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2023 Quality Payment Program
Final Rule Summary

On Tuesday, November 1, 2022, the Centers for Medicare and Medicaid Services (CMS) issued the 2023 Quality Payment Program (QPP) final rule that includes updates to the current program, the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP) framework, Alternative Payment Model (APM), and the APM Performance Pathway (APP).

The QPP encompasses the MIPS and the Alternative Payment Model (APM) programs, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It is important that radiation oncology practices understand key aspects of the QPP, which include a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

MIPS

MIPS Scoring Methodology

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. Also, as required by law, beginning with the 2022 performance year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. Therefore, the performance category weights remain the same for the 2023 performance period:

- Quality – 30 percent
- Improvement Activities – 15 percent
- Promoting Interoperability – 25 percent
- Cost – 30 percent

CMS finalized setting the performance threshold at 75 points for the 2023 performance year based on the mean score from the 2017 performance year. CMS notes that the 2022 performance year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance. The $500 million exception performance fund was included in MACRA for the 2017-2022 performance years only. Only budget neutral adjustments will apply in future years.

The payment adjustment for 2025 (based on 2023 performance) will range from -9 percent to +9 percent, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), excluding Part B drugs.

Facility-Based Measurement

CMS finalized its proposal to permit facility-based measurement of a virtual group so long as it meets the specified eligibility standards beginning with the 2023 performance period.

Additionally, the Agency is finalizing that a MIPS-eligible clinician is eligible for facility-based measurement only if CMS determines it eligible to be facility-based.

The Agency also finalized its proposal to permit facility-based measurement of a virtual group given it meets the specified eligibility standards of having 75% or more of the eligible clinicians in the virtual group and meets the definition of a facility-based MIPS eligible clinician. Therefore, CMS will score eligible virtual groups under facility-based measurement even if no data were submitted. By electing to form a virtual group, virtual groups signal their intent to participate and be scored as a virtual group.

Bonus Points

Complex Patients

CMS finalized its proposal that a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they do not submit for at least one MIPS performance category.

Small Practice Bonus

CMS is retaining the small practice bonus of six points for the 2023 performance year to be applied to the 2025 payment year. The bonus will continue to be added to the Quality performance category. To receive the bonus, a small practice must submit Quality data. This applies to individual clinicians, group practices, virtual groups, and MIPS APM entities that consist of 15 or fewer clinicians.

Quality Performance Category

CMS finalized its proposal to increase the data completeness threshold to 75% for the 2024 and 2025 performance periods. The data completeness threshold remains at 70% for the 2023 performance period and refers to the number of applicable patients included in the quality measures submission. CMS believes that the threshold submitted for each measure is expected to be representative of the individual clinician's overall performance for that measure. The data completeness threshold of less than 100 percent is intended to reduce burden and accommodate operational issues that may arise during data collection during the initial years of the program.

The Agency also finalized that beginning with the 2023 performance period, CMS will calculate a benchmark for an "administrative claims" quality measure using the performance on the measure during the current performance period.

New Measures

CMS finalized the addition of "Screening for Social Drivers of Health" measure to assess the percent of patients who are 18 years or older screened for food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. This measure aligns with the Agency's commitment to introduce plans to close equity gaps and promote health equity

through quality measures, including to "develop and implement measures that reflect social and economic determinants."

Additionally, the Agency finalized the addition of the following measure to the Radiation Oncology Measure Set:

- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. CMS added this measure to the Radiation Oncology specialty set, as it is clinically relevant to this clinician type. This quality measure reinforces the importance that all clinicians should be actively addressing tobacco use across all patient care settings. Decreasing the usage of tobacco will reduce risk of heart disease, lung disease and stroke, lower the prevalence of severe diseases that may be associated with hospitalization, and decrease overall health care costs.

However, the Agency did not finalize its proposal to add the following measure to the Radiation Oncology Measure Set:

- Screening for Social Drivers of Health: The Agency believes that it is critical for individual MIPS eligible clinicians, groups, and virtual groups to have the option of choice in selecting and reporting such a measure. The Radiation Oncology Measure Set would contain five MIPS quality measures if the Screening for Social Drivers of Health measure were implemented within this set. For specialty sets that contain more than six MIPS quality measures, individual MIPS eligible clinicians, groups, and virtual groups have the flexibility to select a minimum of six MIPS quality measures to report to meet the MIPS reporting requirement for the quality performance category. For specialty sets that contain six or less MIPS quality measures, individual MIPS eligible clinicians, groups, and virtual groups must report on all MIPS quality measures within the specialty set. In the case of the Radiation Oncology Measure Set, this measure would inadvertently become mandatory to report. While the Agency believes that the Screening for Social Drivers of Health measure is an important topic for radiation oncologists to assess within their patient population, the inclusion of such measure within this set would eliminate the option of choice to select and report such a measure.

High-Priority Measures

CMS defines a high-priority measure as:

- Outcome (including intermediate-outcome and patient-reported outcome) quality measure,
- Appropriate use quality measure,
- Patient safety quality measure,
- Efficiency quality measure,
- Patient experience quality measure,
- Care coordination quality measure, or
- Opioid-related quality measure.

The Agency finalized its proposal to expand the definition of a high-priority measure to include health equity-related quality measures in order to incentivize the adoption of health equity measures by MIPS eligible clinicians.

Cost Performance Category

Cost Improvement Scoring

CMS finalized its proposal to establish a maximum cost improvement score of 1 percentage point out of 100 percentage points available for the cost performance category starting with the 2022 performance period. This policy would adhere to the statutory requirement of accounting for improvement in the assessment of performance under the cost category.

Medicare Spending Per Beneficiary (MSPB) Clinician Measure

CMS finalized its proposal to update the operational list of care episode and patient condition groups and codes by adding the MSPB Clinician cost measure as a care episode group. The Agency believes that because the measure considers the patient's clinical diagnoses at the time of an inpatient hospitalization and includes the costs of various items and services furnished during an episode of care. The MSPB Clinician measure is constructed using many aspects of the same logic as episode-based measures based on the care episode groups currently on the operational list. Both the MSPB Clinician and the episode-based measures are based on clearly defined episodes and include the services that are clinically related to the clinician's role in the care being assessed.

Improvement Activities Performance Category

The Agency finalized its proposal to add the following activities:

1. Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
2. Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
3. Create and Implement a Language Access Plan
4. COVID-19 Vaccine Promotion for Practice Staff

The Agency finalized its proposal to remove the following activities:

1. Participation in a QCDR that promotes use of patient engagement tools
2. Participation in a QCDR that promotes collaborative learning network opportunities that are interactive
3. Use of a QCDR for feedback reports that incorporate population health
4. Consultation of the Prescription Drug Monitoring Program
5. Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
6. PCI Bleeding Campaign

Promoting Interoperability (PI) Performance Category

In 2022, eligible clinicians could either utilize Certified Electronic Health Record Technology (CEHRT) with a 2015 Base or 2015 Cures Edition rating. Starting in 2023, health care providers will be required to use only certified technology updated to the 2015 Cures Update for EHR reporting to align with federal vendor requirements that go into effect on December 31, 2022. However, health care providers are not required to meet the CEHRT definitions immediately upon the transition date of December 31, 2022. In accordance with the EHR reporting period and performance period established for the Medicare Promoting Interoperability Program and the MIPS Promoting Interoperability performance category, participants are only required to use technology meeting the CEHRT definitions during a self-selected EHR reporting period or performance period of a minimum of any consecutive 90 days in CY 2023, including the final 90 days of 2023.

CMS finalized its proposal to discontinue automatic reweighting for the following clinician types beginning with the 2023 performance period: nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. In addition, the Agency finalized its proposal to continue automatic reweighting for the following clinician types in the 2023 performance period, but not for future performance periods: physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professions. CMS also finalized its proposal to continue the existing policy of reweighting the PI performance category for clinical social workers for the 2023 performance period.

Electronic Prescribing Objective

CMS finalized its proposal to make the Query of Prescription Drug Monitoring Program (PDMP) measure required beginning with the 2023 performance period worth 10 points. The Agency also finalized its proposal to expand the scope of the measure to include not only Schedule II opioids, but also Schedules III and IV drugs. CMS believes that this expansion will further support HHS initiatives related to the treatment of opioid and substance use disorders by expanding the types of drugs included in the Query of PDMP measure while aligning with the PDMP requirements in a majority of States. According to the Agency, the expansion to include additional scheduled drugs will facilitate more informed prescribing practices and improve patient outcomes.

The Agency finalized two exclusions to this measure:

1. Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period, and
2. Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

Health Information Exchange Objective

The Agency finalized its proposal for a third option for satisfying the Health Information Exchange (HIE) objective for the 2023 performance period. Participation in the Trusted Exchange Framework and Common Agreement (TEFCA) will require the MIPS eligible clinician to attest "yes" that the MIPS eligible clinician is a signatory to a Framework Agreement, as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on the Office of the National Coordinator for Health Information Technology (ONC) website, and use CEHRT to exchange information under this Agreement. CMS believes that this new measure will incentivize MIPS eligible clinicians to exchange information by connecting directly or indirectly to a Qualified Health Information Network (QHIN) and support health information exchange at a national level. CMS finalized that a MIPS eligible clinician would attest to the following:

- Participating as a signatory to a Framework Agreement in good standing and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy; and
- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement, which includes capabilities that support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI).

Public Health and Clinical Data Exchange Objective

CMS finalized its proposal that MIPS eligible clinicians submit their level of active engagement for each measure they report beginning with the 2023 performance period in addition to submitting responses for the required measures and any optional measures a MIPS eligible clinician chooses to report. A MIPS eligible clinician must demonstrate their level of active engagement at either Option 1 (Pre-production and Validation) or Option 2 (Validated Data Production) to fulfill each measure beginning with the CY 2023 performance period.

Finalized Scoring Methodology for 2023 Performance Period (Finalized changes in *italics*.)

Objective	Measure	Maximum Points	Redistribution if exclusion is claimed
Electronic Prescribing	e-Prescribing	10 points	10 points to HIE objective
	Query of PDMP	*10 points (required)*	10 points to e-Prescribing measure
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	*15 points (was 20)*	15 points to Provide Patients Electronic Access to Their Health Information measure
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	*15 points (was 20)*	15 points to the Support Electronic Referral Loops by Sending Health Information measure
	OR		
	HIE Bi-Directional Exchange	*30 points (was 40)*	No exclusion
	OR		
	Enabling Exchange under TEFCA	*30 points*	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	*25 points (was 40)*	No exclusion
Public Health and Clinical Data Exchange	*Report the following two measures:* • *Immunization Registry Reporting* • *Electronic Case Reporting*	*25 points (was 10)*	If an exclusion is claimed for both measures, 25 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
	Report one of the following measures: • *Syndromic Surveillance Reporting* • *Public Health Registry Reporting* • *Clinical Data Registry Reporting*	*5 points (bonus)*	
Protect Patient Health Information	Security Risk Assessment Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)	Required, but not scored.	No exclusion

MIPS Value Pathways (MVP)

In 2021, CMS introduced the Merit Based Incentive Program Value Pathways (MVPs). MVPs are a subset of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning in the 2023 performance year. CMS established the following guiding principles associated with MVPs in the 2022 MPFS Final Rule:

- MVP must include at least one outcome measure that is relevant to the MVP topic, so MVP Participants are measured on outcomes that are meaningful to the care they provide.
- Each MVP that is applicable to more than one clinician specialty should include at least one outcome measure that is relevant to each clinician specialty included.
- In instances when outcome measures are not available, each MVP must include at least one high priority measure that is relevant to the MVP topic, so MVP Participants are measured on high priority measures that are meaningful to the care they provide.
- Allow the inclusion of outcomes-based administrative claims measures within the quality component of an MVP.
- Each MVP must include at least one high priority measure that is relevant to each clinician specialty included.
- To be included in an MVP, a qualified clinical data registry (QCDR) measure must be fully tested.

CMS developed the framework to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, the MVP framework incorporates a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health in order to reduce reporting burden.

MVPs have the following reporting criteria:

- Quality Performance Category: MVP Participants will select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome isn't available or applicable). This can include an outcome measure calculated by CMS through administrative claims, if available in the MVP.
- Improvement Activities Performance Category: MVP Participants will select two medium-weighted improvement activities OR one high-weighted improvement activity OR participation in a patient-centered medical home if it is already included in the MVP.
- Promoting Interoperability Performance Category: MVP Participants will report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualify for reweighting of the Promoting Interoperability performance category.

- Cost Performance Category: MVP Participants will be scored on the cost measures included in the MVP that they select and report.
- Foundational Layer (MVP-agnostic): Population Health Measures: MVP Participants will select one population health measure to be calculated on. The results will be added to the quality score.

The Agency finalized the addition of five new MVP and revised the seven previously established MVP that will be available beginning with the 2023 performance year.

The five new proposed MVP for the 2023 performance year are:

1. Advancing Cancer Care (see below for more information)
2. Optimal Care for Kidney Health
3. Optimal Care for Patients with Episodic Neurological Conditions
4. Supporting Care for Neurodegenerative Conditions
5. Promoting Wellness

Subgroups

CMS previously finalized its proposal that registration for subgroup participation would take place between April 1 and November 30 of the performance year. In addition to the required subgroup registration information, the Agency finalized its proposal to require a description of the composition of the subgroup, which may be selected from a list or described in a narrative. The Agency also finalized that a clinician (identified by National Provider Identifier (NPI)) will only be allowed to register for one subgroup per Taxpayer Identification Number (TIN).

Subgroup Scoring

For measures calculated through administrative claims, CMS finalized its proposal to calculate and score these measures at the TIN level (of the affiliate group), not at the subgroup level:

- **Foundational Layer (MVP Agnostic):** for each selected population health measure in an MVP, subgroups will be assigned the affiliated group's score, if available. In instances where a group score is not available, each such measure is excluded from the subgroup's final score.
- **Quality Performance Category:** for each selected outcomes-based administrative claims measure in an MVP, subgroups will be assigned the affiliate group's score, if available. In instances where a group score is not available, each such measure will be assigned a zero score.
- **Cost Performance Category:** subgroups will be assigned the affiliated group's cost score, if available for the cost performance category in an MVP. In instances where a group score is not available, each such measure is excluded from the subgroup's final score.

Finally, CMS finalized its proposal to not assign a score for a subgroup that registers but does not submit data as a subgroup.

Advancing Cancer MIPS Value Pathway

In the 2023 MPFS final rule, CMS establishes the Advancing Care MIPS Value Pathway (MVP). According to the Agency, the MVP framework aims to reduce complexity and burden, move toward more meaningful measurement, capture the patient voice, and move to higher value care.

In the Advancing Cancer MVP, CMS includes the following eleven MIPS quality measures and two QCDR measures within the quality component that assess the patient experience of care, end of life care, and appropriate diagnostics along with possible treatment options for different cancer diagnoses:

- Q143: Oncology: Medical and Radiation – Pain Intensity Quantified
- Q144: Oncology: Medical and Radiation – Plan of Care for Pain
- Q450: Appropriate Treatment for Patients with Stage I (T1c) -III HER 2 Positive Breast Cancer
- Q451: RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor (EHFGR) Monoclonal Antibody Therapy
- Q452: Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies
- Q453: Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
- Q457: Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days
- Q462: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy
- PIMSH2: Oncology: Utilization of GCSF in Metastatic Colorectal Cancer

In addition to the cancer care measures listed above, CMS is including the following broadly applicable MIPS quality measures that are relevant to cancer care. According to the Agency, these measures capture the patient's voice regarding their care and support patient mental health:

- Q047: Advance Care Plan
- Q134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan
- Q321: CAHPS for MIPS Clinician/Group Survey

Within the improvement activities component, CMS is including the following 13 improvement activities that promote patient engagement and patient-centeredness, health equity, shared decision making, and care coordination:

- IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
- IA_BE_15: Engagement of patients, family and caregivers in developing a care plan
- IA_BE_24: Financial Navigation Program
- IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
- IA_CC_17: Patient Navigator Program
- IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
- IA_PCMH: Electronic Submission of Patient Centered Medical Home accreditation
- IA_PM_14: Implementation of Methodologies for Improvements in Longitudinal Care Management for High-Risk Patients
- IA_PM_15: Implementation of Episodic Care Management Practice Improvements
- IA_PM_16: Implementation of Medication Management Practice Improvements
- IA_PM_21: Advance Care Plan
- IA_PSPA_16: Use of Decision Support and Standardized Treatment Protocols

For the cost measure component, CMS is including the Total Per Capita Cost (TPCC) measure because it captures overall costs after establishing a primary care-type relationship.

The Foundational Layer of measures follow:

- Q479: Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups (finalized in CY 2021 PFS Final Rule)

- Q484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (finalized in CY 2022 PFS Final Rule)

According to the 2023 MPFS final rule, the Advancing Care MVP is specific to medical, hematological, and gynecological oncologists. ASTRO noted in its proposed rule comment letter that the Advancing Care MVP description makes no mention of the role of the radiation oncologist. In the final rule, CMS acknowledged the concerns expressed by ASTRO, as well as others, who expressed concern that the MVP was "heavily skewed towards medical oncology." In response, the Agency stated "while we understand that this MVP may not be applicable to all services and providers within the umbrella of oncology, the goal of this MVP is to focus broadly on the care for patients with cancer."

Alternative Payment Models (APM)

Advanced APMs

In the 2023 MPFS final rule, CMS permanently establishes the generally applicable revenue-based nominal risk amount standard at 8% of the average estimated total Medicare Parts A and B

revenue of all providers and suppliers in participating APM Entities for the applicable QP Performance Period, beginning with the 2023 Advanced APM Qualified Participant (QP) Performance Period. In subsequent rules, the Agency had proposed increasing the revenue-based nominal risk about up to as much as 15%; however, those proposed increases were never finalized.

CMS is also making changes to requirements associated with Advanced APM participation. The Agency is making the Promoting Interoperability performance category at the APM Entity Level optional beginning with the 2023 performance period. Additionally, CMS clarified that an Advanced APM payment must be based on quality measures that are either on the finalized MIPS list of measures or endorsed by a consensus-based entity; **OR** determined by CMS to be evidence-based, reliable, and valid. Subsequent regulatory guidance was unclear and there was some confusion regarding whether two measures are required to meet these two criteria. The final rule confirmed that the criterion can be met through the use of a single quality measure.

CMS also finalized its decision to modify the QP determination policy, which initially involved determination at the APM Entity group level. The new policy allows the Agency to establish QP status at the individual eligible clinical level as well. CMS is pursuing this modification to address the practice of APM Entities removing specialists, who were frequently unable to meet QP threshold requirements, from their participation lists in an effort increase the number of eligible clinicians who are determined QPs.

Finally, the Agency sought comment on the transition from the Advanced APM Incentive Payment of 5% to the Enhanced PFS Conversion Factor Update for QPs, which is set at .75% beginning in 2026. CMS recognizes that there is a significant range of potential positive payment adjustments under MIPS that would exceed the higher QP conversion factor. As a result, the QP conversion factor is not expected to equate to the anticipated max available positive payment under MIPS until after 2035. While CMS did not offer any remedies to address this issue, the Agency did note that it would monitor the situation and continue to solicit feedback.

Additional Resources:

CMS 2023 Quality Payment Program Final Rule Resources

2023 Quality Payment Program final rule

ASTRO Quality Payment Program resources