Merit-based Incentive Payment System (MIPS)

Participating in the Quality Performance Category in the 2023 Performance Year: Traditional MIPS

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Purpose: This detailed resource focuses on the quality performance category requirements under the traditional Merit-based Incentive Payment System (MIPS) (original reporting option for collecting and reporting data since the inception of the Quality Payment Program (QPP)), providing requirements and practical information about quality measure selection, data collection, and submission for the 2023 performance period for individual, group, virtual group, and Alternative Payment Model (APM) Entity reporting. This resource doesn't address quality requirements under the MIPS Value Pathways (MVPs) or APM Performance Pathway (APP).

How to Use This Guide

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Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

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Overview

Overview

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program rewards MIPS eligible clinicians for providing high quality care to their patients by reimbursing Medicare Part B-covered professional services.

Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

If you're eligible for MIPS in 2023:

- You generally have to report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you, if applicable.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2023 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2025.

To learn more about MIPS:

- Visit the Learn about MIPS webpage.
- View the 2023 MIPS Overview Quick Start Guide.
- View the 2023 MIPS Quick Start Guide for Small Practices.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- View the 2023 MIPS Eligibility and Participation Quick Start Guide.
- Check your current participation status using the QPP Participation Status Tool.

Overview

What is the Merit-based Incentive Payment System? (Continued)

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS, established in the first year of QPP, is the original reporting option for MIPS. You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS. You'll also report the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

The Alternative Payment Model (APM) Performance Pathway (APP) is a streamlined reporting option for clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. You'll report a predetermined measure set made up of quality measures in addition to the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.

MIPS Value Pathways (MVPs) are the newest reporting option that offer clinicians a subset of measures and activities relevant to a specialty or medical condition. MVPs offer more meaningful groupings of measures and activities, to provide a more connected assessment of the quality of care. Beginning with the 2023 performance year, you'll select, collect, and report on a reduced number of quality measures and improvement activities (as compared to traditional MIPS). You'll also report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). We collect and calculate data for the cost performance category and population health measures for you.

To learn more about traditional MIPS:

- Visit the Traditional MIPS Overview webpage on the Quality Payment Program website.

To learn more about the APP:

- Visit the APM Performance Pathway webpage on the Quality Payment Program website.

To learn more about MVPS:

- Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website.

Overview

What is the Merit-based Incentive Payment System? (Continued)

This resource examines the quality performance category under traditional MIPS for the 2023 performance period. For more information about the quality performance category under the MVPs, please refer to the 2023 MVPs Implementation Guide or Explore MVPs webpage.

For information about the quality performance category under the APP, please refer to the APP Quality Requirements webpage.

Traditional MIPS Performance Category Weights in 2023:
Individual, Group, and Virtual Group Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Traditional MIPS Performance Category Weights in 2023:
APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
55%	0%	15%	30%

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Final Score Calculation – Redistribution Policies for Small Practices

We automatically reweight the Promoting Interoperability performance category for clinicians in small practices. Under this redistribution policy, Promoting Interoperability is weighted at 0%.

Standard weighting for small practices:
(Promoting Interoperability automatically **reweighted** to 0%)

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

When both the **cost** and the **Promoting Interoperability** performance categories are reweighted (such as for APM Entities with the small practice designation):

50% Quality	0% Cost	50% Improvement Activities	0% Promoting Interoperability

Overview

What's New with Quality Under Traditional MIPS in 2023?

- The data completeness threshold remains at 70%; however, for the 2024 and 2025 performance periods, the threshold will increase to 75%.
- The inventory of measures finalized represents a total of 198 MIPS quality measures, including 9 new MIPS quality measures (including 1 administrative claims measure). There are 76 existing MIPS quality measures that have substantive changes, 5 of which won't have a historical benchmark.
    - From the 2022 to the 2023 performance period, 11 MIPS quality measures were removed, and 2 MIPS quality measures were partially removed (removed from traditional MIPS but retained for MVPs). For more information on these measures, review the Appendix.
- The CMS Web Interface is no longer available as a collection or submission type for groups, virtual groups, and APM Entities reporting traditional MIPS.
- Beginning with the 2023 performance period, we'll score administrative claims measures exclusively against performance period benchmarks.

What's New with Quality Under Traditional MIPS in 2023? (Continued)

Updates to Quality Measure Scoring Policies

- Beginning with the 2023 performance period, the 3-point scoring floor for measures will be removed.
    - Measures that can be scored against a benchmark will receive 1 – 10 points based on performance.
    - Measures without a benchmark will receive 0 points (small practices will continue to earn 3 points).
- Measures will earn 0 points for the 2023 performance period~~s~~ if data completeness and case minimum requirements aren't met (small practices will continue to earn 3 points).

NOTE: These scoring policies don't apply to new measures during the first 2 performance periods available for reporting; however, policies related to new measures can be found on slide 31.

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Quality Basics

Quality Basics

Why Focus on Quality?

The quality performance category assesses the quality of care you deliver as demonstrated by your performance on quality measures. Quality measures are tools that help us to measure health care processes, outcomes, and patient care experiences:

Quality measures link health outcomes to one or more of the following Meaningful Measures 2.0 Framework Domains:

For the **2023 performance period**, the quality performance category:

- Is generally worth 30% of your MIPS final score for MIPS eligible individuals, groups, and virtual groups participating in traditional MIPS (55% for MIPS eligible clinicians participating as an APM Entity); and
- Has a 12-month reporting period (January 1, 2023 - December 31, 2023).

Quality Basics

Quality Measures

For the 2023 performance period, you can choose measures most meaningful to your practice from **198 MIPS quality measures,** in addition to hundreds of QCDR measures approved by CMS outside of rulemaking.

High priority measures aren't an additional measure type, but fall within the following measure types:

- Outcome (includes intermediate outcome and patient-reported outcome-based performance);
- Appropriate Use;
- Patient Engagement/Experience;
- Patient Safety;
- Efficiency Measures;
- Care Coordination;
- Opioid-related; and
- **NEW:** Health Equity-related

TIP: To review the 2023 MIPS quality measures and QCDR measures, visit the Explore Measures & Activities section of the Quality Payment Program website and the 2023 MIPS Quality Measures List (XML). Once you have found the MIPS quality measures that work for you, you'll need to look at the appropriate measure specifications for the collection type you choose to use.

Quality Basics

Quality Measures

Below is an overview of the 7 types of quality measures you may report for the quality performance category:

Quality Measures by Measure Type		
Measure Type	**Measure Type Definition**	**Example**
Process Measures	A process measure is a measure that focuses on steps that should be followed to provide good care. There should be a scientific basis for believing that the process, when executed well, will increase the probability of achieving a desired outcome.	The percentage of patients getting preventive services (such as mammograms or immunizations).
Outcome Measures	An outcome measure is a measure that focuses on the health status of a patient (or change in health status) resulting from healthcare – desirable or adverse.	The rate of surgical complications or hospital-acquired infections, such as surgical site infections.
Intermediate Outcome Measures	An intermediate outcome measure is a measure that assesses the change produced by a healthcare intervention that leads to a long-term outcome. Under MIPS, intermediate outcome measures meet the outcome measure criteria.	The percentage of patients diagnosed with hypertension whose blood pressure was adequately controlled during the measurement period. Reducing a patient's blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.

Quality Basics

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Quality Measures (Continued)

Measure Type	Measure Type Definition	Example
Patient-Reported Outcome-Based Performance Measures	A patient-reported outcome-based performance measure (PRO-PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity. The data are collected directly from the patient using the PROM tool, which can be an instrument, scale, or single-item measure. Under MIPS, patient-reported outcome-based performance measures meet the outcome measure criteria.	The percentage of patients who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a preoperative and postoperative visual function survey.
Structure Measures	A structure measure, also known as a structural measure, is a measure that assesses features of a healthcare organization or clinician relevant to its capacity to provide good healthcare.	The percentage of patients with a diagnosis or history of melanoma whose information was entered into a continuity of care recall system that includes a target date for the next physical exam and a process for following up with patients that miss an exam.
Patient Engagement/Experience Measures	Patient engagement/experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys.	Administering the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for MIPS Survey measure.
Efficiency Measures	An efficiency measure is the cost of care (inputs to the health system in the form of expenditures and other resources) associated with a specified level of health outcome.	The percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma and were classified as low risk for traumatic brain injury and who had a head Computed Tomography (CT) for trauma ordered by an emergency care provider. (i.e., Measuring the overuse of diagnostic imaging in a specific patient population, such as patients with minor blunt head trauma who have no indication for a head CT.)

Quality Basics

Quality Measures (Continued)

We are building on the success of the Meaningful Measures Initiative to shape the Meaningful Measures 2.0 Framework. When the Meaningful Measures Initiative was first introduced in 2017, the objective was to reduce the number of Medicare quality measures and ease the burden on users. Although the initial Meaningful Measures Initiative accomplished its initial goals, its scope and purpose have evolved to keep pace with a rapidly changing healthcare environment. With the Meaningful Measures 2.0 Framework, we will not only continue to reduce the number of measures in its programs but will further shape the entire ecosystem of quality measures that drive value-based care. We complete a comprehensive assessment of each quality measure prior to proposing the measure for removal. As part of the process for assessing whether to remove a measure through the rulemaking process, the following factors, but not limited to, are considered:

- **Whether the removal of the process measure impacts the number of measures available for a specific specialty.**
- **Whether the measure addresses a priority area highlighted in the Blueprint content on the CMS Measures Management System (MMS) Hub.**
- **Whether the measure promotes positive clinical outcomes in patients.**
- **Evaluation of the quality measure's performance to ensure there is a gap in patient care that can drive meaningful benchmarks to drive quality care.**
- **Whether the measure represents an important aspect of care for an MVP.**

In addition, we assess the measure's adoption rate by assessing whether the measure meets case minimum and reporting volumes required for establishing a benchmark after being in the program for 2 consecutive performance years. Removing measures by using this methodology ensures that the MIPS quality measures within the program are truly meaningful and measurable, where quality improvement is sought and measures with low reporting rates for 2 consecutive performance periods may be removed from MIPS.

- Appendix A identifies measures that were finalized for removal from the program, beginning with the 2023 performance period.
- Appendix B identifies measures that were finalized for partial removal (removed from traditional MIPS but retained for MVPs), beginning with the 2023 performance period.

Quality Basics

Reporting Requirements

To complete the reporting requirements for the quality performance category, you can:

Report on **at least 6 MIPS quality measures, including at least 1 outcome measure**. If no outcome measures are applicable, you may report another high priority measure.

OR

Report on a defined specialty measure set (if the specialty measure set has fewer than 6 measures, you'll meet quality reporting requirements if you report all the measures in the specialty set).

Starting with the 2023 performance period, the CMS Web Interface is no longer available as a collection or submission type for groups, virtual groups, and APM Entities participating in traditional MIPS.

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) may continue to report using the CMS Web Interface through the 2024 performance period; however, we encourage Shared Savings Program ACOs that have historically reported MIPS quality measures through the CMS Web Interface to start preparing now for their transition to a new collection type. You can start by reviewing general requirements for other collection types available for the quality performance category in this resource. Additional resources to help you prepare for this transition are now available.

TIP: For the quality performance category, all measures must be reported for the 12-month reporting period, January 1, 2023 – December 31, 2023.

NOTE: If you're a specialty group, you're not limited to reporting a defined specialty measure set. You may use the Explore Measures and Activities tool on the Quality Payment Program website to search for measures relevant to your scope of practice.

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Collection Types

Collection Types

Collection Types

Collection Type refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.

For example: Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%), has different specifications depending on whether you're reporting the measure as an electronic clinical quality measure (eCQM) or as a Medicare Part B claims measure.

You should start data collection on January 1, 2023, to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive 0 points for the measure, unless you're a small practice, in which case you'll receive 3 points.

Data completeness refers to the volume of performance data reported for the measure's eligible population. To meet data completeness criteria, you must report performance data (performance met, not met, or any denominator exceptions) for at least 70% of the eligible population (denominator).

NOTE: The data completeness threshold will increase to 75% for the 2024 and 2025 performance periods.

- **For Medicare Part B claims measures,** we identify the eligible denominator patient population based on your submitted Medicare Part B claims.
- **For eCQMs, MIPS Clinical Quality Measures (MIPS CQMs), and QCDR measures,** you (or your third party intermediary) identify the eligible population in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications.

Incomplete reporting of a measure's eligible population or selectively reporting data that misrepresents your performance in a disingenuous manner, commonly referred to as **"cherry-picking,"** results in data that aren't true, accurate, or complete and may subject you to an audit.

Collection Types

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Collection Types

There are 5 collection types, or ways you can collect and submit your quality measures data to CMS.

Electronic Clinical Quality Measures (eCQMs)

MIPS Clinical Quality Measures (MIPS CQMs)

Qualified Clinical Data Registry (QCDR) Measures

Medicare Part B Claims Measures
(Only available to small practices with 15 or fewer clinicians.)

CAHPS for MIPS Survey Measure
(Only available to pre-registered groups, virtual groups, and APM Entities.)

Collection Types

Collection Types (Continued)

There are **4 MIPS quality measures** that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- **NEW:** Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System (MIPS) (ZIP).
    - This measure will have a case minimum of **21 cases** and will only apply to **groups, virtual groups, and APM Entities with at least 1 cardiologist.**
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP).
    - This measure will have a case minimum of **18 cases** and will only apply to **groups, virtual groups, and APM Entities with at least 16 clinicians.**
- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment Program (MIPS) Groups (ZIP).
    - This measure will have a case minimum of **200 cases** and will only apply to **groups, virtual groups, and APM Entities with at least 16 clinicians.**
- Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (ZIP).
    - This measure will have a case minimum of **25 cases** and will apply to **individuals, groups, virtual groups, and APM Entities.**
    - This measure will have a **3-year performance period** (consecutive 36-month timeframe) that will start on October 1, 2020 (3 years prior to the performance period), and end on September 30, 2023 (current performance period) and proceed with a 3-month numerator assessment period.

NOTE: We'll aggregate quality measures collected through multiple collection types into a single quality performance category score. If you submit the same measure through multiple collection types, the one with the greatest number of achievement points will be selected for scoring.

Collection Types

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Collection Types (Continued)

The table below provides additional information on each collection type.

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?
eCQMs	2023 eCQM Specifications 2023 eCQM Flows (ZIP)	You can report eCQMs if you use technology that has the 2015 Edition Cures Update Certified Electronic Health Record Technology (CEHRT) certification from the Office of the National Coordinator for Health Information Technology (ONC) by the time eCQM data is generated for submission. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.

NOTE: Shared Savings Program ACOs are required to report via the APP. If MIPS eligible clinicians or groups within an ACO choose to report via traditional MIPS in addition to the ACO's required reporting via the APP, they will receive the higher MIPS final score and payment adjustment.

Collection Types

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Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?
MIPS CQMs	2023 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may choose to work with a QCDR, Qualified Registry, or Health IT vendor to support your data collection and submission, or you can submit them yourself. To see the lists of CMS-approved QCDRs and Qualified Registries, visit the QPP Resource Library. MIPS CQMs can be reported in combination with Medicare Part B claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
QCDR Measures	2023 QCDR Measure Specifications (XML)	QCDRs are CMS approved entities with the flexibility to develop and track their own quality measures which are approved during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that are relevant to their practice. You'll need to work with the QCDR (XML) to report these measures on your behalf. QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.

Collection Types

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Collection Types (Continued)

Not sure where to begin?: Check out the 2023 Quality Quick Start Guide (PDF) for the 5 steps to help you get started with meeting the reporting requirements for the quality performance category.

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?
Medicare Part B Claims Measures	2023 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP) 2023 Part B Claims Reporting Quick Start Guide (PDF)	Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians). Individual clinicians reporting Medicare Part B claims measures should include their National Provider Identifier (NPI) and Taxpayer Identification Number (TIN), even when participating as a group, virtual group, or APM Entity. Medicare Part B claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
CAHPS for MIPS Survey Measure	The 2023 CAHPS for MIPS Survey Overview Fact Sheet will be available on the QPP Resource Library in March 2023.	Groups, virtual groups and APM Entities can register between April 3, 2023, and June 30, 2023, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience and care within a group, virtual group or APM Entity. This survey must be administered by a CMS-Approved Survey Vendor (PDF). This is a patient engagement/experience survey measure that fulfills the requirement to report at least one high priority measure if no other outcome measure is available. This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.

TIP: To review the 2023 MIPS quality measures, visit the Explore Measures & Activities section of the Quality Payment Program website and choose the 2023 performance period or the quality measure specifications zip file posted by collection type on the QPP Resource Library.

Collection Types

Collection Types (Continued)

What if I don't have 6 applicable measures, or an applicable outcome/high priority measure?

Start by reviewing the specialty measure sets. You can meet quality reporting requirements by reporting a complete specialty measure set, even if the measure set includes fewer than 6 measures.

If a specialty measure set doesn't apply to you, report all the available measures that are clinically relevant to your practice. CMS will use the Eligible Measure Applicability (EMA) process to review the measure data you submitted to determine if there were any other quality measures you may have been able to report. The EMA process is applied to MIPS eligible clinicians, groups, virtual groups and APM Entities that have reported Medicare Part B claims measures or MIPS CQMs and may result in a denominator reduction for those eligible clinicians that reported all applicable measures meeting data completeness and MIPS program requirements.

TIP: More information on the 2023 performance period EMA process and the measures we've identified as clinically related is available on the QPP Resource Library.

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Submitting Quality Data

Submitting Quality Data

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Overview

Following the conclusion of the 2023 performance period on December 31, 2023, we'll assess your performance in the quality performance category based on the quality measure data you submit during the data submission period.

The 2023 performance period data submission period will open on **January 2, 2024, and close on April 1, 2024**.

Exception: For the Medicare Part B claims submission type (only available to small practices), we receive quality data when denominator eligible claims, that include quality data codes (QDCs) from your selected quality measures, are submitted for payment. Please note that your Medicare Part B claims measure data must be processed by your Medicare Administrative Contractor (MAC) and received by CMS no later than 60 days following the close of the 2023 performance period.

If you transition from one EHR system to another during the performance period, you should aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month reporting period prior to submitting the data. If your practice uses multiple EHR systems for clinicians billing, as a group, under the same TIN, you'll also need to aggregate data into a single report prior to submitting the data. If a situation arises where data for the full 12 months is unavailable (for example: data aggregation from both systems is not possible), you should submit as much quality data as possible, **but** we want to emphasize that the 12-month performance period and 70% data completeness threshold are applicable regardless of an EHR transition during the performance year. During the 2023 performance period, the EHR system(s) may use the functionality of 2015 Edition CEHRT for eCQMs; however, the submitting EHR system must be certified to the 2015 Edition Cures Update criteria before the eCQM data is generated for submission.

Preliminary scoring information will be available beginning **January 2, 2024**, once data has been submitted.

We anticipate your final score preview will be available in **early Summer 2024**, and your final performance feedback including payment adjustments will be available in **late Summer 2024**.

You can review your performance feedback by signing in to the Quality Payment Program website.

Submitting Quality Data

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Overview (Continued)

The following chart outlines your options for submitting quality measure data based on your submission and collection types.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When (Submission Period)
You (Individual, Group, Virtual Group, or APM Entity Representative)	Medicare Part B Claims Measures (small practices only)	Through your routine Medicare Part B claims billing practices.	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2024)
	eCQMs	Sign in to the Quality Payment Program website and upload a QRDA III file or a QPP JSON file.	January 2 – April 1, 2024
	MIPS CQMs	Sign in to the Quality Payment Program website and upload a QPP JSON file.	January 2 – April 1, 2024
Third Party Intermediaries: QCDRs, Qualified Registries, and Health Information Technology (IT) Vendors	eCQMs MIPS CQMs QCDR Measures	Sign in to the Quality Payment Program website and upload a QRDA III or QPP JSON file **OR** Use the QPP Submission Application Programming Interface (API).	January 2 – April 1, 2024
CMS-Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of the Quality Payment Program website.	Following data collection (standardized annual timeframe)

Submitting Quality Data

Overview (Continued)

Did you know?

Generally, the level at which you participate in MIPS (individual, group, or virtual group) applies to all MIPS performance categories. We won't combine data submitted at the individual, group, and/or virtual group level into a single MIPS final score.

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all MIPS performance categories as a group.
- If data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all MIPS performance categories, but your MIPS payment adjustment will be based on the higher score.

NEW IN 2023: When participating in MIPS at the APM Entity level, the APM Entity will submit quality measures and improvement activities, but now may choose to report Promoting Interoperability data at the APM Entity level. However, APM Entities will still have the option to report this performance category at the individual level and group level.

NOTE: When small practices report Medicare Part B claims measures, we'll only calculate a group-level quality performance category score if the practice submits data for another performance category as a group. Submitting data as a group for the other performance categories signals your intent to participate as a group.

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Scoring

Scoring

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Overview

Quality measures submitted for the 2023 performance period will receive between 0 and 10 measure achievement points.

You'll receive:

1-10 points

- Between **1 and 10 achievement points** for measures in their **third year** (or later) based on your performance in comparison to a benchmark if the quality measure meets the data completeness criteria (generally 70%), has a benchmark, and case minimum is sufficient (≥ 20 cases for most measures).

7-10 points

- This 7-point scoring floor is only available for new measures in their **first year** of the program.
- Between **7 and 10 achievement points** if the measure can be reliably scored against a benchmark (i.e., a benchmark exists, and the measure meets data completeness and case minimum requirements).
- The quality measure will earn 7 points if the measure meets data completeness but doesn't have a benchmark or meet case minimum.
- For the 2023 performance period, this applies to Quality IDs 485 – 493 and QCDR measures added to the program in the 2023 performance period.

5-10 points

- This 5-point scoring floor is only available for new measures in their **second year** of the program**.**
- Between **5 and 10 achievement points** if the measure can be reliably scored against a benchmark (i.e., a benchmark exists, and the measure meets data completeness and case minimum requirements).
- The quality measure will earn 5 points if the measure meets data completeness but doesn't have a benchmark or meet case minimum.
- For the 2023 performance period, this applies to Quality IDs 481 – 483 and QCDR measures added to the program in the 2022 performance period.

0 points

- 0 achievement points if your quality measure doesn't have a benchmark.
- 0 achievement points if your quality measure doesn't meet data completeness requirements, which varies by collection type.
- 0 achievement points if the case minimum is insufficient (≤ 20 cases for most measures).

Small practices will continue to earn 3 points.

These new measures scoring policies don't apply to measures with substantive changes, only measures that are brand new to the program.

NOTE: These measure achievement points scoring policies don't apply to administrative claims measures.

Scoring

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Overview

The purpose of this slide is to highlight the difference between concepts impacting measure scoring and performance. Each concept below provides guidance on their function within MIPS.

Suppression – Scoring Flexibility

- Applied when data is not available for at least 9 consecutive months, or CMS determines that the measure may result in patient harm or misleading results.

Truncation – Scoring Flexibility

- Applied when there is data available and can be reported without concerns for measure data integrity for 9 consecutive months of the 2023 performance period.
- Timeframe will be specified by CMS in the Truncated and Suppressed MIPS Quality Measures publication, if there are measures identified as being truncated.
- Does not apply to the eCQM collection type.
- Truncation to the 9-month period should be applied to the denominator criteria for the purposes of determining denominator eligibility. The numerator will function as currently specified for those patients that fall into the denominator during the 9-month period.

Benchmark Removal – Not a Scoring Flexibility

- Applies when proposed substantive changes are finalized through public notice and comment rulemaking no longer allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes.
- Benchmark removals are proposed and finalized within the upcoming MIPS performance year rules.

Scoring

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
  - These errors include, but are not limited to:
    - Changes to the active status of codes.
    - The inadvertent omission of codes.
    - The inclusion of inactive or inaccurate codes.
    - Identified analytical challenges to accurately capturing components of the measures.
- Updates to the International Classification of Diseases, Tenth Revision (ICD-10) codes during the performance period.
  - For ICD-10 code updates, we finalized that we would publish a list of measures with a truncated performance period on the QPP Resource Library by October 1st of the performance period if technically feasible, but no later than the beginning of the data submission period (for example, January 2, 2024, for the 2023 performance period).
- Clinical guideline changes.

What happens if a measure is identified as suppressed?

If a measure is identified as suppressed, this means there isn't 9 consecutive months of data available to score the measure appropriately. Each measure will earn 0 achievement points; however, the **total measure achievement points will be reduced by 10 points for each measure submitted that is impacted.**

Suppressed measures must still meet data completeness and case minimum requirements if submitted.

What is the difference between a truncated measure and a suppressed measure?

A truncated measure will have performance assessed based on data for 9 consecutive months of the applicable performance period. Your quality performance category score will be based on the submission of your 6 measures, including truncated measures.

However, suppressed measures aren't included in your quality performance category score, if you submitted data for a suppressed measure and met data completeness and case minimum requirements.

NOTE: If a measure is suppressed in the 2023 performance period, it won't be scored against a benchmark (historical or performance period) in the 2023 performance period. We also won't create a historical benchmark for it in the 2025 performance period, though we would attempt to create a performance period benchmark.

Scoring

Topped Out Quality Measures

A process measure is considered topped out if the median performance rate is 95% or higher (non-inverse measure) or is 5% or lower (inverse measure). A non-process measure is considered topped out if the level of variance is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. We identify topped out measures annually through our benchmarking process. Measures that are topped out for 4 consecutive years can be proposed for removal through rulemaking.

A measure is considered extremely topped out if the average performance rate is 98% or higher (non-inverse measure) or is 2% or lower (inverse measure). We would consider this measure for removal in the next rulemaking cycle, regardless of whether it's in the midst of the topped out measure lifecycle. However, we may consider retaining the measure if there are compelling reasons as to why this measure shouldn't be removed (for example, if the removal would impact the number of measures available to a specialist type).

Are all Topped Out Measures capped at 7 points?

No. A measure is capped at 7 points when it's topped out through the same collection type for 2 consecutive years. The 7-point cap is applied in the second consecutive year the measure is identified as topped out.

To identify if a measure is topped out or capped at 7 points, refer to the 2023 Quality Benchmarks (ZIP).

A measure may be topped out without being capped at 7 points. A "Yes" in the **Seven Point Cap** column (Column S) of the benchmark file referenced above indicates the measure is capped at 7 points.

NOTE: QCDR measures are excluded from the topped out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped out during the annual self-nomination process, it may not be approved for the applicable performance period.

Scoring

Benchmarks

Each MIPS quality measure is assessed against its benchmark to determine how many points the measure earns.

How are the Benchmarks Established?

We establish benchmarks specific to each collection type: QCDR measures, MIPS CQMs, eCQMs, the CAHPS for MIPS Survey measure, Medicare Part B claims measures, and the administrative claims measures.

Whenever possible, we use historical data to establish benchmarks for eCQMs, MIPS CQMs, Medicare Part B claims measures and QCDR measures. The 2023 historical benchmarks are based on actual performance data that was submitted to QPP for the 2021 performance period. If a quality measure doesn't have a historical benchmark for any of these collection types, we'll attempt to calculate a benchmark based on data submitted for the 2023 performance period.

NEW: Beginning with the 2023 performance period, we'll score administrative claims measures exclusively against performance period benchmarks.

TIP: Some measures may have certain substantive changes to their specifications from one year to the next such that the historical data cannot be used to establish a benchmark.

For example, Quality ID 145: Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy (MIPS CQM) underwent a substantive change for the 2023 performance period. This substantive change no longer allows direct comparison of performance data from previous submissions. In this case, we'll attempt to calculate a benchmark based on data submitted for the 2023 performance period.

Scoring

Benchmarks (Continued)

Flat Benchmarks

For each measure that has a benchmark that CMS determines may have the potential to result in inappropriate or overuse of treatment, we will set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent.

For the 2023 performance period, the following measures/collection types met the criteria set by policy to establish flat benchmarks:

- Measure 001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
  - Collection Type: MIPS CQM only
- Measure 236, Controlling High Blood Pressure
  - Collection Type: MIPS CQM and Medicare Part B claims

CAHPS for MIPS Survey Benchmarks

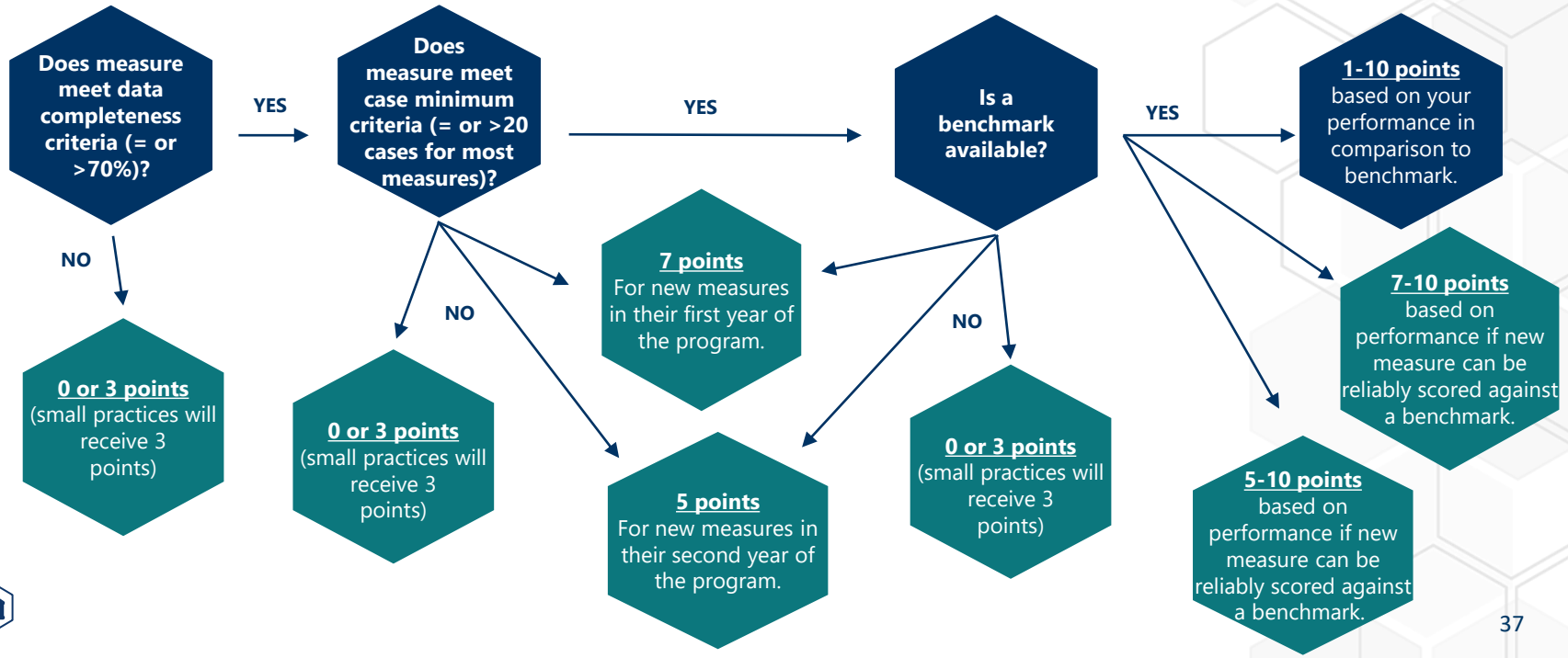
We attempt to establish a benchmark for each summary survey measure (SSM) in the CAHPS for MIPS Survey measure. These benchmarks were calculated using historical data from the 2021 performance period. Each SSM with a historical benchmark is awarded 1 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey score will be the average number of points across all scored SSMs. The CAHPS for MIPS Survey benchmarks can be found in the 2023 Quality Benchmarks (ZIP).

Scoring

Benchmarks (Continued)

How are Benchmarks Converted to Achievement Points?

- Each quality measure with a benchmark is scored using a 10-point scoring system, except for:
  - Measures capped at 7 points because they are in their second consecutive year of being topped out.
  - Measures that don't meet data completeness criteria.
  - Measures that are submitted with an insufficient case volume.
  - New measures in their first and second performance period.
- Historical performance distribution for each measure is used to define deciles of performance that are used as the benchmark for the measure.



Scoring

Benchmarks (Continued)

- The deciles are used to assign a measure score between 1 and 10 points.
- We compare your performance on a quality measure to the performance levels in the benchmark.
- The points you earn are based on the decile range that matches your performance rate.
- For measures with inverse performance rates, such as Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

What if I chose a measure that doesn't have a historical benchmark?

- Beginning in the 2023 performance period, quality measures that can't be reliably scored against a benchmark, or quality measures without an historical benchmark, will receive zero measure achievement points unless a performance period benchmark can be established. Small practices will still receive 3 measure achievement points.
- This applies to measures across all collection types except for the administrative claims measures.

NOTE: Beginning in the 2023 performance period, the 3-point scoring floor for measures that can be reliably scored based on performance has been removed. As a result, measures in the lowest deciles (Deciles 1 and 2) can receive between 1 and 2.9 measure achievement points if it can be reliably scored. (Reliably scored means a national benchmark exists, sufficient case volume has been met, and the data completeness requirement has been met.)

Scoring

Quality Payment PROGRAM

Example 1

The below scoring example shows how to use the 2023 Quality Benchmarks (ZIP) to convert into measure achievement points, assuming that data completeness and case minimum have been met.

Measure 009: Anti-Depressant Medication Management, collected and reported as an eCQM.

Dr. Clark submits data for Measure 009 (eCQM) that results in a performance rate of 60.09% and 1.9 achievement points.

Why?

Scoring Example 1:
Apply the following formula based on the measure performance and decile range.

$$\text{decile \# } X + \frac{[\,q \text{ measure performance rate} - a \text{ bottom of decile range}\,]}{[\,b \text{ bottom of next highest decile range} - a \text{ bottom of decile range}\,]} = \text{Achievement Points}$$

$$1 + \frac{[\,(60.09 - 25.00)\,]}{[\,(62.22 - 25.00)\,]} = \text{Achievement Points}$$

$\frac{(60.09 - 25.00)}{(62.22 - 25.00)} = 0.94277\ldots$

which is truncated to **0.94**

***Achievement points* = 1.94**

NOTE: Partial achievement points are truncated to the hundredths digit for partial points.

X = decile #
q = measure performance rate
a = bottom of decile range
b = bottom of next highest decile range

Scoring

Example 2

The below scoring example assumes the measure does have a benchmark and data completeness and case minimum have been met.

Measure 489: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, collected and reported as a MIPS CQM.

Lakeview Associates, submits data for Measure 489 (MIPS CQM) that results in a performance rate of 42.99% and 7.0 achievement points.

Why?

There's a 7-point scoring floor for measures added to the program in the 2023 performance year. If a performance period benchmark can be created, Lakeview Associates would be eligible for 7 – 10 points, based on their performance in comparison to the performance period benchmark.

NOTE: There's a 5-point scoring floor for measures in their 2nd year in the program.

Bonus Points

There are no measure-level bonus points available.

Will the small practice bonus still be applied for the 2023 performance period?

Yes, 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices that submit data on at least one MIPS quality measure.

This bonus isn't available to small practices that receive a quality performance category score from facility-based measurement.

Scoring

Improvement Scoring

You can earn **up to 10 percentage points** based on the rate of your improvement in the quality performance category from the previous performance period.

You'll be evaluated for improvement scoring when you:

- Meet the quality performance category requirements for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure or submit as many measures as were available and applicable; all measures must meet data completeness requirements).
- Have a quality performance category achievement percent score based on reported measures for the previous performance period.
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

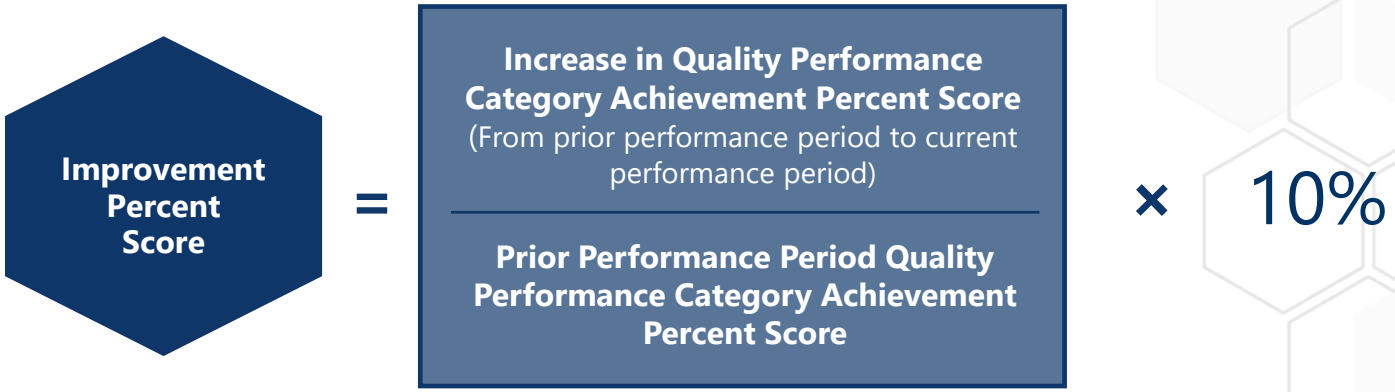
TIP: Improvement scoring isn't available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately prior to the current performance period.

Scoring

Improvement Scoring (Continued)

How is improvement scoring calculated?

Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2022) performance period to the quality performance category achievement percentage score for the current (2023) performance period.



Scoring

Scoring Example

The following provides an example of how to calculate the improvement percent score.

For the **2022 performance period**, Dr. Johnson earned 40 measure achievement points.

For the **2023 performance period,** Dr. Johnson earned 48 measure achievement points.

- 2022 quality performance category achievement percent score = 67%
  - (40/60)
- 2023 quality performance category achievement percent score = 80%
  - (48/60)
- The increase in the quality performance category achievement percent score from the previous (2022) performance period to the current (2023) performance period = 13%
  - (80% - 67%)
- The improvement percent score is 1.9% which will be added to the percent score earned for reported measures.
  - (13%/67%) x 10% = 1.9%

Improvement Percent Score = (2023 Achievement Percent Score (80%) – 2022 Achievement Percent Score (67%) = **13%** **Increase in Quality Performance Category Achievement Percent Score** / **67%** **Prior Performance Period Quality Performance Category Achievement Percent Score**) × 10% → **Improvement Percent Score** = 1.9%

NOTE: The improvement percent score can't be negative and is capped at 10%.

Scoring

Quality Payment PROGRAM

Calculating the Quality Performance Category Percent Score

The quality performance category percent score is a product of the following equation.

Quality Performance Category Percent Score (Not to exceed 100%) = (**Total Measure Achievement Points** / **Total Available Measure Achievement Points*** × 100%) + **Improvement Percent Score**

Example:

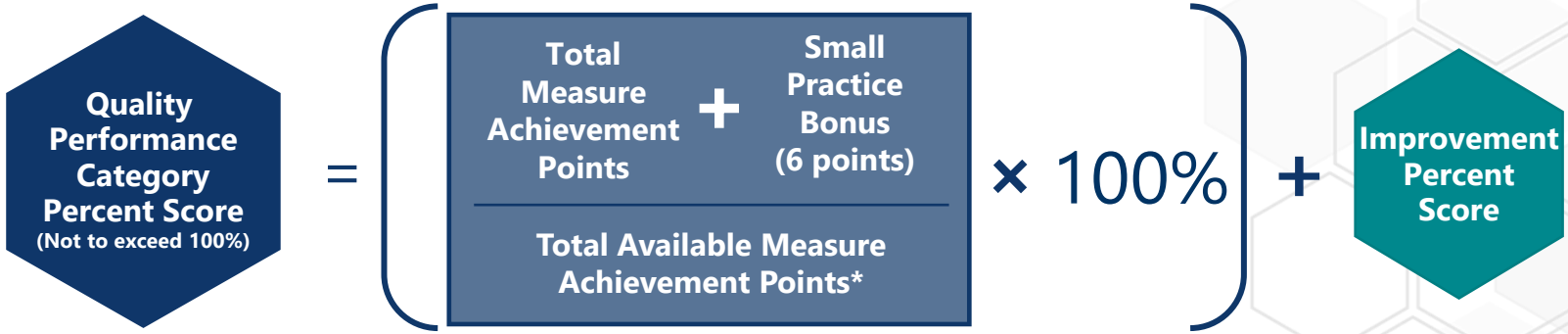
81.9 Quality Performance Category Percent Score (Not to exceed 100%) = (**48** Total Measure Achievement Points / **60** Total Available Measure Achievement Points* × 100%) + **1.9% Improvement Percent Score**

*Total available measure achievement points = # of required measures x 10

Scoring

Calculating the Quality Performance Category Percent Score (Continued)

The quality performance category percent score **for small practices** is a product of the following equation.



TIP: Your quality performance category percent score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your MIPS final score.

Scoring

Calculating the Quality Performance Category Percent Score (Continued)

Your quality performance category percent score is multiplied by the category weight and then by 100% to determine the number of points that contribute to your MIPS final score.

Example 1
The MIPS eligible clinician, group, or virtual group is scored on all 4 MIPS performance categories.

81.9% x **30%** x 100 = **24.56**
Points under the quality performance category contributing to the MIPS final score

Example 2
The MIPS eligible clinician, group, or virtual group can't be scored on the cost performance category.

81.9% x **55%** x 100 = **45.05**
Points under the quality performance category contributing to the MIPS final score

Example 3
The MIPS eligible clinician, group, or virtual group is a small practice that receives automatic reweight of the Promoting Interoperability performance category.

81.9% x **40%** x 100 = **32.76**
Points under the quality performance category contributing to the MIPS final score

Scoring

Quality Payment PROGRAM

Maximum Points Available in the Quality Performance Category

Your quality performance category score is determined by dividing the achievement points that you receive for the measures you submitted by the maximum number of achievement points that you could receive, which will depend on your collection type. The maximum number of points available can vary.

Maximum Points	Available To	Scored On
60 points	Individuals/Groups/Virtual Groups/APM Entities	6 required measures + 0 administrative claims measures
70 points	Individuals/Groups/Virtual Groups/APM Entities	6 required measures + 1 administrative claims measure
80 points	Groups/Virtual Groups/APM Entities	6 required measures + 2 administrative claims measures
90 points	Groups/Virtual Groups/APM Entities	6 required measures + 3 administrative claims measures
100 points	Groups/Virtual Groups/APM Entities	6 required measures + 4 administrative claims measures

Scoring

Facility-Based Scoring

Facility-based scoring may be applied to facility-based clinicians, groups, and virtual groups.

Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility-based,
- You're attributed to a facility when a FY 2024 Hospital Value-Based Purchasing (VBP) Program score (we won't know this until the end of the 2023 performance period), and
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

NOTE: For more information on facility-based scoring, review the 2023 Facility-Based Quick Start Guide.

Scoring

Quality Payment PROGRAM

Reweighting the Quality Performance Category

If you don't submit data for the quality performance category because there are no quality measures available to you or you qualify for reweighting under our MIPS extreme and uncontrollable circumstances policies, you won't earn any points for the quality performance category, and its performance category weight will be redistributed to other performance categories.

The following example outlines the weight distributions for each performance category when the quality performance category is weighed to 0% for individuals, groups, or virtual groups.

Quality	Cost	Improvement Activities	Promoting Interoperability
			
0% of MIPS Score	30%* of MIPS Score	15% of MIPS Score	55% of MIPS Score

***** The example assumes that you/your group/your virtual group can be scored for the cost performance category.

NOTE: We anticipate that reweighting of the quality performance category for lack of available measures would be a rare occurrence because there are quality measures applicable and available for most clinicians. Please contact QPP Service Center.

Quality Payment
PROGRAM

Help, Acronyms, and Version History

Help, Acronyms, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET).

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Help, Acronyms, and Version History

Quality Payment PROGRAM

Acronyms

ACO Accountable Care Organization

APM Alternative Payment Model

APP APM Performance Pathway

CAHPS Consumer Assessment of Healthcare Providers and Systems

CEHRT Certified Electronic Health Record Technology

CMS Centers for Medicare & Medicaid Services

CQM Clinical Quality Measure

EHR Electronic Health Record

eCQM Electronic Clinical Quality Measure

EMA Eligible Measure Applicability

JSON JavaScript Object Notation

MAC Medicare Administrative Coordinator

MACRA Medicare Access and CHIP Reauthorization Act of 2015

MIPS Merit-based Incentive Payment System

MVPs MIPS Value Pathways

NPI National Provider Identifier

PFS Physician Fee Schedule

QDC Quality Data Codes

QP Qualifying APM Participant

QPP Quality Payment Program

QRDA Quality Reporting Document Architecture

SSM Summary Survey Measure

TIN Taxpayer Identification Number

VBP Value-based Purchasing

Help, Acronyms, and Version History

Quality Payment PROGRAM

Version History

If we need to update this document, changes will be identified here.

Date	Description
05/30/2024	Updated slides 21 and 47; the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System measure isn't available to individual clinicians.
04/17/2023	Original Posting.

Appendices

Appendices

APPENDIX A: Measures Finalized for Removal in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
076	Process	Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections	MIPS CQM Medicare Part B claims
119	Process	Diabetes: Medical Attention for Nephropathy	MIPS CQM eCQM
258	Outcome	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)	MIPS CQM
265	Process	Biopsy Follow-Up	MIPS CQM
323	Efficiency	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	MIPS CQM
375	Process	Functional Status Assessment for Total Knee Replacement	eCQM
425	Process	Photodocumentation of Cecal Intubation	MIPS CQM
455	Outcome	Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)	MIPS CQM
460	Patient-Reported Outcome-based Performance	Back Pain After Lumbar Fusion	MIPS CQM
469	Patient-Reported Outcome-based Performance	Functional Status After Lumbar Fusion	MIPS CQM
473	Patient-Reported Outcome-based Performance	Leg Pain After Lumbar Fusion	MIPS CQM

Appendices

APPENDIX B: Measures Finalized for Partial Removal (Removed from Traditional MIPS and Retained for MVPs) in the CY 2023 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
110	Process	Preventive Care and Screening: Influenza Immunization	Medicare Part B Claims eCQM MIPS CQM
111	Process	Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims eCQM MIPS CQM

Appendices

APPENDIX C: Measures Finalized for Addition in the CY 2023 PFS Final Rule

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
485	Patient-Reported Outcome-based Performance	Psoriasis – Improvement in Patient-Reported Itch Severity	MIPS CQM
486	Patient-Reported Outcome-based Performance	Dermatitis – Improvement in Patient-Reported Itch Severity	MIPS CQM
487	Process	Screening for Social Drivers of Health	MIPS CQM
488	Process	Kidney Health Evaluation	MIPS eCQM
489	Process	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	MIPS CQM
490	Process	Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	MIPS CQM
491	Process	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma	MIPS CQM
492	Outcome	Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	Administrative Claims
493	Process	Adult Immunization Status	MIPS CQM

Appendices

APPENDIX D: Measures Finalized with Substantive Changes in the CY 2023 PFS Final Rule, Resulting in No Historical Benchmark for the 2023 Performance Period

Quality ID	Measure Type	MIPS Quality Measure Title	Collection Type(s)
145	Process	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	Medicare Part B claims MIPS CQM
277	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis	MIPS CQM
459	Patient-Reported Outcome-based Performance	Back Pain After Lumbar Surgery	MIPS CQM
461	Patient-Reported Outcome-based Performance	Leg Pain After Lumbar Surgery	MIPS CQM
471	Patient-Reported Outcome-based Performance	Functional Status After Lumbar Surgery	MIPS CQM