" to include a beneficiary who has a minimum of one claim for any covered professional service furnished by an eligible clinician who is on the Participation List for the APM Entity at any determination date during the QP Performance Period.

4. QP thresholds and Partial QP Thresholds

Section 1833(z)(2) of the Act specifies the thresholds for the level of participation in Advanced APMs required for an eligible clinician to become a QP for a year. Since payment year 2019 (performance year 2017), the *Medicare Option* has been in effect, based on Part B payments or counts of patients. Since payment year 2021 (performance year 2019), the *All-Payer Combination Option* has been available, through which QP status is calculated using the Medicare Option as well as an eligible clinician's participation in Other Payer Advanced APMs (§414.1420). The 2017 Quality Payment Program final rule (81 FR 77433 through 77439) also codified CMS' policy for QP and Partial QP Thresholds for the Medicare Option (§414.1430(a)) and the All-Payer Combination Option (§414.1430(b)).

Under the statute, QP thresholds increase significantly for certain years. For example, the QP payment amount threshold under the Medicare option was slated to increase from 50 percent (as applicable for payment years 2021-2024) to 75 percent for 2025 and later. Section 4111(a)(2) of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328, December 29, 2022) the QP payment amount thresholds that applied in payment year 2024 (performance year 2022) to payment year 2025 (performance year 2023).

To conform with CAA, 23, CMS proposes to update the QP and Partial QP thresholds for the Medicare Option and All-Payer Combination Option, extending the thresholds for payment year 2024 to apply to payment year 2025, as summarized in Table 53 below.

Table 53. QP Threshold Score Updates

Performance year / Payment Year	**2021/2023 (Percent)**		**2022/2024 (Percent)**		**2023/2025 (Percent)***		**2024/2026 and later (Percent)****	
Medicare Option - Payment Amount Method								
QP Payment Amount Threshold	50		50		50		75	
Partial QP Payment Amount Threshold	40		40		40		50***	
Medicare Option - Patient Count Method								
QP Patient Count Threshold	35		35		35		50	
Partial QP Patient Count Threshold	25		25		25		35	
All-Payer Combination Option - Payment Amount Method								
QP Patient Count Threshold	50	25	50	25	50	25	75	25
Partial QP Patient Count Threshold†	40	20	40	20	40	20	50	20
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

Performance year / Payment Year	2021/2023 (Percent)		2022/2024 (Percent)		2023/2025 (Percent)*		2024/2026 and later (Percent)**	
All-Payer Combination Option - Patient Count Method								
QP Patient Count Threshold	35	20	35	20	35	20	50	20
Partial QP Patient Count Threshold	25	10	25	10	25	10	35	10
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

* This column shows the amounts proposed to be amended in §414.1430, for performance year 2023—that is, payment year 2025.

** Unless otherwise noted, this column shows the amounts that appear in current regulations in §414.1430 for performance year 2023/payment year 2025 and that would have applied for that year in the absence of CAA, 23.

*** Current regulations appear to erroneously—that is, inconsistent with the statute—have used 75 percent for the Medicare option's partial QP payment amount threshold in §414.1430(a)(2)(iv) for 2025 and later, rather than 50 percent. CMS appears to be fixing this number as it changes the applicability date to payment year 2026 and later.

† Current regulations appear to erroneously—that is, inconsistent with the statute—have used 35 percent for the All-Payer Combination option's partial QP payment amount threshold in §414.1430(b)(2)(i)(A), rather than 40 percent displayed here. CMS appears to be fixing this number as it changes the applicability date to extend through payment year 2025, from 2024.

5. APM Incentive Payment

Before the CAA, 23, the last APM Incentive Payment was slated to occur for performance year 2022/payment year 2024. For a QP, that APM Incentive Payment is calculated as 5 percent of the eligible clinician's estimated aggregate payment amounts for such covered professional services.[51] The CAA, 23 extends APM Incentive Payments to performance year 2023/payment year 2025, but using 3.5 percent rather than 5 percent.

To conform with the statutory changes, CMS proposes in §414.1450 to apply an APM Incentive Payment of 3.5 percent for performance year 2023/payment year 2025.[52]

N. Advanced APMs

1. Background

a. *Advanced APM CEHRT Use Criterion*

The statute requires Advanced APMs to require participants to use CEHRT, with regulations (§414.1415(a)(1)) requiring a specific minimum percentage of eligible clinicians using CEHRT to document and communicate clinical care to their patients or health care providers. This

[51] Per section 1848(k)(3)(A), "covered professional services" are services for which payment is made under, or is based on, the fee schedule established under Part B and are furnished by an eligible clinician (physician; practitioner as defined in section 1842(b)(18)(C) of the Act; PT, OT, or speech-language pathologist; or qualified audiologist).
[52] Post-APM Incentive Payment Policies would therefore apply one year later, beginning in performance year 2024/payment year 2026—specifically, per section 1848(d)(1)(A), the PFS conversion factor for QPs will be the conversion factor for the previous year multiplied by 0.75 percent; for all others, the PFS conversion factor will be the conversion factor for the previous year multiplied by 0.25 percent.

percentage was set at 50 percent in the 2017 Quality Payment Program final rule, increasing to 75 percent in the 2019 Quality Payment Program final rule.

b. *Definition of CEHRT*

Under section 1848(o)(4) of the Act, CEHRT is a qualified electronic health record (EHR) that is certified by the Office of the National Coordinator for Health Information Technology (ONC) in accordance with the certification standards that ONC adopted under section 3004 of the Public Health Service Act.

The regulatory definition of CEHRT adopted at §414.1305 for both the MIPS track and the Advanced APM track of the Quality Payment Program copied the definition from the Medicare EHR Incentive Program (also known as "Meaningful Use") at §495.4. When adopting this approach in the 2017 final rule, CMS acknowledged there would be some required EHR functionality that may be less relevant for APM participants or those in MIPS, but deemed the shared definition of greater importance—even though this "would go beyond what the statute requires" (81 FR 77412).

2. Proposal to Update CEHRT Definition and CEHRT Use Criterion for Advanced APMs

a. *Rationale*

CMS now believes that the standard for CEHRT use for Advanced APMs may have been unnecessarily burdensome, imposing unwarranted barriers to Advanced APMs and not being clinically relevant for many prospective and current participants. Many interested parties told CMS that its current CEHRT requirements have led Advanced APMs to apply an inflexible standard that does not allow them to take into account whether certain CEHRT modules are relevant for, and applicable to, the specific clinical practice areas of their intended or actual participants.

Specifically, interested parties noted that the agency's requirement that *Advanced APMs* must require participants to use health IT certified as meeting criteria necessary to report on objectives and measures of the *MIPS* Promoting Interoperability performance category, even when such health IT is not clinically relevant for or applicable to APM participants' practice, is needlessly burdensome and a barrier to innovation and participation in APMs. For example, application of Advanced APM CEHRT use criterion has required specialists in the Kidney Care Choices (KCC) Model or providers in the ACO Realizing Equity, Access, and Community Health (REACH) Model to purchase certified Health IT Modules beyond those required as part of the 2015 Edition Base EHR definition at 45 CFR §170.102 that are not immediately necessary or applicable to their clinical practice.

The agency also recognizes the need to update the current CEHRT use criterion that specifies 75 percent of participants in the APM must use CEHRT, which allows for 25 percent of participants to not have or use CEHRT. This policy gives no consideration of which eligible clinicians in each participating APM Entity (or hospital) must use CEHRT, or whether it is clinically appropriate for any of those eligible clinicians to not use CEHRT. This policy could allow eligible clinicians who could and should be using CEHRT to forgo CEHRT use solely because enough of their colleagues are using CEHRT to meet the requirement. For most Advanced APM participants, CEHRT use among eligible clinicians is close to 100 percent. Given this, plus the fact that the 70 percent CEHRT use standard has been in effect for almost five years, CMS

believes it is appropriate to re-evaluate its approach to the application of the CEHRT use requirement to Advanced APMs and their participants—to maintain the rigor of its CEHRT use criterion while providing flexibility to require CEHRT use that is applicable for the practice areas of their participants and their eligible clinicians. Any exceptions to CEHRT use permitted for the Advanced APM should be based on clinical appropriateness, rather than generalized percentages.

b. *Proposal*

CMS proposes to amend the definition of CEHRT at §414.1305 by adding a new paragraph (3) to specify that, for purposes of the Advanced APM criterion under §414.1415(a)(1), beginning with 2024, CEHRT means EHR technology certified under the ONC Health IT Certification Program that meets:

- The 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR §170.102); and
- Any such ONC health IT certification criteria adopted or updated in 45 CFR §170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

CMS says this would provide flexibility to each APM to determine what CEHRT functionalities are relevant to the model and its participant APM Entities and eligible clinicians.[53]

CMS also proposes to amend the current Advanced APM CEHRT use criterion at §414.1415(a)(1) to end the current 75 percent CEHRT use requirement with the 2023 QP performance period. To be an Advanced APM, the APM must require *all* eligible clinicians in each participating APM Entity—or for APMs in which hospitals are the participants, each hospital—to use CEHRT that meets the proposed new paragraph (3) of the CEHRT definition at §414.1305 described above.

Thus, CMS is proposing to no longer specify a minimum percentage of eligible clinicians that an Advanced APM must require to use CEHRT, but to simply specify that the Advanced APM must require all participating eligible clinicians to use CEHRT that meets the proposed modified, and more flexible, definition. According to CMS, Advanced APMs could create their own CEHRT

[53] CMS notes that participation in an Advanced APM does not automatically exclude eligible clinicians from MIPS. If clinicians do not obtain QP status or Partial QP status, or are not otherwise exempt from MIPS, they are subject to MIPS reporting requirements and the MIPS payment adjustment. The proposed amendment under paragraph (3) at §414.1305 for Advanced APMs has limited effect on the requirement to participate in MIPS if QP or Partial QP status is not achieved. Eligible clinicians in Advanced APMs would still need to be prepared to report to MIPS, including using CEHRT as necessary to report on applicable objectives and measures specified for the MIPS Promoting Interoperability performance category, in the event that they do not achieve QP or Partial QP status.

CMS also notes that this provision is in addition to, but is consistent with, the amendment described in section IV.A.4.f.(4) of this proposed rule to modify the CEHRT definition at §414.1305 to be more flexible in reflecting any changes ONC may make to its Base EHR definition, certification criteria, and other standards for health IT at 45 CFR part 170.

use requirements, potentially beyond what the agency currently requires, tailored to the various types of clinicians and practice areas the Advanced APM intends to include in its model.

CMS proposes to also amend the Other Payer Advanced APM criteria to conform to the changes proposed for the Medicare Advanced APMs—specifically, to remove the 75 percent minimum CEHRT use requirement for Advanced APMs and replace it with a more flexible CEHRT use requirement based on the proposed revised definition of CEHRT for purposes of Advanced APM determinations (along with other non-substantive technical edits).