Quality Payment PROGRAM

Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule

Quality Payment Program (QPP) Policy Overview

The Centers for Medicare & Medicaid Services (CMS) remains committed to promoting more meaningful participation in the Quality Payment Program (QPP) for clinicians and creating policies that continue to drive value and improved health outcomes for patients. To further the goals under the Merit-based Incentive Payment System (MIPS), the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule includes policies regarding the development of new MIPS Value Pathways (MVPs) and refinement of subgroup participation, revisions to the quality measure and improvement activities inventories, and other policies regarding Alternative Payment Models (APMs) that reduce burden and facilitate participation.

MVP and Subgroup Policies

We're expanding the MVP inventory by finalizing 5 new MVPs and revising the 7 previously finalized MVPs to account for the addition of new measures and activities, the removal of measures and activities, and the expansion of an MVP topic that would allow additional specialties to report the MVP. MVPs provide clinicians with the opportunity for more meaningful participation by reporting a more connected, cohesive set of measures and activities and allowing for comparative feedback that may be more useful to patients. MVPs are in alignment with our strategic objectives for QPP and the CMS National Quality Strategy, as they embed quality into the care journey, advance health equity through careful measure and improvement activity selection, foster engagement and maximize clinical participation, and improve data and information sharing through enhanced, comparative feedback.

We also finalized several policies to modify our engagement strategy on MVP development and maintenance. Our intention is to solicit feedback from a broader set of interested parties and the general public while reducing the operational burden associated with the current engagement process. The policies advance CMS goals of having more robust engagement to ensure that MVPs are meaningful to clinicians, patients, and the public.

We believe subgroup reporting will allow comprehensive measurement of clinician performance in MIPS since a cohort of clinicians can form subgroups and report on measures and activities relevant to the scope of care they provide to patients. Most clinicians report as a group and multispecialty groups often select measures that don't represent their diverse clinical care. Subgroup reporting is intended to help address this issue by allowing clinicians to choose measures relevant to their scope of care and hopefully improve the quality of care by better matching the work performed by clinicians with their MIPS measures and activities. Furthermore, we anticipate subgroup reporting will allow CMS to capture clinician performance at a more granular level, provide performance feedback to clinicians relevant to the scope of care they

provide, and provide patients with better data they can use to make informed decisions about their care needs.

General MIPS Policies

In order to provide clinicians continuity and consistency while they prepare to transition from traditional MIPS to MVPs, we limited the number of changes to policies within MIPS. For example, we're continuing to streamline and strengthen the quality measure and improvement activities inventories by removing duplicative and topped out measures and activities. Maintaining a quality measure inventory that drives quality outcomes for patients is a key goal of quality measure reporting, while new and modified activities help fill some gaps we've identified in the improvement activities inventory and standardize language related to equity across the performance category.

APM Policies

We're also finalizing several policies for Advanced APMs. For example, we're permanently establishing the 8% minimum Generally Applicable Nominal Risk standard for Advanced APMs, which is currently set to expire in 2024. We also previously finalized a policy to set a limit of 50 on the number of clinicians in an organization that participates in an Advanced APM through a Medical Home Model, using the Medical Home Model nominal financial risk criteria. At that time, we described the way in which we would identify APM Entities that meet this standard as looking for "APM Entities that participate in Medical Home Models and that have 50 or fewer eligible clinicians in the organization through which the entity is owned and operated." We defined organizational size as measured based on the size of the "parent organization" rather than the size of the APM Entity itself. We finalized a policy to apply the 50 eligible clinician limit to the APM Entity participating in the Medical Home Model based on the TIN/NPIs on the APM Entity's participation list and conforming changes to our Other Payer Advanced APM policies in these areas.

For more information on the specific QPP policies finalized in the CY 2023 PFS Final Rule, please refer to:

- **MVPs Policies Table** in the 2023 Quality Payment Program Final Rule Resources (ZIP)
- **CY 2023 QPP Policy Comparison Table** in the 2023 Quality Payment Program Final Rule Resources (ZIP)