

2023 Quality Payment Program Proposed Rule Summary

On Thursday, July 7, 2022, the Centers for Medicare and Medicaid Services (CMS) issued the 2023 Quality Payment Program (QPP) proposed 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. Comments in response to the proposed rule are due September 7, 2022.

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 is proposing to set 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 2023 performance year is the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

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 is proposing 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 proposing that a MIPS eligible clinician is eligible for facility-based measurement only if CMS determines it eligible to be facility-based.

The Agency is also proposing 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. Under this proposal, CMS would 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 is proposing 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 is proposing 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.

The Agency is proposing 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 is proposing 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 would align 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 is proposing to add the following measures to the Radiation Oncology Measure set:

- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Screening for Social Drivers of Health

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 is proposing 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 is proposing 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 2023 performance period. This proposed 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 is proposing 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

CMS is not proposing any changes to the traditional MIPS improvement activities policies for the 2023 performance period. However, the Agency is proposing changes to the improvement activity inventory for the 2023 performance period.

The Agency is proposing the addition of 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 is proposing the removal of 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

CMS is proposing 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 is proposing 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 dietitians or nutrition professions. CMS is also proposing to continue the existing policy of reweighting the PI performance category for clinical social workers for the 2023 performance period.

Electronic Prescribing Objective

CMS is proposing to make the Query of Prescription Drug Monitoring Program (PDMP) measure required beginning with the 2023 performance period worth 10 points. The Agency is also proposing 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 would 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 would facilitate more informed prescribing practices and improve patient outcomes.

The Agency is proposing 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 is proposing 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) would 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 certified electronic health record technology (CEHRT) to exchange information under this Agreement. CMS believes that this new measure would 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.

Public Health and Clinical Data Exchange Objective

CMS is proposing 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.

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

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Query of PDMP	<i>10 points (required)</i>
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	<i>15 points (was 20)</i>
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	<i>15 points (was 20)</i>
	OR	
	HIE Bi-Directional Exchange	<i>30 points (was 40)</i>
	OR	
	<i>Enabling Exchange under TEFCA</i>	<i>30 points</i>
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	<i>25 points (was 40)</i>
Public Health and Clinical Data Exchange	<i>Report the following two measures:</i> <ul style="list-style-type: none"> • <i>Immunization Registry Reporting</i> • <i>Electronic Case Reporting</i> 	<i>25 points (was 10)</i>
	<i>Report one of the following measures:</i> <ul style="list-style-type: none"> • <i>Syndromic Surveillance Reporting</i> • <i>Public Health Registry Reporting</i> • <i>Clinical Data Registry Reporting</i> 	<i>5 points (bonus)</i>
Protect Patient Health Information	Security Risk Assessment Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)	Required, but not scored.

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 is proposing the addition of five new MVP and revising the seven previously established MVP that would 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 is proposing to require a description of the composition of the subgroup, which may be selected from a list or described in a narrative. The Agency is also proposing that a clinician (identified by National Provider Identifier (NPI)) would only be allowed to register for one subgroup per Taxpayer Identification Number (TIN).

Subgroup Scoring

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

- **Foundational Layer (MVP Agnostic):** CMS is proposing for each selected population health measure in an MVP, subgroups would 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:** CMS is proposing for each selected outcomes-based administrative claims measure in an MVP, subgroups would 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:** CMS is proposing that subgroups would 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 is proposing to not assign a score for a subgroup that registers but does not submit data as a subgroup.

Advancing Cancer MIPS Value Pathway

CMS is proposing the introduction of the Advancing Care MIPS Value Pathway (MVP), which would include 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
- PIMSH8: Oncology: Mutation Testing for Lung Cancer Completed Prior to Start of Targeted Therapy

In addition to the cancer care measures listed above, CMS is also proposing to include 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 proposing the following thirteen 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 proposing to include 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:

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

According to CMS, the Advancing Care MVP is specific to medical, hematological, and gynecological oncologists. The proposed rule makes no mention of the role of the radiation oncologist. CMS is seeking comments in response to the proposed parameters associated with the Advancing Cancer MVP.

Alternative Payment Models (APM)

Advanced APM

In the 2023 MPFS proposed rule, CMS lists the RO Model among the designated Advanced APMS for 2023. In April 2022, CMS proposed an indefinite hold on the RO Model. Given that the RO Model proposed rule has not yet been finalized it is reasonable that CMS would include the RO Model on its list of potential Advanced APMS in 2023. Once the RO Model proposed rule is finalized, ASTRO expects that the Agency will remove the model from the list of viable APMS in 2023.

CMS is seeking to permanently establish 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 previous rules, the Agency had proposed increasing the revenue-based nominal risk up to as much as 15%, however those proposed increases were never finalized. If finalized the 8% rate would be permanent.

CMS is proposing changes to requirements associated with Advanced APM participation. Specifically, the Agency is proposing to introduce an option for APM Entities to report the Promoting Interoperability performance category at the APM Entity Level. CMS is also issuing an RFI regarding QP determination calculations at the individual eligible clinical level only. The Agency is proposing this modification in order to reduce the practice of APM Entities removing specialists from their participation lists, increase the number of eligible clinicians who are

determined QPs, and eliminate QP status for those eligible clinicians whose individual participation is below the threshold score.

In the 2019 MPFS final rule, CMS finalized that 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. Subsequently, CMS revised its policy to require that payment be based on at least one outcomes measure unless there were no available or applicable outcomes measure. Since then, there has been some confusion regarding whether two measures are required to meet these two criteria. In the 2023 MPFS proposed rule, CMS is seeking to clarify that only one measure is necessary if it satisfies both criteria.

Finally, the Agency is seeking comment on the transition from the APM Incentive Payment of 5% to the Enhanced PFS Conversion Factor Update for QPs which is set at .75% beginning in 2026.

Requests for Information

CMS is seeking comment on the following Requests for Information:

- Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR)
- Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)
- MIPS Quality Performance Category Health Equity
- Patient Access to Health Information Measure
- Risk Indicators for the Complex Patient Bonus Formula
- Risk Indicators Within Complex Patient Bonus Formula to Continue to Align with CMS Approach to Operationalizing Health Equity
- Third Party Intermediary Support of MVP
- National Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities
- Value of Adding CME Accreditation Organizations as Third Party Intermediaries
- Criteria for Selecting the CME Accreditation Organizations
- Third Party Intermediary Implementation Policies
- Incorporating Health Equity into Public Reporting
- Quality Payment Program Incentives beginning in Performance Year 2023
- Potential Transition to Individual QP Determinations Only

Additional Resources:

CMS 2023 Quality Payment Program Proposed Rule [Resources](#)

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