Merit-based Incentive Payment System (MIPS)

CMS Web Interface Transition Guide

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How to Use This Guide

How to Use This Guide

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

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Hyperlinks

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

Overview

Background

In the Calendar Year (CY) 2022 Physician Fee Schedule Final Rule, we finalized policies regarding the sunset of the CMS Web Interface as a collection and submission type under the Merit-based Incentive Payment System (MIPS).

- The 2022 performance period will be the last performance period that groups, virtual groups, and Alternative Payment Model (APM) Entities reporting traditional MIPS can report quality data through the CMS Web Interface. Beginning with the 2023 performance period, these groups, virtual groups and APM Entities will need to use alternative options for collection and submitting their quality data.
- The 2024 performance period will be the last performance period that Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) reporting the APM Performance Pathway (APP) can report quality data through the CMS Web Interface. Beginning with the 2025 performance period, Shared Savings Program ACOs will need to use alternative options for collection and submitting the quality measures required by the APP.

NOTE: The policy to sunset the CMS Web Interface doesn't affect the 2022 performance period or the 2022 data submission period starting on January 3, 2023.

The policy relates to quality data collection beginning with the 2023 performance period (January 1-December 31, 2023) and its applicable 2023 data submission period, which starts in January of 2024.

Purpose

This guide provides the following information to groups and virtual groups that previously used the CMS Web Interface, in preparation for the sunsetting of the CMS Web Interface in traditional MIPS, beginning with the 2023 performance period:

- An overview of the traditional MIPS quality performance category requirements outside of the CMS Web Interface.
- Alternative options for quality data collection and submission in traditional MIPS.
- Key elements and timelines to consider as groups and virtual groups prepare for the transition of meeting traditional MIPS quality reporting requirements using an alternative option.

This guide **doesn't** review:

- Quality requirements under the APM Performance Pathway (APP).
  - This reporting framework is an option for any MIPS eligible clinician, group, or APM Entity that participates in a MIPS APM, and a requirement for Shared Savings Program ACOs.
- Reporting requirements for the MIPS Value Pathways (MVPs).
  - This reporting framework will be available to MIPS eligible clinicians, groups, subgroups, and APM Entities beginning with the 2023 performance period. For more information about reporting MVPs, please refer to the CY 2022 Physician Fee Schedule Final Rule Resources (ZIP) and the QPP website.

Alternative Reporting Options

Traditional MIPS Quality Reporting Requirements

For the 2023 performance period, the following outlines the general quality performance category data collection requirements for the alternative options (alternative options discussed in section, Alternative Reporting Options: Data Collection and Submission Types for Quality Measures).

- **Number of Measures:** Select at least 6 measures, including 1 outcome measure (if there isn't an applicable outcome measure, then report on a high-priority measure).
- **Data Completeness**: Report aggregated performance data for at least 70% of denominator eligible encounters (across all payers) that are eligible for each measure selected.
- **Case Minimum:** In order for a measure to be scored, a measure would need to have a minimum of 20 denominator eligible encounters for the measure.

Traditional MIPS Quality Reporting Requirements (Continued)

Table 1 provides a comparison between the CMS Web Interface requirements and alternative option requirements to illustrate some of the differences between the experiences. Any changes to the requirements for the 2023 performance period would be established through future rulemaking.

Table 1. Quality Performance Requirement Comparison

Quality Performance Category Basic Requirements	CMS Web Interface	Alternative Reporting Options
Registration	Pre-registration is required to report on the CMS Web Interface measures.	Pre-registration **isn't** required to report on quality measures using alternative options. **Exception:** Pre-registration is required to administer the CAHPS for MIPS Survey measure.
Measure Selection Options	Don't select measures. Must report on all 10 pre-determined measures.	Choose from approximately 200 MIPS quality measures, including measures that are **equivalent to measures currently reported through the CMS Web Interface.** Alternatively, groups and virtual groups can choose quality measures from a defined **specialty measure set** developed with input by specialty societies or boards, **or custom measures** developed by a Qualified Clinical Data Registry (QCDR).

Traditional MIPS Quality Reporting Requirements (Continued)

Table 1. Quality Performance Requirement Comparison (Continued)

Quality Performance Category Basic Requirements	CMS Web Interface	Alternative Reporting Options
# of Required Measures	Report on all 10 pre-determined measures.	Select and report on at least 6 measures. • One measure must include an outcome measure. If no outcome measures are applicable, you may report a high-priority measure instead.
Data Completeness	Report patient-level data for the first 248 consecutively ranked Medicare patients identified from the sample for each measure (or 100% of patients if there are fewer than 248 patients assigned to a measure). • Groups and virtual groups are reporting **performance data for individual patients from a sample for each measure**. • CMS assigns and ranks a group or virtual group's patient population for each measure.	Report aggregated performance data for at least 70% of denominator eligible encounters (across all payers) that are eligible for each measure you've selected. • Groups and virtual groups are reporting **performance data (numerators, denominators, etc.) aggregated for all denominator eligible encounters for each measure.** • CMS doesn't assign and rank a patient population based on a patient sample for groups or virtual groups to report data when using alternative options. Groups and virtual groups determine and identify their entire denominator eligible patient population, as defined within the measure specification.
Case Minimum	20 patients	20 denominator eligible encounters

Data Collection and Submission Types for Quality Measures

Collection Types

A collection type refers to the way data is collected for a quality measure. Data for one measure may be collected in multiple ways. Each collection type has its own specification (instructions) for how to report that measure and meet the data completeness/case minimum requirements. To become familiar with the various collection types and quality measures associated with the collections in advance of the 2023 performance period, please review the 2022 measure specifications. Table 2 outlines the different collection types and provides links to the 2022 measure specifications. (Table 2 doesn't include the Medicare Part B claims measure collection type, since it's only available to small practices with15 or fewer clinicians.) Please note that quality measures available for the 2023 performance period will be established through future rulemaking with the exception of QCDR measures.

Table 2. Quality Measure Collection Types

Collection Type	Quality Measures Available for 2022	What You Need to Know
Electronic Clinical Quality Measures (eCQM)	2022 eCQM specifications (ZIP) 2022 eCQM measure flows (ZIP)	• You'll need to ensure that your certified electronic health record technology (CEHRT) coding is updated to collect the most recent version of the eCQMs you've selected. • Groups and virtual groups that don't have CEHRT should anticipate 12 to 18 months to fully transition to the implementation of CEHRT; groups and virtual groups that haven't begun this transition should check with the electronic health record (EHR) vendor to determine if they'll need to explore a different collection type for the 2023 performance period. • **There's an eCQM equivalent for all 10 CMS Web Interface measures.**

MIPS Clinical Quality Measures (MIPS CQMs)	2022 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	• Performance data may be captured in your medical record (EHR or paper chart) and/or other data source(s). If you're collecting data in your EHR, you'll want to make sure that your system is coded to collect data according to the MIPS CQM specifications for your selected measures.
		• A group or virtual group can submit MIPS CQMs on their own if they can submit a properly formatted file.
		• A group or virtual group can work with a Qualified Clinical Data Registry (QCDR), Qualified Registry, or health information technology (IT) vendor to support data collection and submission.
		  ○ Not all QCDRs and Qualified Registries support all MIPS quality measures.
		• **There's a MIPS CQM equivalent for 9 of the 10 CMS Web Interface measures.**
		  ○ CARE-2/318 (Falls: Screening for Future Fall Risk) isn't available to report as a MIPS CQM.

Data Collection and Submission Types for Quality Measures (Continued)

Table 2. Quality Measure Collection Types (Continued)

Collection Type	Quality Measures Available for 2022	What You Need to Know
Qualified Clinical Data Registry (QCDR) Measures	2022 Qualified Clinical Data Registry (QCDR) Measure Specifications (XLSX)	• A group or virtual group can only report QCDR measures by working with a QCDR. ○ QCDRs have their own set of measures that have been developed and tested. The measures are reviewed and approved by CMS for implementation and use within MIPS. QCDRs support groups and virtual groups in the submission of the measure data to CMS. • QCDR measures submitted for CMS review are approved outside of the rulemaking process. • These measures can be a great option for groups and virtual groups that provide specialized care or have trouble finding MIPS quality measures that are relevant to their group or virtual group. • There are no QCDR measure equivalents to CMS Web Interface measures.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey	2021 CAHPS for MIPS Survey Overview Fact Sheet (PDF) (2022 Fact Sheet Available March 2022)	• The CAHPS for MIPS Survey measure offers an opportunity for groups and virtual groups to capture the patient voice. • This survey measure **counts as 1 of the required 6 measures**. • This survey measure satisfies the requirement to report an outcome measure. • Groups and virtual groups that want to administer this survey must register during the performance period (between April 1 and June 30) and authorize a CMS-approved certified survey vendor to administer the survey on their behalf.
Administrative Claims Measures	• We review Medicare claims data for groups and virtual groups to determine if they meet the case minimum for any administrative claims measures. • If a group or virtual group meets the case minimum, we'll use Medicare claims data to calculate performance. • There's no data collection or submission requirement, since performance is calculated for the group or virtual group.	

Data Collection and Submission Types for Quality Measures (Continued)

Submission Types

In addition to selecting quality measures and collecting data for each measure, groups and virtual groups will need to consider if they'll submit their own quality data or work with a third party intermediary to submit data on their behalf.

Submitting Data Using Third Party Intermediaries: QCDRs and Qualified Registries

QCDRs and Qualified Registries are vetted and approved by CMS to support data collection and submission of quality measures, Promoting Interoperability measures, and improvement activities on behalf of a group or virtual group.

- QCDRs and Qualified Registries are required to support all MIPS performance categories that require data submission, with some exceptions for the Promoting Interoperability performance category.
- QCDRs and Qualified Registries provide performance feedback at least 4 times a year. The feedback can help drive practice improvement and alert groups and virtual groups of the changes needed in workflows or processes to improve performance prior to submission.
- CMS publishes a list of approved organizations (with contact information, services offered, pricing, and the specific quality measures and/or QCDR measures they support) prior to the start of the performance period.

In general, the population of approved QCDRs and Qualified Registries is fairly consistent from year to year. We encourage groups and virtual groups to review the 2022 Qualified Postings to get a sense of the costs and services offered by these organizations.

- The 2022 Qualified Clinical Data Registry (QCDR) Qualified Posting (XLS) and 2022 Qualified Registry Qualified Posting (XLS) are available, and the 2023 Qualified Clinical Data Registry (QCDR) Qualified Posting and 2023 Qualified Registry Qualified Posting will be available in December of 2022.

Alternately, groups and virtual groups can choose to work with a health information technology (IT) vendor that isn't a QCDR or Qualified Registry. There isn't a vetting or approval process specific to MIPS for health IT vendors that aren't QCDRs or Qualified Registries, but you can search the Certified Health IT Product List (CHPL) for vendors ("developers") that offer CEHRT products.

Data Collection and Submission Types for Quality Measures (Continued)

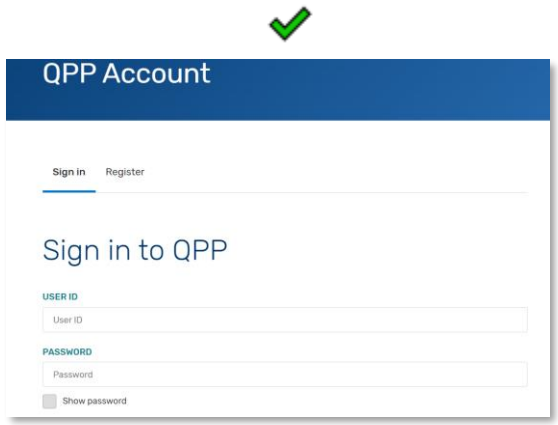
Submitting Data Yourself

The process for groups and virtual groups to submit their own eCQMs and/or MIPS CQMs is similar to the process experienced under the CMS Web Interface.

- The main challenge groups and virtual groups face when submitting their own data is the ability to properly format their submission according to the file specifications indicated below.

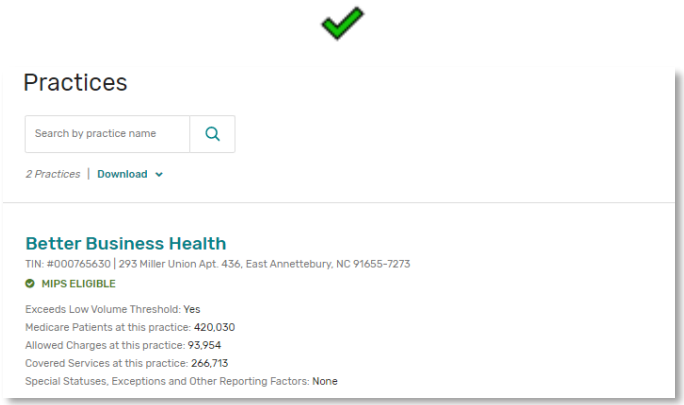
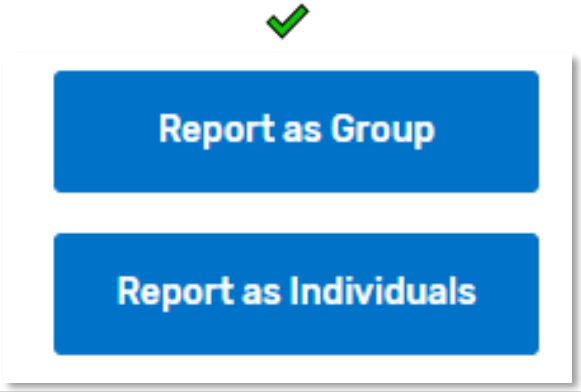
(**NOTE:** The following screenshots reflect the data submission user-experience for the 2021 performance period. There may be differences in the user-experience for future submission periods.)

Table 3. Data Submission Process on the QPP Website

	CMS Web Interface	eCQMs and/or MIPS CQMs
1. Sign in to the QPP website		

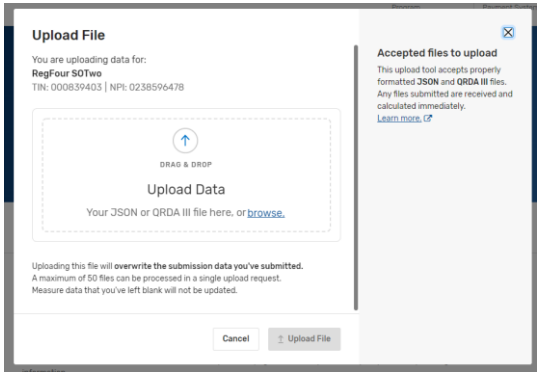
Data Collection and Submission Types for Quality Measures (Continued)

Table 3. Data Submission Process on the QPP Website (Continued)

	CMS Web Interface	eCQMs and/or MIPS CQMs
2. Find your practice (or virtual group)		
3. Select "Report as a Group" (or Report as a Virtual Group)		

Data Collection and Submission Types for Quality Measures (Continued)

Table 3. Data Submission Process on the QPP Website (Continued)

	CMS Web Interface	eCQMs and/or MIPS CQMs
4. Manually enter data for individual patients for each measure	✓	N/A
5. Upload a file	✓	✓ Much smaller files with faster upload times. 
Performance category scoring available immediately	Not until all measures have been reported and data completeness requirements are met	✓

Data Collection and Submission Types for Quality Measures (Continued)

Interaction Between Data Collection and Submission Type

Table 4 outlines how data submission is completed for each collection type if a group or virtual group is submitting their own data or working with a third party intermediary.

Table 4. Data Submission for Different Quality Measure Collection Types

Collection Type	Submission Type	
	Performance Period (January 1 – December 31)	**Data Submission Period** (January – March of the calendar year following the performance period)
eCQMs	**Collecting and Submitting Your Own Data**	
	A group or virtual group's CEHRT must be configured to collect data according to the eCQM specifications for the 2023 performance period before the performance period begins. Performance data is captured in a group or virtual group's 2015 Edition CEHRT (including Cures Update criteria) throughout the performance period.	Run and export a report of aggregated measure data from the group or virtual group's CEHRT. • If using multiple CEHRT systems, data must be aggregated into a single file before a group or virtual group can submit it. Upload the report (a Quality Reporting Document Architecture Category III (QRDA III file)) to the QPP website. Groups and virtual groups aren't allowed to submit their data directly to CMS using the QPP Submission Application Programming Interface (API).
	Working with a Third Party Intermediary	
	A group or virtual group's CEHRT must be configured to collect data according to the eCQM specifications for the 2023 performance period before the performance period begins. Performance data is captured in your 2015 Edition CEHRT (including Cures Update criteria) throughout the performance period.	Third party intermediary will submit your data to CMS via file upload or QPP Submission API.

Data Collection and Submission Types for Quality Measures (Continued)

Table 4. Data Submission for Different Quality Measure Collection Types (Continued)

Collection Type	Submission Type	
	Performance Period (January 1 – December 31)	**Data Submission Period** (January – March of the calendar year following the performance period)
MIPS CQMs	**Collecting and Submitting Your Own Data**	
	Performance data is captured in a group or virtual group's medical record (EHR or paper chart) and/or other data source(s) throughout the performance period. To extract data from an EHR, the group or virtual group's EHR must be configured to collect data according to the MIPS CQM specifications for the appropriate performance period before the performance period begins.	If collecting measure data in an EHR, run and export a report of aggregated measure data from the group or virtual group's EHR. • If you use multiple EHR systems, all denominator eligible encounters and performance data for each quality measure must be aggregated into a single file for submission. Data must be formatted according to the QPP JavaScript Object Notation (JSON) file specifications. Upload the file to the QPP website.
	Working with a Third Party Intermediary	
	Performance data is captured in a group or virtual group's EHR **and/or** as specified by a group or virtual group's selected Qualified Registry, QCDR, or other Health IT Vendor throughout the performance period.	A third party intermediary will submit a group or virtual group's data to CMS via file upload or QPP Submission API.
QCDR Measures	**Collecting and Submitting Your Own Data**	
	N/A	N/A
	Working with a QCDR	
	Performance data is captured in a group or virtual group's medical record (EHR or paper chart) and/or other data source(s) as specified by a group or virtual group's selected QCDR throughout the performance period.	QCDR will submit your data to CMS via file upload or QPP Submission API.

Alternative Reporting Options

Scoring

The scoring policies for quality measures that are available under alternative collection types differ from the CMS Web Interface scoring policies. Table 5 outlines the 2022 performance period scoring policies for the CMS Web Interface in contrast to the 2023 performance period scoring policies that have been finalized to date for alternative collection types. (These policies are subject to change in future rulemaking.) Table 5 illustrates the differences in scoring that groups and virtual groups can expect once they've transitioned to an alternative collection type in the 2023 performance period.

Table 5. Scoring Differences Between the CMS Web Interface and Alternative Collection Types

Scoring Topic	CMS Web Interface: Performance Period 2022 Scoring Policies	Alternative Collection Types: Performance Period 2023 Scoring Policies (Subject to Change in Future Rulemaking)
Benchmarks	Benchmarks for the CMS Web Interface are historical benchmarks established under the Shared Savings Program. If there isn't a historical benchmark, the measure is excluded from scoring, provided data completeness requirements are met.	Historical benchmarks are developed based on data submitted to MIPS by individual MIPS eligible clinicians, groups, virtual groups and APM Entities 2 years prior to the performance period. Benchmarks are specific to collection type. • The same measure will have different benchmarks if it can be reported through multiple collection types. **If there isn't a historical benchmark, a performance period benchmark is calculated** when 20 or more individuals, groups, virtual groups, and/or APM Entities report the measure through the same collection type.
Measure Achievement Points	Group/virtual group will receive: • **Between 3 and 10 achievement points** based on performance if the measure meets case minimum and data completeness criteria and can be scored against a benchmark. • **0 out of 10 points** for measures that aren't reported. • **0 out of 10 points** for measures that don't meet data completeness criteria. • **N/A (0 out of 0 points) –** A measure isn't scored if the measure sample has fewer than 20 patients (the case minimum), provided that the group or virtual group reported on the entire sample. • **N/A (0 out of 0 points) –** A measure without a benchmark isn't scored, provided that the group or virtual group meets data completeness criteria.	Group/virtual group will receive: • **Between 1 and 10 achievement points** based on performance if the measure meets case minimum and data completeness criteria and can be scored against a benchmark. (Exceptions for new measures in their first 2 years in the program.)* • **0 out of 10 points** for required measures that aren't reported. • **0 out of 10 points** for measures that don't meet data completeness requirements. • **0 out of 10 achievement points** for measures that don't meet case minimum requirements (fewer than 20 denominator eligible encounters reported). (Exceptions for new measures in their first 2 years in the program.)* • **0 out of 10 achievement points** for measures that can't be scored against a benchmark. (Exceptions for new measures in their first 2 years in the program.)* *These policies were finalized in the CY 2022 Physician Fee Schedule Final Rule to begin with the 2023 performance period.

Alternative Reporting Options

Scoring (Continued)

Table 5. Scoring Differences Between the CMS Web Interface and Alternative Collection Types (Continued)

Scoring Topic	CMS Web Interface: Performance Period 2022 Scoring Policies	Alternative Collection Types: Performance Period 2023 Scoring Policies (Subject to Change in Future Rulemaking)
Bonus Points	End-to-End Electronic Reporting Bonus • Not available, beginning with the 2022 performance period. High Priority/Outcome Measure Bonus • Not available.	End-to-End Electronic Reporting Bonus • Not available, beginning with the 2022 performance period. High Priority/Outcome Measure Bonus • Not available, beginning with the 2022 performance period.
Maximum Achievement Points Available **IMPORTANT:** While the number of achievement points differs between the CMS Web Interface and other collection types, there's no difference in the number of points the quality category can contribute to a group or virtual group's final score.	• **70 points** for CMS Web Interface measures. • **80 points** for CMS Web Interface measures + 1 administrative claims measure. • **80 points** for CMS Web Interface measures + CAHPS for MIPS Survey measure. • **90 points** for CMS Web Interface measures + CAHPS for MIPS Survey measure + 1 administrative claims measure. • **90 points** for CMS Web Interface measures + 2 administrative claims measures. • **100 points** for CMS Web Interface measures + 2 administrative claims measures + CAHPS for MIPS Survey measure. • **100 points** for CMS Web Interface measures + 3 administrative claims measures. • **110 points** for CMS Web Interface measures + 3 administrative claims measures + CAHPS for MIPS Survey measure.	• **60 points** for 6 submitted measures (can include CAHPS for MIPS Survey measure). • **70 points** for 6 submitted measures + 1 administrative claims measure. • **80 points** for 6 submitted measures + 2 administrative claims measures. • **90 points** for 6 submitted measures + 3 administrative claims measures.

Alternative Reporting Options

Scoring (Continued)

Benchmarks

Benchmarks are established specific to each collection type: MIPS CQMs, eCQMs, and QCDR measures. For example, performance on a MIPS CQM will be compared to a benchmark developed specifically for the MIPS CQM, while performance on an eCQM will be compared to a benchmark developed specifically for the eCQM, even though the MIPS CQM and eCQM are the same measure. (CMS Web Interface measures are scored against the Shared Savings Program benchmarks.)

Example: Quality ID 112 (Breast Cancer Screening) can be reported as an eCQM and a MIPS CQM for the 2022 performance period.

- A performance rate of 92% will earn different points based on the collection type

Table 6 below shows the different achievement points available for the same measure when reported as an eCQM versus a MIPS CQM. Please note that measures will be scored from Decile 1 (earning 1 – 1.9 points) through Decile 10 beginning with the 2023 performance period.

Table 6: Difference in Potential Points Earned for a Quality Measure Based on Collection Type for the 2022 Performance Period (Quality ID 112 Example)

Quality ID #	Collection Type	Decile 3 (earn 3 – 3.9 points)	Decile 4 (earn 4 – 4.9 points)	Decile 5 (earn 5 – 5.9 points)	Decile 6 (earn 6 – 6.9 points)	Decile 7 (earn 7 – 7.9 points)	Decile 8 (earn 8 – 8.9 points)	Decile 9 (earn 9 – 9.9 points)	Decile 10 (earn 10 points)
		Points are earned based on where your performance rate falls in the Decile ranges below							
112 (CMS125v8)	eCQM	24.55 - 41.49	41.50 - 51.24	51.25 - 60.64	60.65 - 68.27	68.28 - 74.86	74.87 - 84.77	84.78 - 97.66	>= 97.67
112	MIPS CQM	64.66 - 74.99	75.00 - 81.65	81.66 - 86.44	86.45 - 91.03	91.04 - 95.82	95.83 - 98.84	98.85 - 99.99	100.00

Next Steps and Key Elements to Consider

Next Steps and Key Elements to Consider for Quality Reporting in the 2023 Performance Period

Quality Payment PROGRAM

Getting Started with Alternative Collection Type Quality Measure Reporting

Review the various steps, associated timelines, and elements to consider as groups and virtual groups prepare for the 2023 performance period.

Steps and Timelines to Prepare for the 2023 Performance Period

Determine Your Collection Type

Start Planning Now

Elements/Questions to Consider

Does your group or virtual group have the 2015 Edition or 2015 Edition Cures Update CEHRT? This is required to report eCQMs.

- If your group or virtual group's EHR or Health IT module is listed on the Certified Health IT Product List (CHPL), it has been certified through the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. There will be an indicator alerting the group or virtual group to the certification edition.
- For detailed instructions on how to generate an ONC-ACB/CHPL ID (your CMS EHR Certification ID), review pages 25-28 of the CHPL Public User Guide (PDF).

We recognize that **ONC certification can be a lengthy process**. You can still report eCQMs for the 2023 performance period if the following 2 criteria are met:

- Your systems have 2015 Edition or 2015 Edition Cures Update (or a combination of both) CEHRT functionality in place at the start of the 2023 performance period.
- Your systems obtain ONC certification (2015 Edition, 2015 Edition Cures Update, or a combination of both) by December 31, 2023.

You'll need to consider reporting MIPS CQMs and/or QCDR measures if your group or virtual group's EHR isn't certified or isn't on track for 2015 Edition certification, according to the timeline above.

TIP: Review the systems your group or virtual group uses. This may assist with determining the collection type that allows for a smooth transition from CMS Web Interface reporting.

Next Steps and Key Elements to Consider for Quality Reporting in the 2023 Performance Period

Quality Payment PROGRAM

Getting Started with Alternative Collection Type Quality Measure Reporting (Continued)

Steps and Timelines to Prepare for the 2023 Performance Period (Continued)

Determine if You'll Work with a Third Party Intermediary

Start Planning Now

Elements/Questions to Consider

Does your group or virtual have multiple EHRs or multiple data sources (EHR, paper chart, or other data source)? All denominator eligible encounters and performance data for each quality measure must be aggregated into a single file for submission.

Does your group or virtual group have an IT department to support measure coding and data extraction?

Select Your Measures

Start Planning in 2022

Elements/Questions to Consider

Do you want to continue reporting the primary care measures that were available for reporting via the CMS Web Interface through another collection type?

Are there other quality measures that capture metrics your group or virtual group would like to improve?

Quality measures available for the 2023 performance period will be finalized in the CY 2023 Physician Fee Schedule (PFS) Final Rule (published in November of 2022), but you can start preparing by:

- Reviewing the 2022 MIPS CQM specifications
  - 2023 eCQM specifications will be available in May 2022
- Reviewing the CY 2023 PFS Proposed Rule (published in the summer of 2022) for proposals related to the addition or removal of measures, as well changes to the specifications

Review the Single Source documentation for Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes you commonly bill – this will help you identify denominator eligible encounters for available measures.

TIP: Ensure the measures you select are offered within your chosen collection type. If not, you may need to consider a different collection type or different measures.

Next Steps and Key Elements to Consider for Quality Reporting in the 2023 Performance Period

Quality Payment PROGRAM

Getting Started with Alternative Collection Type Quality Measure Reporting (Continued)

Steps and Timelines to Prepare for the 2023 Performance Period (Continued)

Choose a Third Party Intermediary (if applicable)

Start Planning in 2022

Elements/Questions to Consider

Will the third party intermediary work well within your current systems?

Does the third party intermediary support the measures you've selected?

The 2023 QCDR and Qualified Registry Qualified Postings won't be available until December 2022, but the population of approved QCDRs and Qualified Registries is fairly consistent from year to year. You can start preparing now by reviewing the 2022 QCDR and Qualified Registry Qualified Postings.

- Start by searching for third party intermediaries that support group or virtual group participation.
- Then refine that list by searching for those that support your group or virtual group's selected quality measures.
- Finally, narrow down the options by cost, services offered, and other criteria that are important to your group or virtual group.

TIP: The quality measures and/or QCDR measures may change each year, but your group or virtual group can review the measures supported by QCDRs/Qualified Registries for the 2022 performance period to identify quality measures that may continue to be supported for the 2023 performance period.

Next Steps and Key Elements to Consider for Quality Reporting in the 2023 Performance Period

Quality Payment PROGRAM

Getting Started with Alternative Collection Type Quality Measure Reporting (Continued)

Steps and Timelines to Prepare for the 2023 Performance Period (Continued)

Update Your Systems (as applicable)

Begin in June of 2022 for eCQM Reporting

Begin in December of 2022 for MIPS CQM Reporting

Elements/Questions to Consider

eCQM Reporting

- Review the eCQM Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) Resource Center.
- Connect with your EHR vendor as needed about coding updates they may provide for 2023 eCQMs.

MIPS CQM Reporting

- Update your systems to be able to capture the denominator eligible encounters identified by HCPCS, CPT, and ICD-10 coding for the measures you've selected.
- Connect with your EHR vendor as needed about coding updates they may provide for 2023 MIPS CQMs.

What if we can't get our systems updated to start collecting data starting on January 1, 2023?
To meet quality measure reporting requirements, a group or virtual group will need to be able to identify and report all denominator eligible encounters for their selected measures and report performance data for at least 70% of the measure's denominator eligible encounters for the 12-month performance period. (Note that 70% is the finalized data completeness requirement for the 2023 performance period.)

If a group or virtual group's systems won't be set up for data collection on January 1, 2023 when the performance period begins, look for a third party intermediary that can help your group or virtual group retroactively identify and capture all denominator eligible encounters in order for your group or virtual group to have complete reporting.

Next Steps and Key Elements to Consider for Quality Reporting the 2023 Performance Period

Quality Payment PROGRAM

Timeline

Timeline		
Now	**Now – December 2022**	**June – December 2022**

• Determine certification status of your group or virtual group's EHR system(s).
  ○ Start the certification process now if your group or virtual group intends to report eCQMs for the 2023 performance period; this process can take 12 to 18 months.
	• Determine your collection type(s).
	• Determine whether you would need or want to work with a third party intermediary.
	• Become familiar with the existing quality measures and quality measures that are proposed for removal, update or addition for the 2023 performance period (see the CY 2023 PFS Proposed Rule published in the summer of 2022).
	  ○ A final list of 2023 quality measures and updated specifications will be available in December of 2022 (following publication of the CY 2023 PFS Final Rule).
	  ○ eCQMs and their specifications will be available in May of 2022 but won't be finalized for inclusion in MIPS until the CY 2023 PFS Final Rule is released in November of 2022.
	• Review the QCDRs and Qualified Registries currently approved for the 2022 performance period to become familiar with the services offered.
	  ○ Qualified postings identifying the QCDRs and Qualified Registries approved for 2023 will be available in December of 2022.
		• Update your systems to identify and track denominator eligible encounters for your selected eCQMs according to their 2023 specifications.
		  ○ eCQMs and their 2023 specifications will be available in May of 2022 but won't be finalized for inclusion in MIPS until the CY 2023 PFS Final Rule is released in November of 2022.

Next Steps and Key Elements to Consider for Quality Reporting for the 2023 Performance Period

Quality Payment PROGRAM

Timeline (Continued)

Timeline (Continued)			
December 2022	**January 2023**	**April – June 2023**	**January – March 2024**
• Confirm your quality measures for the 2023 performance period. • Choose a third party intermediary, if applicable. • Update your systems to identify and track denominator eligible encounters for your selected MIPS CQMs according to their 2023 specifications.	• Start capturing performance data for the 2023 performance period.	• Register for the CAHPS for MIPS Survey measure, if planning to administer for the 2023 performance period.	• Submit MIPS CQM/eCQM/QCDR measure data for the 2023 performance period.

Help, Resources, and Version History

Help, Resources, and Version History

Quality Payment PROGRAM

Where Can I Get Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. ET, or by email at: QPP@cms.hhs.gov. To receive assistance more quicky, please consider calling during non-peak hours – before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Help, Resources, and Version History

Additional Resources

The following resources can also help prepare you for the transition to alternative reporting options.

Resource	Description
Getting Started with MIPS CQMs	This resource provides additional information about the transition to MIPS CQM reporting.
Getting Started with eCQMs	This resource provides additional information about the transition to eCQM reporting.

Help, Resources, and Version History

Quality Payment PROGRAM

Version History

Date	Description
02/07/2022	Original Posting.