Quality Payment
PROGRAM

Changes to Quality Payment Program (QPP) Policies in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule

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We refer you to the **MVPs Policies Table** in the 2023 Quality Payment Program Final Rule Resources (ZIP) for information about the newly finalized policies related to MVPs.

We refer you to the **Medicare Shared Savings Program Fact Sheet** for information about proposals related to the Medicare Shared Savings Program.

Merit-based Incentive Payment System (MIPS) Overview

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
MIPS Performance Categories – These Policies Apply to Traditional MIPS, MIPS Value Pathways (MVPs), and the APM Performance Pathway (APP), Unless Otherwise Noted		
Quality Performance Category		
Quality Measures	**Quality Measure Inventory** There are 200 quality measures available for the 2022 performance period.	**Quality Measure Inventory** We're finalizing a total of 198 quality measures for the 2023 performance period; there are 4 measures that were proposed, but not finalized, for removal. (See Appendix D) As a reminder, Qualified Clinical Data Registry (QCDR) measures are approved outside the rulemaking process and aren't included in the above total. The inventory for the 198 quality measures reflects the following: • Addition of 9 quality measures, including 1 new administrative claims measure, 1 composite measure, 5 high priority measures, and 2 new patient-reported outcome measures (see Appendix B). • Substantive changes to 76 existing MIPS quality measures. • Addition of measures for specific specialty sets. • Removal of measures for specific specialty sets.

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
		• Removal of 11 quality measures from the MIPS quality measure inventory (see Appendix C). • Partial removal of 2 quality measures from the MIPS quality measure inventory (2 measures finalized for removal in traditional MIPS and finalized for retention in MVPs) (see Appendix E).
Administrative Claims Measures	**Benchmarks for Scoring** Quality measures are scored against a historical benchmark (using data from a baseline period 2 years before the performance period) if available; if no historical benchmark is available, we attempt to calculate a performance period benchmark for scoring purposes.	**Benchmarks for Scoring** We'll score administrative claims measures exclusively against performance period benchmarks.
High Priority Measures	**Definition** A high priority measure is defined as an: • Outcome (including intermediate-outcome and patient-reported outcome) quality measure; • Appropriate use quality measure; • Patient safety quality measure; • Efficiency quality measure; • Patient experience quality measure; • Care coordination quality measure; or • Opioid-related quality measure.	**Definition** We're expanding the definition of a high priority measure to also **include health equity-related quality measures**.

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
CAHPS for MIPS Survey	**Case-Mix Adjustment** The case-mix adjustment models for the CAHPS for MIPS Survey adjust for patients' characteristics that may impact survey responses but are outside the control of the group. The CAHPS for MIPS Survey case-mix adjustment model includes the following case-mix adjustors: • Age; • Education; • Self-reported general health status; • Self-reported mental health status; • Proxy response; • Medicaid dual eligibility; • Eligibility for Medicare's low-income subsidy; and • Asian language survey completion (beginning 2022).	**Case-Mix Adjustment** We're changing the case-mix adjustor for "Asian language survey completion" to use the "Spanish language spoken at home," Asian language spoken at home," and "other language spoken at home" variables instead. The refinement to the CAHPS for MIPS Survey case-mix adjustment methodology is intended to capture language preference more accurately, as well as response patterns of participants with similar experiences, for a more meaningful comparison of performance between MIPS groups.

Data Completeness: • Electronic Clinical Quality Measures (eCQMs) • MIPS Clinical Quality Measures (MIPS CQMs) • Medicare Part B Claims Measures • QCDR Measures	Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria in the 2022 and 2023 performance periods, you must report performance data (performance met or not met, or denominator exceptions) for 70% of denominator eligible encounters.	We're **increasing** the data completeness threshold **to 75%** for the **2024 and 2025 performance periods**. For the 2023 performance period, the data completeness threshold remains at 70% as finalized in the CY 2022 Physician Fee Schedule Final Rule. **Note:** The data completeness threshold policies regarding 70% or 75% doesn't apply to CMS Web Interface measures since the CMS Web Interface measures have different data completeness requirements (report on the first 248 consecutively ranked Medicare patients in a sample for a measure or all patients if a sample has less than 248 patients). As a reminder, starting with the 2023 performance period, the CMS Web Interface is only available to Medicare Shared Savings Program Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP).

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
Cost Performance Category		
Cost Improvement Scoring	Cost improvement scoring to begin in the 2022 performance period.	We're establishing a maximum cost improvement score of 1 percentage point out of 100 percentage points available for the cost performance category, starting with the 2022 performance period. We note that all MIPS eligible clinicians will receive a cost improvement score of zero percentage points for the 2022 performance period because we didn't calculate cost measure scores for the 2021 performance period. We're establishing this policy to adhere to the statutory requirement of accounting for improvement in the assessment of performance under the cost performance category.
Improvement Activities Performance Category		
Activity Inventory	**Improvement Activities Inventory** There are 106 improvement activities available for the 2022 performance period.	**Improvement Activities Inventory** We're **adding 4** new improvement activities (See Appendix F). We're **modifying 5** existing improvement activities. We're **removing 6** existing improvement activities (See Appendix G).

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
Promoting Interoperability Performance Category		
Automatic Reweighting	**Reweighting** Automatic reweighting applies to the following clinician types for the 2022 performance period: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologist • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals Automatic reweighting applies to MIPS eligible clinicians, groups and virtual groups with the following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practice	**Reweighting** We're **discontinuing automatic reweighting** for the following clinician types, beginning with this 2023 performance period: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists We're **continuing automatic reweighting** for the following clinician types in the 2023 performance period: • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals We note that MIPS eligible clinicians, groups and virtual groups with **the following** special statuses **will continue to receive automatic reweighting**: • Ambulatory Surgical Center (ASC)-based • Hospital-based

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
		• Non-patient facing • Small practice
Data Submission	**APM Entity-Level Participation** When participating in MIPS at the APM Entity level (reporting either the APP or traditional MIPS), Promoting Interoperability data must be reported at the individual or group level.	**APM Entity-Level Participation** When participating in MIPS at the APM Entity level (reporting the APP, traditional MIPS or an MVP), APM Entities can choose to report Promoting Interoperability data at the APM Entity level. APM Entities will still have the option to report this performance category at the individual and group level.
Measures and Reporting Requirements	**Public Health and Clinical Data Exchange Objective** Currently, there are 3 active engagement options for the measures within this objective: • Option 1: Completed Registration to Submit Data • Option 2: Testing and Validation • Option 3: Production	**Public Health and Clinical Data Exchange Objective** We're modifying the options for active engagement for the Public Health and Clinical Data Exchange Objective measures. We're combining active engagement Options 1 and 2 into a single option titled "Pre-production and Validation" and renaming Option 3 to "Validated Data Production" for a total of 2 options. In addition to requiring a yes/no response for the required Public Health and Clinical Data Exchange measures, we're also requiring MIPS eligible clinicians to submit their level of active engagement.

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
		We're finalizing our proposal that MIPS eligible clinicians may spend only one performance period at the Preproduction and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level in the next performance period for which they report a particular measure but will delay this requirement until performance periods in CY 2024.
	Query of Prescription Drug Monitoring Program (PDMP) measure This is an optional measure, worth 10 bonus points in the 2022 performance period.	**Query of Prescription Drug Monitoring Program (PDMP) measure** We're making this a **required measure** beginning with the 2023 performance period. • We're adding exclusions for the measure and making it worth 10 points. • We're also expanding the scope of the measure to include not only Schedule II opioids but also Schedules III and IV drugs.
	Health Information Exchange (HIE) Objective There are 2 options for satisfying the HIE objective in the 2022 performance period. **Option 1:** Report both • Support Electronic Referral Loops by Sending Health Information, **and**	**Health Information Exchange (HIE) Objective** We're adding a 3rd option for satisfying the HIE objective for the 2023 performance period, in addition to the 2 existing options. **Option 3:** Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)

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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2023 Final Policies</th></tr>
<tr><td></td><td>

- Support Electronic Referral Loops by Receiving and Reconciling Health Information.

Option 2: Health Information Exchange Bi-Directional Exchange

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- This measure requires the MIPS eligible clinician to attest **YES** that a MIPS eligible clinician is a signatory to a Framework Agreement as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on the Office of the National Coordinator for Health Information Technology (ONC) website and uses certified electronic health record technology (CEHRT) to exchange information under this Agreement.

</td></tr>
<tr><td>Measure Points</td><td>

Promoting Interoperability measures are worth the following maximum points in the 2022 performance period:

<table>
<tr><th>Objective</th><th>Measure</th><th>Maximum Points</th></tr>
<tr><td rowspan="2">Electronic Prescribing</td><td>e-Prescribing</td><td>10 points</td></tr>
<tr><td>Bonus: Query of PDMP</td><td>10 points (bonus)</td></tr>
<tr><td rowspan="3">Health Information Exchange</td><td>Support Electronic Referral Loops by Sending Health Information</td><td>20 points</td></tr>
<tr><td>Support Electronic Referral Loops by Receiving and Reconciling Health Information</td><td>20 points</td></tr>
<tr><td colspan="2">-OR-</td></tr>
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We’re finalizing that Promoting Interoperability measures will be worth the following maximum points, beginning with the 2023 performance period (changes from 2022 noted with an asterisk):

<table>
<tr><th>Objective</th><th>Measure</th><th>Maximum Points</th></tr>
<tr><td rowspan="2">Electronic Prescribing</td><td>e-Prescribing</td><td>10 points</td></tr>
<tr><td>Query of PDMP</td><td>10 points*</td></tr>
<tr><td rowspan="3">Health Information Exchange</td><td>Support Electronic Referral Loops by Sending Health Information</td><td>15 points*</td></tr>
<tr><td>Support Electronic Referral Loops by Receiving and Reconciling Health Information</td><td>15 points*</td></tr>
<tr><td colspan="2">-OR-</td></tr>
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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2023 Final Policies</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>Health Information Exchange Bi-Directional Exchange*</td><td>40 points</td></tr>
<tr><td>Provider to Patient Exchange</td><td>Provide Patients Electronic Access to Their Health Information</td><td>40 points</td></tr>
<tr><th>Objective</th><th>Measure</th><th>Maximum Points</th></tr>
<tr><td rowspan="2">Public Health and Clinical Data Exchange</td><td>Report the following 2 measures:*
• Immunization Registry Reporting
• Electronic Case Reporting</td><td>10 points</td></tr>
<tr><td>Report one of the following measures:
• Syndromic Surveillance Reporting
• Public Health Registry Reporting
• Clinical Data Registry Reporting</td><td>5 points (bonus)</td></tr>
</table>
</td><td>
<table>
<tr><td rowspan="3"></td><td>Health Information Exchange Bi-Directional Exchange*</td><td>30 points*</td></tr>
<tr><td colspan="2">-OR-</td></tr>
<tr><td>Participation in TEFCA</td><td>30 points*</td></tr>
<tr><th>Objective</th><th>Measure</th><th>Maximum Points</th></tr>
<tr><td>Provider to Patient Exchange</td><td>Provide Patients Electronic Access to Their Health Information</td><td>25 points*</td></tr>
<tr><td rowspan="2">Public Health and Clinical Data Exchange</td><td>Report the following 2 measures:
• Immunization Registry Reporting
• Electronic Case Reporting</td><td>25 points*</td></tr>
<tr><td>Report one of the following measures:
• Syndromic Surveillance Reporting
• Public Health Registry Reporting
• Clinical Data Registry Reporting</td><td>5 points (bonus)*</td></tr>
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POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
	Final Scoring	
Facility-based Measurement	N/A	**Complex Patient Bonus** We're finalizing that a facility-based MIPS eligible clinician will be eligible to receive the complex patient bonus, even if they don't submit data for at least one MIPS performance category. **Virtual Groups** We're finalizing that a virtual group is eligible for facility-based measurement provided CMS determines the virtual group meets the specified eligibility standards of having 75% or more of the eligible clinicians in the virtual group meet the definition of a facility-based MIPS eligible clinician.
Performance Threshold / Additional Performance Threshold / Payment Adjustment	**Performance Threshold** As required by statute, beginning with the 2022 performance year/2024 payment year, we must set the performance threshold as either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. We're using the **mean final score from the 2017 performance year/2019 MIPS payment year** to establish the performance threshold. For the 2022 performance year (2024 payment year)	**Performance Threshold** We're continuing to use the mean final score from the 2017 performance year/2019 MIPS payment year: • We're setting the **performance threshold at 75 points** for the 2023 performance year/2025 payment year. We note the 2022 performance year/2024 payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
	• The performance threshold is set at **75 points**. • An additional performance threshold is set at **89 points** for exceptional performance.	
Third Party Intermediaries		
QCDRs	**QCDR Measure Testing Requirements** Beginning with the 2023 performance period, QCDRs must fully develop and test their measures, with complete testing results at the clinician level, prior to self-nomination.	**QCDR Measure Testing Requirements** We're delaying the requirement for full measure testing, which will now begin with the 2024 performance period. • We're not changing the requirements that QCDR measures be fully tested prior to inclusion in an MVP.
	QCDR Measure Specifications Our current policy requires QCDRs to post measure specifications no later than 15 calendar days following CMS approval of any QCDR measure specifications. The entity must publicly post the measure specifications for that QCDR measure (including the CMS- assigned QCDR measure ID) and provide CMS with a link to where this information is posted.	**QCDR Measure Specifications** We're updating our language to clarify requirements for publicly posting the approved measure specifications: within 15 calendar days after CMS has posted the approved QCDR measure specifications, the QCDR entity must publicly post their specifications, confirm the measure specifications they post align with the measure specifications posted by CMS, and provide to CMS a link to where the information is posted.
	Remedial Action and Termination Policies A corrective action plan (CAP) must address the following: • The issues that contributed to the non-compliance.	**Remedial Action and Termination Policies** We're broadening the scope of affected parties under the second CAP requirement to also identify impacts to any

POLICY AREA	EXISTING POLICY	CY 2023 Final Policies
	• The impact to individual clinicians, groups, or virtual groups, regardless of whether they're participating in the program because they're MIPS eligible, voluntary participating, or opting in to participating in the MIPS program. • The corrective actions the third party intermediary will implement to ensure they have resolved the non-compliance and that it won't recur in the future. • The detailed timeline for achieving compliance with the applicable requirements.	QCDRs that were granted licenses to the measures of the affected QCDR (rather than limit the identification of impacts to clinicians only): • The impact to individual clinicians, groups, virtual groups, subgroups, or APM Entities, regardless of whether they're participating in the program because they're MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program, **and any QCDRs that were granted licenses to the measures of a QCDR upon which a CAP has been imposed.** We're also adding a new CAP requirement to require the third party intermediary to develop a communication plan for communicating the impact to the parties identified in the second CAP requirement.
	QCDRs and Qualified Registries That Don't Submit Performance Data Beginning with the 2024 performance period, a QCDR or qualified registry that was approved but didn't submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan for CMS' approval. The participation plan must include the QCDR and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry.	**Action Against QCDRs and Qualified Registries That Continue Not to Submit Performance Data** Beginning with the 2024 performance period, we're terminating those QCDRs or qualified registries that are required to submit participation plans as required under existing policy during the applicable self-nomination period (because they didn't submit any MIPS data for either of the 2 years preceding the applicable self-nomination period) and continue to not submit MIPS data to CMS for the applicable performance period.

Advanced Alternative Payment Models (APMs) Overview

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
Advanced APMs	**Nominal Risk Expiration** In the CY 2017 Quality Payment Program (QPP) Final Rule, we established an 8% Generally Applicable Nominal Risk standard for Advanced APMs (those through which eligible clinician participants can become eligible for QP status). Note that the generally applicable nominal risk standard does not apply to Medical Home Models. The statute specifies that one of the Advanced APM criteria is that the APM must require participants to take on more than a nominal amount of financial risk. In 2017 we set that "more than nominal financial risk" threshold at 8% and suggested that over time the 8% threshold may become too low relative to the amount of risk participants in newer and more advanced APMs were capable of bearing. Therefore, we set an expiration date of the 2024 performance year for this threshold, at which point we would reconsider the threshold value.	**Nominal Risk Expiration** We're **removing** the 2024 expiration of the 8% minimum on the Generally Applicable Nominal Risk standard for Advanced APMs and making the 8% minimum permanent.
	Medical Home Model 50 Eligible Clinician Limit In the CY 2017 QPP Final Rule (81 FR 77428), we finalized a policy to set a limit of 50 on the number of eligible clinicians in an organization that participates in an Advanced APM through a Medical Home Model, using the Medical Home	**Medical Home Model 50 Eligible Clinician Limit** We're applying the 50 eligible clinician limit to the APM Entity participating in the Medical Home Model. We'll identify the clinicians in the APM Entity by using the TIN/NPIs on the participation list of the APM Entity on each of the 3 QP

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
	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.	determination dates (March 31, June 30, and August 31). This policy will become effective in the 2023 performance year.

Public Reporting via Doctors and Clinicians Care Compare Overview

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
Public Reporting	**Telehealth Indicators** N/A	**Telehealth Indicators** We're finalizing a policy to publicly report a telehealth indicator, as applicable and technically feasible, on individual clinician profile pages for those clinicians furnishing covered telehealth services. • Adding telehealth indicators to clinician profile pages will help to empower patients' healthcare decisions.
	Utilization Data There's no existing policy on utilization data even though we sought public comment through a Request for Information (RFI) in the CY 2022 Notice of Proposed Rulemaking on the	**Utilization Data** We're finalizing a policy to publicly report certain procedure information (utilization data) on individual clinician profile

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
	types of utilization data we could add to Care Compare to inform patients' healthcare decisions.	pages to aid patients in finding clinicians who may appropriately serve their needs. • Adding utilization data to clinician profile pages will allow patients to find clinicians who have performed specific types of procedures.

Contact Us

We'll continue to provide support to clinicians who need assistance. While our support offerings will reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance to help them successfully participate.

We also encourage clinicians to contact the QPP Service Center at 1-866-288-8292, Monday through Friday, 8 a.m. – 8 p.m. ET or by email at QPP@cms.hhs.gov. Customers who are hearing impaired can dial 711 to connect to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History Table

Date	Change Description
11/01/2022	Original posting

Appendix A: Previously Finalized Policies for Calendar Year 2023

The table below identifies policies finalized in the CY 2022 PFS Final Rule that apply in the 2023 performance period.

POLICY AREA	PREVIOUSLY FINALIZED POLICY APPLICABLE IN CALENDAR YEAR 2023
Quality Performance Category	
Collection Types	We previously finalized that the CMS Web Interface will sunset as a collection type and submission type for traditional MIPS, beginning with the 2023 performance period. The CMS Web Interface will remain an available collection type only for Medicare Shared Savings Program ACOs reporting via the APP in the 2023 and 2024 performance periods.
Data Completeness	We previously finalized a 70% data completeness threshold for the 2023 performance period.
Scoring	**Measures that can be reliably scored against a benchmark:** • **We're removing the 3-point floor** for measures that can be reliably scored against a benchmark (i.e., those that meet the data completeness and case minimum criteria). ○ These measures will receive 1-10 points. **Note:** This policy doesn't apply to new measures in the first 2 performance periods available for reporting.

	Measures without an available benchmark (historical or performance period):
	• **We're removing the 3-point floor** for measures without a benchmark, even when the data completeness and case minimum criteria are met (except for small practices).
	  ○ These measures will receive zero points.
	  ○ **Small practices** will continue to earn 3 points.
	
	Note: This policy doesn't apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures.

	Measures that don't meet the case minimum criteria: **We're removing the 3-point floor** for measures that don't meet the case minimum criteria (except for small practices). • These measures will earn zero points. • Small practices will continue to earn 3 points. **Note:** This policy doesn't apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum criteria aren't met.
Certified EHR Technology Edition	We previously finalized that EHR technology must be certified to the 2015 Edition Cures Update for the 2023 performance period. (Functionality must be in place by the start of the performance period with certification obtained by the last day of the performance period.) This requirement applies to: • The Promoting Interoperability performance category. • eCQM reporting in the quality performance category.

Appendix B: New Quality Measures for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

MEASURE TITLE	DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
Psoriasis – Improvement in Patient-Reported Itch Severity	The percentage of patients, aged 18 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.	• MIPS CQMs Specifications • High Priority • Patient Reported Outcome-Based Performance Measure
Dermatitis – Improvement in Patient-Reported Itch Severity	The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.	• MIPS CQMs Specifications • High Priority • Patient-Reported Outcome-Based Performance Measure
Screening for Social Drivers of Health	Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	• MIPS CQMs Specifications • High Priority • Process

MEASURE TITLE	DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
Kidney Health Evaluation	Percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the measurement period.	• eCQM Specifications, MIPS CQMs Specifications • Process
Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (Stages 1-5, not receiving Renal Replacement Therapy (RRT)) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.	• MIPS CQMs Specifications • Process
Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	Percentage of patients, aged 18 years and older, with a diagnosis of cancer, on immune checkpoint inhibitor therapy, and grade 2 or above diarrhea and/or grade 2 or above colitis, who have immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered.	• MIPS CQMs Specifications • Process
Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma	Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both.	• MIPS CQMs Specifications • High Priority • Process

MEASURE TITLE	DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	Annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.	• Administrative Claims • High Priority • Outcome
Adult Immunization Status	Percentage of patients 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.	• MIPS CQMs Specifications • Process • Composite

Appendix C: Quality Measure Removals Finalized for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
076	**Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	• Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications • High Priority • Process
119	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	• eCQM Specifications, MIPS CQMs Specifications • Process
258	**Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7):** Percent of patients undergoing open repair of small or moderate sized non-ruptured infrarenal abdominal aortic aneurysms (AAA) who do not experience a major complication (discharge to home no later than post-operative day #7).	• MIPS CQMs Specifications • High Priority • Outcome

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
265	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient.	• MIPS CQMs Specifications • High Priority • Process
323	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI):** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status.	• MIPS CQMs Specifications • High Priority • Efficiency
375	**Functional Status Assessment for Total Knee Replacement:** Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	• eCQM Specifications • High Priority • Process
425	**Photodocumentation of Cecal Intubation:** The rate of screening and surveillance colonoscopies for which photodocumentation of at least two landmarks of cecal intubation is performed to establish a complete examination.	• MIPS CQMs Specifications • Process

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
455	**Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better):** Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.	• MIPS CQMs Specifications • High Priority • Outcome
460	**Back Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at one year (9 to 15 months) postoperatively.	• MIPS CQMs Specifications • High Priority • Patient-Reported Outcome-Based Performance Measure
469	**Functional Status After Lumbar Fusion:** For patients 18 years of age and older who had a lumbar fusion procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) at one year (9 to 15 months) postoperatively.	• MIPS CQMs Specifications • High Priority • Patient-Reported Outcome-Based Performance Measure
473	**Leg Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at one year (9 to 15 months) postoperatively.	• MIPS CQMs Specifications • High Priority • Patient-Reported Outcome-Based Performance Measure

Appendix D: Quality Measures Proposed – but NOT Finalized – for Removal for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

The following measures will remain in the MIPS quality measure inventory for the 2023 performance period.

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
260	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing Carotid Endarterectomy (CEA) who are discharged to home no later than post-operative day #2.	• MIPS CQMs Specifications • High Priority • Outcome
261	**Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness:** Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness.	• Medicare Part B Claims Measures Specifications, MIPS CQMs Specifications • High Priority • Process
275	**Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted prior to initiating anti-TNF (tumor necrosis factor) therapy.	• MIPS CQMs Specifications • Process

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
439	**Age Appropriate Screening Colonoscopy:** The percentage of screening colonoscopies performed in patients greater than or equal to 86 years of age from January 1 to December 31.	• MIPS CQMs Specifications • High Priority • Efficiency

Appendix E: Quality Measure Removals from Traditional MIPS for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE / MEASURE TYPE
110	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization. **Note**: This measure was finalized for retention in MVPs.	• Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications • Process
111	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 66 years of age and older who have ever received a pneumococcal vaccine. **Note**: This measure was finalized for retention in MVPs.	• Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications • Process

Appendix F: New Improvement Activities for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data	Use security labeling services available in certified health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation.	Medium / Achieving Health Equity
Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying target goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology (ONC) US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients,	High / Achieving Health Equity

	and/or utilizing anatomical inventories when documenting patient health histories.	
Create and Implement a Language Access Plan	Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).	High / Expanded Practice Access
COVID-19 Vaccine Achievement for Practice Staff	Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff staying up to date with COVID vaccines according to the Center for Disease Control and Prevention (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified by CDC recommendations are excluded from this activity.	Medium / Emergency Response and Preparedness

Appendix G: Improvement Activities Finalized for Removal for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

Activity ID	Activity Title and Description	Activity Weight / Subcategory
IA_BE_7	**Participation in a QCDR, that promotes use of patient engagement tools:** Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision-making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium / Beneficiary Engagement
IA_BE_8	**Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive:** Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Medium / Beneficiary Engagement
IA_PM_7	**Use of QCDR for feedback reports that incorporate population health:** Use of a QCDR to generate regular feedback reports that summarize local practice patterns	High / Population Management

	and treatment outcomes, including for vulnerable populations.	
IA_PSPA_6	**Consultation of the Prescription Drug Monitoring Program:** Review the history of controlled substance prescriptions for 90 percent* of patients using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. *Apply exceptions for patients receiving palliative and hospice care.	High / Patient Safety and Practice Assessment
IA_PSPA_20	**Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes:** Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: • Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or	Medium / Patient Safety and Practice Assessment

	• Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	
IA_PSPA_30	**PCI Bleeding Campaign:** Participation in the PCI Bleeding Campaign which is a national quality improvement program that provides infrastructure for a learning network and offers evidence-based resources and tools to reduce avoidable bleeding associated with patients who receive a percutaneous coronary intervention (PCI). The program uses a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for PCI patients by implementing quality improvement strategies: • Radial-artery access, • Bivalirudin, and • Use of vascular closure devices.	High / Patient Safety and Practice Assessment

Version History

Date	Comment
11/21/2022	Updated page 12 to reflect language from the CY 2023 PFS Final Rule around virtual group participation.
11/01/2022	Original version