Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) Notice of Proposed Rule Making

Quality Payment Program Policy Overview: Proposals and Requests for Information

We recognize the many challenges the COVID-19 public health emergency (PHE) has created for our country and specifically, our healthcare system, over the past 3 years. We're grateful for the dedication, flexibility, and excellent care that clinicians have provided to patients throughout this difficult time. As we begin to transition away from the emergency response to COVID-19 with the end of the PHE and return our focus on the path ahead, we look forward to getting the Quality Payment Program (QPP) back on track with the trajectory we had planned before the PHE. In this Notice of Proposed Rule Making (NPRM) we've proposed policies that continue the development and maintenance of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), support the use of digital measurement and health information technology, support the integrity of program data, and increase the potential return on investment for MIPS participation.

We've also issued several Requests for Information (RFIs) to get your feedback on the future of QPP, specifically the future of MVPs, the alignment across QPP and the Medicare Shared Savings Program (Shared Savings Program), and recommendations on publicly displaying data on Care Compare.

Development and Maintenance of MVPs.
We've long signaled our intent that MVPs are the future of MIPS. To further this vision, we've proposed 5 new MVPs to be available with the 2024 performance year, along with revisions to all previously finalized MVPs.

The 5 newly proposed MVPs are:

1. Focusing on Women's Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care.

One of the goals of the CMS National Quality Strategy is to improve quality and health outcomes across the health care journey through implementation of a "Universal Foundation" of impactful measures across all CMS quality and value-based programs. The QPP measure inventory already included quality measures in the adult core set from the Universal Foundation. One of our proposals related to previously finalized MVPs would consolidate the previously

finalized Promoting Wellness MVP and Optimizing Chronic Disease Management MVP into a single primary care MVP that aligns with the adult core set from the Universal Foundation. We'll continue to identify additional measures, which may be included in future MVPs, to capture aspects of specialist quality in the Universal Foundation. Other proposals to update finalized MVPs are based on MVP inclusion criteria and feedback received through the MVP maintenance process.

For more information on MVP proposals, we refer you to the 2024 Proposed and Modified MVPs Guide.

Finally, we've included an RFI on MVP reporting incentives for Shared Savings Program ACOs. We're soliciting comments on scoring incentives that would be applied to an ACO's health equity adjusted quality performance score beginning in the 2025 performance year when specialists who participate in the ACO report quality MVPs.

Strategic Vision.
As part of our path forward with QPP, we're advancing our strategic vision for QPP and the Shared Savings Program to encourage equitable, safe, and high value patient care. We're interested in how QPP can facilitate continuous improvement of Medicare beneficiaries' healthcare and best build on existing CMS Innovation Center model policies and Medicare programs, such as the Medicare Shared Savings Program. We included an RFI on how we might be able to change performance standards to encourage clinicians to continuously improve care, particularly clinicians with little room for improvement under MIPS.

Support of Digital Measurement.
For the 2024 performance year and subsequent performance years, we're proposing to establish the Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) as a new collection type for Shared Saving Program ACOs under the Alternative Payment Model (APM) Performance Pathway (APP). Medicare CQMs would serve as a transition collection type to help some ACOs build the infrastructure, skills, knowledge, and expertise necessary to report the all-payer/all-patient MIPS CQMs and eCQMs by focusing on Medicare patients with claims encounters with ACO professionals with specialty designations used in the Shared Savings Program assignment methodology and continue to support ACOs in the transition to digital quality measurement reporting.

In order to align certified electronic health record technology (CEHRT) threshold requirements for Shared Savings Program ACOs with MIPS requirements, we are proposing to remove the Shared Savings Program CEHRT threshold requirements beginning performance year 2024, and adding a new requirement that, for performance years beginning on or after January 1, 2024, unless otherwise excluded, all MIPS eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in an ACO, regardless of track, satisfy all of the following:

- Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS according to 42 CFR part 414 subpart O as either of the following:
  ++All MIPS eligible clinicians, QPs, and partial QPs participating in the ACO as an individual, group; or virtual group; or
  ++The ACO as an APM entity.
- Earn a MIPS performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level.

We're also proposing to remove the numerical 75% threshold and simply have the Advanced APM require the use of the certified electronic health record technology (CEHRT) for QP performance periods beginning in 2024.

Health IT Vendors.
We're aware of situations in which health information technology (IT) vendors have submitted data that are inaccurate and unusable, which could undercut the integrity of the MIPS program. We believe this demands a reconsideration of the lack of data validation requirements for health IT vendors in contrast to those requirements for Qualified Clinical Data Registries (QCDRs) and qualified registries.

We observe today that many vendors serve in capacities as qualified registries, QCDRs or health IT vendors with similar technology. Rather than establish identical or nearly identical requirements for different categories of third party intermediaries, we're instead proposing to eliminate the health IT vendor category beginning with the CY 2025 performance period. We believe that eliminating the category of health IT vendor as a distinct type of third party intermediary will improve the integrity of program data, by ensuring consistent data validation and audit requirements for all third party intermediaries.

Health IT vendors would still be able to participate in MIPS as third party intermediaries by self-nominating to become a qualified registry or QCDR (if requirements are met). They could also continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.

Performance Threshold.
We propose increasing the performance threshold from 75 to 82 points. This modest increase, which would be applicable to all 3 MIPS reporting options (traditional MIPS, MVPs, and the APP), aligns with our goal to provide practices with a greater return on their investment in MIPS participation by giving an opportunity to achieve a higher positive payment adjustment.

Public Reporting.
We're proposing to modify existing policy about publicly reporting procedure utilization data on individual clinician profile pages by incorporating Medicare Advantage (MA)[1] data for a more accurate representation of procedure volumes.

Additionally, we've signaled our intent to begin publicly reporting cost measures, beginning with the CY 2024 performance period/2026 MIPS payment year, and included an RFI seeking comment on potential approaches to, and considerations for, public reporting.

We have a lot of work ahead of us, but we're committed to improving QPP so that we're providing patients with valuable performance data that informs their clinician choice and ensuring that participation is meaningful for clinicians. We want QPP to support clinicians' continued improvement in the quality and equity of care for all patients. We encourage interested parties to submit formal comments along with feedback on the RFIs in this NPRM so that your voice is included in the future of QPP.

For more information on the specific policies proposed in the CY 2024 PFS NPRM, please refer to:

- **2024 Proposed and Modified MVPs Guide (PDF)**
- **Medicare Shared Savings Program Proposals Fact Sheet (PDF)**
- **QPP Policy Comparison Table**

[1] We propose amending § 422.310(f)(3) to align the release of this MA data with the existing disclosure timelines on the Care Compare website, thereby providing beneficiaries with the necessary information for choosing a healthcare provider.

Changes to Quality Payment Program (QPP) Policies Proposed in the Calendar Year (CY) 2024 Physician Fee Schedule (PFS) Notice of Proposed Rule Making (NPRM)

- Merit-based Incentive Payment System (MIPS) Overview
- Advanced Alternative Payment Models (APMs) Overview
- Public Reporting via Doctors and Clinicians Care Compare Overview

- How Do I Comment on the CY 2024 Proposed Rule?

- **Appendix A:** Previously Finalized Policies for CY 2024
- **Appendix B:** New Quality Measures Proposed
- **Appendix C:** Quality Measures Proposed for Removal
- **Appendix D:** Quality Measures Proposed for Removal from Traditional MIPS (Retained for MVPs)
- **Appendix E:** New Improvement Activities Proposed
- **Appendix F:** Improvement Activities Proposed for Removal

We refer you to the 2024 Proposed and Modified MVPs Guide for information about the newly proposed MVPs and proposed changes to previously finalized MVPs.

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

Merit-based Incentive Payment System (MIPS) Overview

This table reviews proposed policies that are applicable to one or more MIPS reporting option. There are 3 MIPS reporting options available:

- Traditional MIPS
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

Refer to the 2024 Proposed and Modified MVPs Guide for information about newly proposed MVPs and proposals to update existing MVPs.

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
Quality Performance Category			
Quality Measures	**Quality Measure Inventory** There are 198 quality measures available for the 2023 performance period, excluding Qualified Clinical Data Registry (QCDR) measures.	**Quality Measure Inventory** We're proposing changes to the quality measures inventory that would result in a total of 200 quality measures for the 2024 performance period. Note that QCDR measures are approved outside the rulemaking process and aren't included in this total. These proposals reflect: • Addition of 14 quality measures, including 1 composite measure and 7 high priority measures, of which 4 are patient-reported outcome measures. (See Appendix B)	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		• Removal of 12 quality measures from the MIPS quality measure inventory. (See Appendix C) • Partial removal of 3 quality measures from the MIPS quality measure inventory (proposed for removal for traditional MIPS and retained for MVP use only*). (See Appendix D). • Substantive changes to 59 existing quality measures. * Measures are retained for use in MVP reporting to ensure the robust and comprehensive capture of quality data aligns with the MVP topic in cases where the replacement measure wouldn't be appropriate for the topic and clinicians reporting.	
Quality Measures	**Collection Types for Shared Savings Program Accountable Care Organizations (ACOs)** Shared Savings Program ACOs can report their quality measures under the APP using the following collection types for the 2024 performance period: • CMS Web Interface Measures • Electronic Clinical Quality Measures (eCQMs)	**Collection Types for Shared Savings Program ACOs** We're proposing to establish a new collection type (the way in which data is collected for a measure), specifically for ACOs: Medicare CQMs, which can only be reported under the APP. • Under the Medicare CQM collection type, an ACO that participates in the Shared Savings Program would only be required to collect and report data on only the ACO's Medicare fee-for-	• **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	• MIPS Clinical Quality Measures (MIPS CQMs)	service beneficiaries that meet the proposed definition of a beneficiary eligible for Medicare CQM at § 425.20, instead of its all payer/all patient population. • The addition of Medicare CQMs as a collection type is intended to address some of the data aggregation and patient matching issues Shared Savings Program ACOs experienced when reporting eCQMs and MIPS CQMs under the APP.	
Quality Measures	**Data Completeness** In the CY 2023 PFS Final Rule, we finalized an increase to the data completeness threshold to 75% for the 2024 and 2025 performance periods. The data completeness threshold applies to: eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.	**Data Completeness** The data completeness threshold is applicable to: • All patients, regardless of payer, for eCQMs, MIPS CQMs, and QCDR measures. • Medicare Part B patients for Medicare Part B claims measures (small practices only). • Beneficiaries that meet the proposed definition of a beneficiary eligible for Medicare CQM at § 425.20 for Medicare CQMs (Shared Savings Program ACOs only). No changes proposed to the 75% data completeness threshold previously finalized for the 2024 or 2025 performance periods for eCQMs, MIPS CQMs,	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		Medicare Part B claims measures, and QCDR measures. We're proposing the following data completeness thresholds for subsequent performance periods (for eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures): • 75% for the 2026 performance period. 80% for the 2027 performance period. We're also proposing the following data completeness criteria thresholds for Medicare CQMs: • 75% for the 2024,2025 and 2026 performance periods. • 80% for the 2027 performance period.	

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
Quality Measures	**Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey** We changed the case-mix adjustor to use the "Spanish language spoken at home," Asian language spoken at home," and "other language spoken at home." • The refinement 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.	**CAHPS for MIPS Survey** We're proposing to require groups, virtual groups, subgroups, and APM Entities to contract with a CAHPS for MIPS survey vendor to administer the Spanish survey translation to Spanish-preferring patients using the procedures detailed in the CAHPS for MIPS Quality Assurance Guidelines. We're also recommending that groups, virtual groups, subgroups, and APM Entities administer the CAHPS for MIPS Survey in the other available translations (Cantonese, Korean, Mandarin, Portuguese, Russian, and Vietnamese).	• **Traditional MIPS** • **MVPs** • **APP**
Quality Measures	**ICD-10 Coding Changes** • Measures are truncated (9-month performance period) when there's a **more than 10% change** in codes in the measure numerator, denominator, exclusions, and exceptions; clinical guideline changes or new products or procedures reflected in ICD–10 code changes effective October 1 each year. (In this circumstance, eCQMs have been suppressed.)	**ICD-10 Coding Changes** We're proposing to modify the criteria used to assess ICD-10 coding updates: • **Eliminate the automatic 10% threshold** of coding changes that triggers measure suppression or truncation. • Assess the impact of coding changes on a case-by-case basis (i.e., assess if coding changes are substantive, particularly to determine whether or not the coding changes impact the numerator,	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		denominator, exceptions, exclusions, or other elements of a measure that would change the scope or intent of a measure). • Assess each collection type separately of a given measure in order to determine the appropriate action to take for a measure affected by an ICD-10 coding update.	
Cost Performance Category			
Cost Improvement Scoring	**Calculation** The cost improvement score is determined for a MIPS eligible clinician that demonstrates improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period. • Under previously finalized policy, cost improvement scoring will be calculated **at the measure level**. • The cost improvement score is determined by comparing of the number of cost measures **with statistically significant change** (improvement or decline) in performance, based on application of a t-test.	**Calculation** We're proposing to calculate improvement scoring for the cost performance category **at the <u>category level</u> without using statistical significance beginning with the CY <u>2023</u> performance period/2025 MIPS payment year**. • This updated methodology would ensure mathematical and operational feasibility to allow for improvement to be scored in the cost performance category starting with the 2023 performance period/2025 MIPS payment year. • This update would also align with our methodology for scoring improvement in the quality performance category.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	*We note that this methodology hasn't been applied to date as cost improvement has yet to be scored.		
	Scoring The maximum cost improvement score available in the cost performance category beginning with the CY 2022 performance period/2024 MIPS payment year is **1 percentage point out of 100 percentage points**. • The cost performance category score is the sum of the following, not to exceed 100 percent: (1) the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points; and (2) the cost improvement score. *The cost improvement score can't be lower than zero.	**Scoring** We're proposing that the maximum cost improvement score of **1 percentage point out of 100 percentage points** will be available **beginning with the CY 2023 performance period/2025 MIPS payment year**. We're proposing that the maximum cost improvement score available for the **CY 2022 performance period/2024 MIPS payment year** will be **0 percentage points**.	• **Traditional MIPS** • **MVPs**
Measure Inventory	There are a total of 25 cost measures available: • Total per Cost Capita (TPCC) measure	In addition to the existing measures, we're proposing to **add 5 new episode-based cost measures** beginning with the CY 2024 performance period, each	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	• Medicare Spending per Beneficiary (MSBP) Clinician Measure • 23 episode-based cost measures	with a 20-episode case minimum. The measures are: • An acute inpatient medical condition measure (**Psychoses and Related Conditions**) • Three chronic condition measures (**Depression**, **Heart Failure**, and **Low Back Pain**) • A measure focusing on care provided in the emergency department setting (**Emergency Medicine**). We're proposing to **remove** the acute inpatient medical condition measure **Simple Pneumonia with Hospitalization**, **beginning with the CY 2024 performance period/2026 MIPS payment year**. • Due to coding changes, the measure no longer assesses the cost of pneumonia-related care as originally intended. We're also proposing to make the following changes to the operational list of care episode and patient condition groups and codes: • Add Emergency Medicine and Psychoses and Related Conditions as care episode groups. • Add Depression, Heart Failure, and Low Back Pain as patient condition groups. • Remove Simple Pneumonia with Hospitalization.	

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		If these proposals are finalized, there would be a total of 29 cost measures available beginning with the 2024 performance period.	
Improvement Activities Performance Category			
Improvement Activity Inventory	There are 104 improvement activities available for the 2023 performance period.	We're proposing to **add 5** new improvement activities (See Appendix E). These proposals include an MVP-specific improvement activity titled "Practice-Wide Quality Improvement in MIPS Value Pathways". • This improvement activity would allow clinicians to receive full credit in this performance category for adopting a formal model for quality improvement related to a minimum of 3 of the measures reported as part of a specific MVP. We're proposing to **modify 1** existing improvement activity. We're proposing to **remove 3** existing improvement activities (See Appendix F). If these proposals are finalized, there would be a total of 106 improvement activities in the MIPS inventory.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
Promoting Interoperability Performance Category			
Certified EHR Technology (CEHRT) Requirements	The current CEHRT definition, which specifies the set of certified technology that MIPS eligible clinicians must use for Promoting Interoperability, is tied to the 21st Century Cures Update of health IT certification criteria. • The requirement for the 2023 performance period is certification to the **2015 Edition Cures Update** criteria. **Shared Savings Program ACOs** • ACOs in a track that doesn't meet the financial risk standard to be an Advanced APM, which includes ACOs participating under BASIC track Levels A through D, must certify annually that at least 50% of the eligible clinicians participating in the ACO use CEHRT to document and communicate clinical care to their patients or other health care providers. • ACOs in a track that meets the financial risk standard to be an Advanced APM, which includes ACOs participating	We're proposing to update the CEHRT definition to align with the Office of the National Coordinator for Health IT (ONC)'s regulations. • In a recent proposed rule, ONC signaled a move away from the "edition" construct for certification criteria. • Instead, all certification criteria will be maintained and updated at 45 CFR 170.315. • We're proposing to align with this new definition for QPP and the Medicare Promoting Interoperability Program. **Shared Savings Program ACOs** We're proposing to remove the CEHRT threshold requirements for Shared Savings Program ACOs.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	under BASIC track Level E or the ENCHANCED track, must certify annually that at least 75% of the eligible clinicians participating in the ACO that use CEHRT to document and communicate clinical care to their patients or other health care providers.		
Applicability to Shared Savings Program ACOs	When participating in MIPS at the APM Entity level (reporting the APP, traditional MIPS or an MVP), APM Entities can now report Promoting Interoperability data at the APM Entity level. APM Entities still have the option to report this performance category at the individual and group level.	We're proposing that, unless otherwise excluded, all MIPS eligible clinicians, QPs, and Partial QPs participating in an ACO, regardless of track, satisfy all of the following: • Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS according to 42 CFR part 414 subpart O as either of the following: ++All MIPS eligible clinicians, QPs, and partial QPs participating in the ACO as an individual, group; or ++The ACO as an APM entity. • Earn a MIPS performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
Automatic Reweighting	Clinicians that qualify for automatic reweighting will have the Promoting Interoperability performance category automatically weighted at 0% of their final score; the weight would be redistributed to another performance category(ies) unless data were submitted for this performance category. Automatic reweighting applies to the following clinician types for the 2023 performance period: • 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	We're proposing to **continue** automatic reweighting for the following clinician type in the 2024 performance period: • **Clinical social workers** We note that we didn't propose to continue automatic reweighting for physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitians or nutrition professionals for the 2024 performance period. • These clinicians **won't** be automatically reweighted beginning with the 2024 performance period. No proposals to change automatic reweighting for ASC-based, hospital-based, or non-patient facing clinicians and groups, or for clinicians in a small practice. • These clinicians will continue to be automatically reweighted.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	• Non-patient facing • Small practice		
Performance Period	The performance period is a minimum of **90 continuous days** within the calendar year.	We're proposing to **increase** the performance period to a minimum of **180 continuous days** within the calendar year. • This proposal ensures that the MIPS Promoting Interoperability performance category continues to align with the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals.	• **Traditional MIPS** • **MVPs** • **APP**
Measures	**Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion** The current exclusion is available if a clinician or group "writes fewer than 100 permissible prescriptions during the performance period"	**Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion** We're proposing to modify this exclusion to the following: • "Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period." The current exclusion is too broad and doesn't necessarily accommodate clinicians who don't electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.	• **Traditional MIPS** • **MVPs** • **APP**
Measure Points	**Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure**	**Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure**	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	For the 2022 and 2023 performance periods a "yes" or a "no" response fulfills the SAFER Guide measure.	We're proposing to require a "yes" response for the SAFER Guide measure beginning with the CY 2024 performance period. • Clinicians only need to review the High Priority Practices SAFER guide.	• **APP**
Final Scoring			
Facility-Based Scoring	A facility-based score, if available, would be assigned to clinicians participating as a subgroup.	We're proposing a policy to clarify that we won't calculate a facility-based score at the subgroup level. • There's isn't a facility-based MVP. • Facility-based scores are only calculated as part of a final score in traditional MIPS* which isn't an available reporting option for subgroups. *A facility-based clinician or group can still report an MVP or the APP. In this instance we'd: • Calculate one final score in traditional MIPS using facility-based measurement, and • Calculate one final score from MVP or APP reporting, and • Assign the higher of these final scores.	• **MVPs**
Complex Patient Bonus	Beginning with the 2023 performance period, a complex patient bonus score will be added to the subgroup's final score.	We're proposing to add § 414.1365(e)(4)(i) to clarify that **beginning with the 2023 performance period/2025 MIPS payment year**, subgroups would	• **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		receive their affiliated group's complex patient bonus, if available.	
Performance Category Reweighting	For an MVP Participant that is a subgroup, any reweighting applied to its affiliated group will also be applied to the subgroup. • If reweighting isn't applied to the affiliated group, the subgroup may request reweighting independent of the affiliated group through a MIPS extreme and uncontrollable circumstances exception application.	We're proposing that subgroups would only receive reweighting based on any reweighting applied to its affiliated group. • Under current policy, we're only able to review and approve a subgroup's reweighting request after we confirmed an affiliated group didn't submit a reweighting request or if any reweighting was applied to the affiliated group. • Therefore, a subgroup wouldn't know of its reweighting status until later in the performance period. • We believe this delayed review of a subgroup's reweighting application disrupts the capability of a subgroup to determine its reweighting status and data submission needs.	• **MVPs**
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 proposing to use the mean of final scores from the **2017 – 2019 MIPS performance periods/2019 – 2021 MIPS payment years** to set the MIPS performance threshold. (In the CY 2022 PFS final rule, we selected the mean as the methodology for determining the performance threshold for the CY 2022 through 2024 performance periods/2024	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	We continued to use the **mean final score from the 2017 performance year/2019 MIPS payment year** to establish the performance threshold for the 2023 MIPS performance period/2025 MIPS payment year. • The performance threshold is set at **75 points**.	through 2026 MIPS payment years.) • This would **increase the performance threshold to 82 points** for the 2024 MIPS performance period/2026 MIPS payment year. This proposal stems from our reinterpretation of "prior period", within statutory language, such that it could mean a time span of 3 consecutive performance periods.	

Targeted Review	**Targeted Review Timeline**
	
	There is a 60-day period during which clinicians, groups, virtual groups and APM Entities can request a targeted review.
	
	• The 60-day period begins on the day CMS makes MIPS payment adjustment information available.
		Targeted Review Timeline
		
		We're proposing to **open the targeted review submission period upon release of MIPS final scores and to keep it open for 30 days after MIPS payment adjustments are released.**
		
		• This would maintain an approximately 60-day period for requesting a targeted review:
		  ○ 30 days **before** payment adjustments are released.
		  ○ 30 days **after** payment adjustments are released.
		
		To date, the targeted review process has allowed us to review and address concerns about whether a
			• **Traditional MIPS**
			• **MVPs**
			• **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
		clinician qualifies for Qualifying APM Participant (QP) designation. It's essential to compiling an accurate list of QPs, which is necessary for purposes of determining who will receive the application of the higher PFS conversion factor (also known as "qualifying APM conversion factor") of 0.75 percent (versus non-QPs, who will receive 0.25 percent) beginning in the 2026 payment year. This information must be available by October 1 so that accurate payments reflective of performance across QPP (that is, MIPS payment adjustments and PFS conversion factors) can be implemented as of January 1 of the payment year.	
	Targeted Review Documentation/Information Requests If CMS requests additional information under the targeted review process, the additional information must be provided to and received by CMS within 30 days of receipt of such request.	**Targeted Review Documentation/Information Requests** We're also proposing that, if CMS requests additional information under the targeted review process, that additional information must be provided to and received by CMS **within 15** days of receipt of such request. This proposal would also support our ability to finalize scores and QP status by October 1.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	Targeted Review Requests Targeted reviews may be submitted by or on behalf of individual clinicians, groups and APM Entities.	**Targeted Review Requests** We're proposing to add subgroups and virtual groups to the list of entities that may submit a request for a targeted review for the MIPS payment adjustment factor beginning with the 2023 MIPS performance period/2025 MIPS payment year.	• **MVPs (subgroups)** • **Traditional MIPS (virtual groups)**
Third Party Intermediaries			
Health Information Technology (IT) Vendors	Health IT vendors are a category of third party intermediaries, authorized to submit data on behalf of MIPS eligible clinicians. • Health IT vendors are required to support data submission for all performance categories in traditional MIPS. • Beginning with the 2023 MIPS performance period/2025 MIPS payment year, Health IT vendors must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. • Health IT vendors may also support the APP.	We're proposing to **eliminate the health IT vendor category of third party intermediaries**, beginning with the CY 2025 performance period, to remove gaps in third party intermediary requirements and improve data integrity. In order to submit data on behalf of clinicians, a health IT vendor would need to meet the requirements of and self-nominate to become a qualified registry or QCDR. They can continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.	• **Traditional MIPS** • **MVPs** • **APP**
Qualified Clinical Data Registries (QCDRs)	**Self-Nomination and Approval Policies** We refer you to § 42 CFR 414.1400(b)(2) and § 42 CFR 414.1400(b)(3) for information about	**Self-Nomination and Approval Policies** We're proposing the following policies related to the self-nomination and approval process for QCDRs and	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
and Qualified Registries	previously finalized policies related to self-nomination requirements and approval criteria.	qualified registries, including: • Updating self-nomination requirements to require that QCDRs and qualified registries must include MVP titles and measure and activity identifiers for the improvement activities and Promoting Interoperability performance categories. Specifying requirements for a simplified self-nomination form to existing Qualified Clinical Data Registries (QCDRs) and qualified registries in good standing. • Adding “measures submitted after self-nomination” to our list of reasons for rejecting a QCDR measure. • Implementing a requirement that QCDRs publicly post their approved measure specifications through the duration of the performance period and associated submission period. • Specifying the required sampling methodology for third party intermediary data validation audits. • Requiring QCDRs and qualified registries to attest to the accuracy of their information in qualified postings. • Requiring QCDRs and qualified registries to attest that they have the ability to provide CMS with access to review the data, upon request.	

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	Support of MVPs Beginning with the CY 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries must support MVPs that are applicable to the MVP participants on whose behalf they submit MIPS data. QCDRs and qualified registries may also support the APP. Third party intermediaries who support MVPs are required to support all measures and activities available in the MVP across the quality, improvement activities, and Promoting Interoperability performance categories. The exceptions to this requirement are the cost measures, population health measure, QCDR measures and the CAHPS for MIPS Survey measure.	**Support of MVPs** Given that many third party intermediaries may not support measures for clinicians in all specialty areas that might report a MVP, we're proposing to clarify that a QCDR or a qualified registry must support all measures and improvement activities available in the MVP with 2 exceptions: 1. If an MVP includes several specialties, then the QCDR or qualified registry is only expected to support the measures that are pertinent to the specialty of their clinicians. 2. QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR doesn't own the QCDR measures in the MVP, the QCDR can only support the QCDR measures if they have the appropriate permissions.	• **MVPs**
	Remedial Action and Termination Policies We may take remedial action if we determine that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, has submitted a false certification, or	**Remedial Action and Termination Policies** We're proposing the following policies related to third party intermediaries: • CMS would indicate in the public qualified postings that a third party intermediary has been placed on a remedial action plan or terminated.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS	Applicable MIPS Reporting Option(s)
	has submitted data that are inaccurate, unusable, or otherwise compromised. We may immediately or with advance notice terminate a third party intermediary for one or more of the following reasons: • CMS has grounds to impose remedial action; • CMS hasn't received a corrective action plan (CAP) within the specified time-period or the CAP is not accepted by CMS; or • The third party intermediary fails to correct the deficiencies or data errors by the date specified by CMS. • A data submission that contains data inaccuracies affecting the third party intermediary's total clinicians may lead to remedial action/termination of the third party intermediary for future program year(s) based on CMS discretion.	• CMS could take remedial action, including termination, for third party intermediaries that fail to maintain up-to-date contact information. • Third party intermediaries would be required to notify CMS when a CAP has been successfully completed. • CMS could initiate termination of third party intermediaries that are on remedial action for two consecutive years.	

Advanced Alternative Payment Models (APMs) Overview

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS
Advanced APMs	**Use of Certified Electronic Health Record Technology (CEHRT)** Our regulations at 42 C.F.R. § 414.1415 state that 75% of eligible clinicians in each participating APM Entity (for example, an ACO) must be required under the terms of the APM to use CEHRT in order for the APM to be an Advanced APM.	**Use of Certified Electronic Health Record Technology (CEHRT)** We're proposing to remove the numerical 75% threshold and specify that, to be an Advanced APM, the APM must require the use of certified EHR technology, which means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.
APM Incentive	**QP Determinations** For purposes of QP determination, we assess most eligible clinicians as a group at the APM Entity level.	**QP Determinations** We're proposing to make QP determinations at the individual eligible clinician level only, instead of the APM Entity level.
	QP and Partial QP Threshold Percentages	**QP and Partial QP Threshold Percentages**

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS
	The statutory QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer Option at 42 C.F.R. § 414.1430 provide the values for performance year 2022/payment year 2024 and performance year 2023/payment year 2025.	In accordance with the Consolidated Appropriations Act, 2023, the QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer Option are "frozen" for performance year 2023/payment year 2025; in other words, the values remain unchanged from last year. Under current statute, the QP threshold percentages will increase beginning with the 2024 performance year/2026 payment year. Medicare payments: • QP threshold increasing from 50% to 75% • Partial QP threshold increasing from 40% to 50% Medicare patients: • QP threshold increasing from 35% to 50% • Partial QP threshold increasing from 25% to 35%
	APM Incentive Payment and Transition to Qualifying APM Conversion Factor For payment years 2019-2024, the APM Incentive Payment is equal to 5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period (the calendar year immediately preceding the payment year).	**APM Incentive Payment and Transition to Qualifying APM Conversion Factor** In accordance with amendments made by the Consolidated Appropriations Act, 2023, the APM Incentive Payment with respect to payment year 2025 is 3.5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period.

POLICY AREA	EXISTING POLICY	CY 2024 NPRM PROPOSALS
		After the 2023 performance year/2025 payment year, the APM Incentive Payment will end. Instead, beginning for the 2024 performance year/2026 payment year, QPs will receive a higher Medicare Physician Fee Schedule (PFS) update ("qualifying APM conversion factor") of 0.75% compared to non-QPs, who will receive a 0.25% Medicare PFS update, which will result in a differentially higher PFS payment rate for eligible clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year.

Public Reporting via Doctors and Clinicians Care Compare Overview

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
Public Reporting	**Telehealth Indicators** We publicly report a telehealth indicator, as applicable and technically feasible, on individual clinician profile pages for those clinicians furnishing covered telehealth services to help empower patients' healthcare decisions.	**Telehealth Indicators** We're proposing to modify existing policy about identifying telehealth services furnished to inform the public reporting of telehealth indicators on individual clinician profile pages: • Instead of using specific Place of Service (POS) and claims modifier codes such as POS code 02, 10, or modifier 95, to identify telehealth services through annual rulemaking, we would use the most recent POS and claims modifier codes available as of the time the information is refreshed on clinician profile pages. We believe this proposal would give us more flexibility to ensure the accuracy of the telehealth indicator and reduce annual regulatory burden.
	Utilization Data We'll publicly report certain procedure information (utilization data) on individual clinician profile 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.	**Utilization Data** We're proposing to modify existing policies about publicly reporting procedure utilization data on individual clinician profile pages in the following ways:

POLICY AREA	EXISTING POLICY	CY 2023 PROPOSED
		• Provide additional procedure grouping flexibility for CMS to create clinically meaningful categories when one isn't available. • Publicly reporting Medicare Advantage (MA)[2] data, in addition to Medicare FFS utilization data counts, as appropriate and technically feasible, to address low volume counts and provide a more complete scope of a clinician's experience. • Removing the policy to publicly report on the Provider Data Catalog (PDC), a subset of procedures from the Medicare Public Use File (PUF) and instead, providing a single downloadable dataset reflecting the same utilization data that would appear on clinician profile pages. These proposals would address procedure category and procedure volume limitations, provide a more complete scope of a clinician's experience by adding MA data to procedure counts, align the data in the PDC with the procedural groupings shown on profile pages, and reduce redundancy with information already publicly available in the PUF.

[2] We propose amending § 422.310(f)(3) to align the release of this MA data with the existing disclosure timelines on the Care Compare website, thereby providing beneficiaries with the necessary information for choosing a healthcare provider.

How Do I Comment on the CY 2024 Proposed Rule?

The proposed rule includes directions for submitting comments. We must receive comments within the 60-day comment period. When commenting, refer to file code: CMS-1784-P.

We won't accept FAX transmissions. Use one of the 3 following ways to officially submit your comments:

- **Electronically:** www.regulations.gov
- **Regular mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1784-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- **Express or overnight mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1784-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

You can access the proposed rule through the "Regulatory Resources" section of the QPP Resource Library.

Contact Us

We will 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. Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-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. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History Table

Date	Change Description
07/13/2023	Original posting

Appendix A: Previously Finalized Policies for Calendar Year 2024

The table below identifies policies finalized in the CY 2022 or 2023 PFS Final Rules that apply in the 2024 performance period.

POLICY AREA	PREVIOUSLY FINALIZED POLICY APPLICABLE IN CALENDAR YEAR 2024
Quality Performance Category	
Collection Types	The 2024 performance year will be the final performance year that the CMS Web Interface will be an available collection type for Shared Savings Program ACOs reporting quality measures under the APP.
Data Completeness	We previously finalized a 75% data completeness threshold for the 2024 performance period.
Promoting Interoperability Performance Category	
Public Health and Clinical Data Exchange Objective	There are 2 levels of active engagement which must be submitted for the Public Health and Clinical Data Exchange Objective measures. • "Pre-production and Validation" • "Validated Data Production"
Third Party Intermediary Policies	
Termination	Beginning with the 2024 performance period, we're proposing to terminate 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.

Appendix B: New Quality Measures Proposed for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)	This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible. This eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate	eCQM	Intermediate Outcome	We are proposing this eCQM to enhance patient safety, drive quality care in diagnostic radiology, and assess outcomes of care for patients undergoing diagnostic CT imaging. This measure would improve patient safety by supporting clinician actions that are associated with a reduction in population-level cancer risks, in addition to associated cancer-related morbidity and mortality. As a result, this measure may also reduce the cost of caring for these patients. This measure would support radiologists with a clinically relevant outcome measure within MIPS and meet the high priority definition for MIPS reporting as an outcome and patient safety measure. This measure will enhance the accessibility of data contained in electronic clinical data systems for increased efficiency, which would decrease clinician burden.

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
	them into data elements that can be ingested by this eCQM. Additional details are included in the Guidance field.			
Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	The percentage of top-box responses among patients aged 18 years and older who had an ambulatory palliative care visit and report feeling heard and understood by their palliative care clinician and team within 2 months (60 days) of the ambulatory palliative care visit.	MIPS CQM	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are proposing this patient-reported outcome measure because it will fill a gap in the current quality measure inventory for patients in palliative care. Assessment of how well patients feel heard and understood complements and adds an important dimension to existing quality measures of care planning by including patient experience of care for this unique patient population. This measure is intended to facilitate and improve effective patient-provider communication that better engenders trust, acknowledgement, and a whole-person orientation to the care that is provided.
Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of	Percentage of pregnant or postpartum patients who received a CVD risk assessment with a standardized instrument.	MIPS CQM	Process	We are proposing this measure because it fills a high priority clinical gap area in MIPS under the wellness and prevention domain for maternal health. This process measure would address screening and care for pregnant/postpartum patients by

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument				assessing for the completion of a standardized CVD risk assessment for this high-risk population.
First Year Standardized Waitlist Ratio (FYSWR)	The number of incident (newly initiated on dialysis) patients in a practitioner (inclusive of physicians and advanced practice providers) group who are under the age of 75, and were listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis. The measure is calculated to compare the observed number of waitlist events in a practitioner group to its expected number of waitlist events. The measure uses the expected waitlist events calculated from a Cox model,	MIPS CQM	Process	We are proposing this measure because it is a CMS high priority clinical topic: patients with ESRD. This measure assesses whether patients that are in their first year of dialysis were placed on the kidney or kidney-pancreas transplant waitlist, or that the patient received a living donor transplant. Data submitted by the measure developer indicates a performance gap for a process that can be directly linked to improved patient outcomes. This measure is separate from the other transplant waitlist measure, the next measure listed below, as it is limited to assessing the first year after initiation of dialysis and the timely addition of those patients to transplant waitlist – a

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
	adjusted for age, patient comorbidities, and other risk factors at incidence of dialysis.			crucial step in driving positive outcomes in the patient population.
Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)	The percentage of patients in each dialysis practitioner group practice who were on the kidney or kidney-pancreas transplant waitlist (all patients or patients in active status). Results are averaged across patients prevalent on the last day of each month during the reporting year. The measure is a directly standardized percentage, which is adjusted for covariates (e.g., age and risk factors).	MIPS CQM	Process	We are proposing this measure because it is a CMS high priority clinical topic: patients with ESRD. This measure captures the adjusted count of patient months on the kidney and kidney-pancreas transplant waitlist for all dialysis patients in a dialysis practitioner or group practice by assessing patient status on the last day of each month during the reporting year and those on the transplant waitlist in active status as of the last day of the month during the reporting year. This process measure is directly linked to driving positive outcomes and measure data indicates a performance gap.
Preventive Care and Wellness (composite)	Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations	MIPS CQM	Process	We are proposing this composite measure which combines 7 current preventive care measures with age and sex appropriate preventive screenings and wellness services to create a robust, broadly encompassing preventive care assessment. The measure developer submitted data

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
	for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), American Association of Clinical Endocrinology (AACE), and American College of Endocrinology (ACE).			demonstrating a performance gap. Initially, the measure would be implemented as a weighted average analytic, representing performance for quality actions linked to positive patient outcomes.
Connection to Community Service Provider	Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.	MIPS CQM	Process	We are proposing this measure because it address 5 social and economic determinants CMS identified as both a measurement priority and performance gap. This measure assesses patients who screen positive for one or more of the 5 HRSNs (food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety) and had contact with a CSP (defined as any independent, for-profit, non-profit, state, territorial, or local agency capable of addressing core or supplemental HRSNs) for at least 1 of their HRSNs within 60 days after screening. This measure does contain an exclusion for patients to opt out of CSP. This measure leverages the data

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
				and experience from the CMMI Accountable Health Community (AHC) Model, which has screened nearly one million beneficiaries for HRSNs.
Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy	Percentage of patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) who, within seven (7) weeks following the date of injection, are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP =<25 mm Hg for injected eye OR if the IOP was >25 mm Hg, a plan of care was documented.	MIPS CQM	Process	We are proposing this measure because it would address the MIPS priority area of patient safety. This measure would directly evaluate intraocular pressure (IOP) after corticosteroid injections. Currently there are no measures in MIPS which address the screening and plan of care for elevated IOP following intravitreal or periocular steroid therapy. This measure may be important to provide measure options for retinal specialists.

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks.	MIPS CQM	Process	We are proposing this measure because this measure addresses the appropriate screening and follow-up for patients with posterior vitreous detachment (PVD). Currently, there are no measures in MIPS which address care improvement for patients at risk of retinal tears due to PVD. This measure would provide a clinically relevant measure option for retinal specialists.
Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) and acute vitreous hemorrhage in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks.	MIPS CQM	Process	We are proposing this measure because it would address the MIPS priority area of patient safety by incentivizing physicians to see patients in a timely manner. This measure addresses appropriate screening and follow-up for patients with PVD and acute vitreous hemorrhage, due to the increased risk for complications such as risk of retinal tears and subsequent retinal detachment in this population. When retinal tears are treated promptly, the risk of detachment decreases driving positive health outcomes. Currently, there are no measures in MIPS which address the appropriate

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
				screening and follow-up for patients with PVD and acute vitreous hemorrhage, due to the increased risk for complications such as risk of retinal tears and subsequent retinal detachment in this population. This measure would provide a clinically relevant may be important to provide measure option for retinal specialists.
Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	The percentage of patients aged 18 and older with a mental and/or substance use disorder who demonstrated improvement or maintenance of functioning based on results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) or Sheehan Disability Scale (SDS) 30 to 180 days after an index assessment.	MIPS CQM	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are proposing this measure because it is a high priority specialty area and high priority clinical topic, mental health, and substance use disorders, and is not duplicative of any existing measure within MIPS. This measure is comprehensive and broadly inclusive of mental health and substance use disorder and, uses a measurement-based care framework for implementation across various settings and populations to assess the outcome of care for patients with mental health and substance use disorders.

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Gains in Patient Activation Measure (PAM®) Scores at 12 Months	The Patient Activation Measure® (PAM®) is a 10- or 13- item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM® performance measure (PAM®-PM) is the change in score on the PAM® from baseline to follow-up measurement.	MIPS CQM	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are proposing this measure because this measure, while disease agnostic, addresses chronic conditions and patient reported outcomes, both of which are high-priority areas for measure consideration in MIPS. This PRO-PM provides a standardized method for clinicians to assess patient activation through the continuum of care. The PAM® survey collects information directly from patients regarding their knowledge, skill, and confidence in managing their health and healthcare. This measure has been used with a wide variety of chronic conditions, as well as with people with no medical diagnosis.
Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts,	Percentage of adults aged 18 years and older with suicidal ideation or behavior symptoms (based on results of a standardized assessment tool or screening tool) or increased suicide risk (based on the clinician's evaluation or clinician-rating tool) for whom a suicide safety plan is initiated, reviewed, and/or	MIPS CQM	Process	We are proposing this measure because it would address the MIPS priority area of behavioral health. This measure focuses on a process where initiating and reviewing a suicide safety plan with a patient at risk of suicide is a proxy for the clinical outcome of a reduction in suicides, suicide attempts, and suicidal ideation; thereby, addressing behavioral health.

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Behavior, Or Suicide Risk	updated in collaboration between the patient and their clinician.			
Reduction in Suicidal Ideation or Behavior Symptoms	The percentage of patients aged 18 years and older with a mental and/or substance use disorder AND suicidal thoughts, behaviors or risk symptoms who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale (C-SSRS) "Screen Version" or "Since Last Visit", within 120 days after an index assessment.	MIPS CQM	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are proposing this PRO-PM because this measure focuses on mental health and substance use disorder (SUD), which are a CMS high-priority area for MIPS measure consideration. This PRO-PM collects information related to a demonstrated reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale (C-SSRS) "Screen Version" versus "Since Last Visit", within 120 days after an index assessment.

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

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
014	MIPS CQM / Process	No	**Age-Related Macular Degeneration (AMD): Dilated Macular Examination:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity during one or more office visits within the 12 month performance period.	American Academy of Ophthalmology	End of Topped out Lifecycle.
093	MIPS CQM / Process	Yes	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngo-logy – Head and Neck Surgery	End of Topped out Lifecycle.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
107	eCQM / Process	No	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of all patient visits for those patients that turn 18 or older during the measurement period in which a new or recurrent diagnosis of major depressive disorder (MDD) was identified and a suicide risk assessment was completed during the visit.	Mathematica	Duplicative to new MUC2022-127: Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk measure being proposed for 2024.
110	Medicare Part B Claims Measure, eCQM, MIPS CQM / Process	No	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit during the measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization.	National Committee for Quality Assurance	Duplicative to measure Q493: Adult Immunization Status. Measure is being replaced by Q493: Adult Immunization Measure in all applicable MVPs.
111	Medicare Part B Claims Measure, eCQM, MIPS CQM / Process	No	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 66 years of age and older who have received a pneumococcal vaccine.	National Committee for Quality Assurance	Duplicative to measure Q493: Adult Immunization Status. Measure is being replaced by Q493: Adult Immunization Measure in all applicable MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
138	MIPS CQM / Process	Yes	**Melanoma: Coordination of Care:** Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	American Academy of Dermatology	End of Topped out Lifecycle.
147	Medicare Part B Claims Measure, MIPS CQM / Process	Yes	**Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy:** Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), etc.) that were performed.	Society of Nuclear Medicine and Molecular Imaging	End of Topped out Lifecycle.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
283	MIPS CQM / Process	No	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Academy of Neurology/American Psychiatric Association	End of Topped out Lifecycle.
324	MIPS CQM / Efficiency	Yes	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:** 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 asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment.	American College of Cardiology Foundation	Extremely Topped Out.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
391	MIPS CQM / Process	Yes	**Follow-Up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are submitted: • The percentage of discharges for which the patient received follow-up within 30 days after discharge • The percentage of discharges for which the patient received follow-up within 7 days after discharge.	National Committee for Quality Assurance	Attribution/Burden
402	MIPS CQM / Process	No	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance	Duplicative to measure Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Removal
436	Medicare Part B Claims Measure, MIPS CQM / Process	No	**Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques:** Percentage of final reports for patients aged 18 years and older undergoing computed tomography (CT) with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control. • Adjustment of the mA and/or kV according to patient size. • Use of iterative reconstruction technique.	American College of Radiology/ American Medical Association/ National Committee for Quality Assurance	Duplicative to new MUC2022-007: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) measure being proposed for 2024.

Appendix D: Quality Measure Removals from Traditional MIPS (Retained for MVPs) Proposed for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Partial Removal
112	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	N	**Breast Cancer Screening** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	National Committee for Quality Assurance	A more robust and comprehensive measure is proposed under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we propose to remove this measure from traditional MIPS and propose retention of this measure for use in relevant MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Partial Removal
113	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	N	**Colorectal Cancer Screening** Percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance	A more robust and comprehensive measure is proposed under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we propose to remove this measure from traditional MIPS and propose retention of this measure for use in relevant MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	2024 Proposed Rule Rationale for Partial Removal
128	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	N	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters.	Centers for Medicare & Medicaid Services	A more robust and comprehensive measure is proposed under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we propose to remove this measure from traditional MIPS and propose retention of this measure for use in relevant MVPs.

Appendix E: New Improvement Activities Proposed for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services	Establish policies and procedures to improve practice capacity to increase HIV prevention screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities: • Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening; • Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or • Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV testing processes, universal HIV screening, and PrEP initiation.	Medium / Population Management

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
Practice-Wide Quality Improvement in MIPS Value Pathways	Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity. Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following: • Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice; • Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff; • Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives;	High / N/A

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
	• Designate regular team meetings to review data and plan improvement cycles with defined, iterative goals as appropriate; and/or • Promote transparency and engage patients and families by sharing practice-level quality of care and patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data. In addition, clinicians may consider: • Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and • Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
Use of Decision Support to Improve Adherence to Cervical Cancer Screening and Management Guidelines (submitted by CDC)	Incorporate the Cervical Cancer Screening and Management (CCSM) Clinical Decision Support (CDS) tool within the electronic health record (EHR) system to provide clinicians with ready access to and assisted interpretation of the most up-to-date clinical practice guidelines in CCSM to ensure adequate screening, timely follow-up, and optimal patient care. The CCSM CDS helps ensure that patient populations receive adequate screening and management, according to evidence-based recommendations in the United States Preventive Services Task Force (USPSTF) screening and American Society for Colposcopy and Cervical Pathology (ASCCP) management guidelines for cervical cancer. The CDS integrates into the clinical workflow a clinician-facing dashboard to support the clinician's awareness and adoption of and preventive care for cervical cancer, including screening and any necessary follow-up treatment.	High / Population Management

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
	The CCSM CDS is fully conformant with the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, so it can be used with any certified EHR platform. The CDS Hooks and SMART-on-FHIR interoperability interface standards provide two ways to integrate with the clinical workflow in a way that complements existing displays and information pre-visit, during visit, and for post-visit follow-up. CCSM CDS helps the clinician evaluate the patient's clinical data against existing guidance and displays patient-specific recommendations.	
Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in-patient care plans.	High / Behavioral and Mental Health
Behavioral/Mental Health and Substance Use	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to	High / Behavioral and Mental Health

ACTIVITY TITLE	ACTIVITY DESCRIPTION	ACTIVITY WEIGHT / SUBCATEGORY
Screening & Referral for Older Adults	treatment and/or referral to appropriate social services, and document this in-patient care plans.	

Appendix F: Improvement Activities Proposed for Removal for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

Activity ID	Activity Title and Description	Activity Weight / Subcategory
IA_BMH_6	Implementation of co-location PCP and MH services	Medium / Behavioral and Mental Health
IA_BMH_13	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder	Medium / Behavioral and Mental Health
IA_ PSPA_29	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	High / Patient Safety and Practice Assessment