Merit-based Incentive Payment System (MIPS)

2023 MIPS Group Participation Guide: Traditional MIPS

Quality Payment
PROGRAM

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Already know what MIPS is?
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Purpose: This resource focuses on Merit-based Incentive Payment System (MIPS) eligibility and participation for groups and provides high-level information and actionable steps for interpreting your eligibility and participation requirements, selecting measures and activities, and submitting data for the 2023 MIPS performance period.

How to Use This Guide

How to Use This Guide

Table of Contents

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

Hyperlinks

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

Overview

Overview

What is the Merit-based Incentive Payment System?

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

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

If you're eligible for MIPS in 2023:

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

TO LEARN MORE ABOUT MIPS:

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

TO LEARN MORE ABOUT MIPS ELIGIBILITY AND PARTICIPATION OPTIONS:

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

Overview

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

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

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

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

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

TO LEARN MORE ABOUT TRADITIONAL MIPS:

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

TO LEARN MORE ABOUT THE APP:

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

TO LEARN MORE ABOUT MVPS:

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

Overview

Quick Reference: Group Participation at a Glance for Traditional MIPS

The following table provides a high-level overview of the different aspects of group participation in traditional MIPS, which are explored in greater detail throughout this guide. To learn about other participation options, see the 2023 Eligibility and Participation Quick Start Guide (PDF). For a timeline about group participation in traditional MIPS, please refer to Appendix A.

Eligibility & Participation	• To participate in MIPS as a group, the practice (identified by Taxpayer Identification Number (TIN) must:
	  ○ Exceed the established low-volume threshold **OR** be eligible to opt-in as a group; **and**
	  ○ Have at least 2 clinicians billing under the group's TIN; **and**
	  ○ Include at least 1 MIPS eligible clinician.
	• You may also have a special status or other designation that qualifies you for reduced reporting requirements or bonus points.
	  ○ Find your eligibility information by entering your National Provider Identifier (NPI) in the QPP Participation Status Tool.
	
	Helpful hint: Sign in to the QPP website to review current eligibility information for your practice. Check your final eligibility status in December 2023.
	Don't have an account? Review the Quality Payment Program Access User Guide (ZIP).

Measure & Activity Selection/ Review	• Choose your 2023 quality measures. ○ Groups that want to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey need to register between April 3, 2023, and June 30, 2023. • Choose your 2023 improvement activities. • Review the required 2023 Promoting Interoperability measures. • Review cost measures. No measure selection or data submission required. We collect and evaluate this data for you. **Note:** Groups will be automatically evaluated and scored on up to 4 administrative claims measures, provided they meet the group size, case minimum, and clinician requirements.

Overview

Quick Reference: Group Participation at a Glance for Traditional MIPS (Continued)

Data Collection	• Clinicians in the group perform the quality actions associated with the practice's selected measures (as appropriate to their scope of practice). Data is collected for the entire 12-month performance period. • At least 50% of the clinicians in the group implement each selected improvement activity for a minimum of 90 continuous days, unless otherwise specified in the activity description. • All clinicians perform the required Promoting Interoperability measures and collect the data in your practice's electronic health record (EHR) technology certified to the 2015 Edition Cures Update certification criteria for a minimum of 90 continuous days. **Note:** In group participation, the practice aggregates data across the TIN, which could include covered professional services furnished by clinicians within the TIN who aren't required to participate in MIPS.

Data Submission	• Groups may submit their data themselves or use a third party intermediary to submit their measure and activity data.
	  ○ The available **submission type(s)** – or method(s) by which data is submitted to CMS – vary by performance category.
	  ○ For data submission checklists by performance category, please see Appendix B.

Scoring	• Clinicians will have their performance assessed and scored across all performance categories at the group level.
	  ○ MIPS eligible clinicians participating as a group will get the group's final score, unless they earn a higher score through individual or APM Entity participation.
	  ○ To learn about the 2023 Performance Year Performance Category Weight Redistribution Policies see Appendix C and Appendix D (for small practices).

Payment Adjustments	• Each MIPS eligible clinician included in the group will receive a MIPS payment adjustment based on the group's performance, unless they have another final score (from individual or APM Entity participation) that's higher than the group's final score.

Overview

Group Participation Frequently Asked Questions

What does it mean to participate in traditional MIPS as a group?

When you participate in traditional MIPS as a group, you're choosing to submit aggregated data on behalf of all clinicians billing under the group's TIN for each performance category requiring data submission: quality, improvement activities and Promoting Interoperability. (There are no data submission requirements for the cost performance category; we collect this data for you and calculate a score for the group.)

- The group will earn a final score based on the aggregated data submitted (or collected for you) across all performance categories.

Each MIPS eligible clinician in the group will receive the same final score and payment adjustment unless the clinician receives a higher final score from individual or APM Entity participation.

Overview

Group Participation Frequently Asked Questions (Continued)

How do we know if our practice can participate as a group?

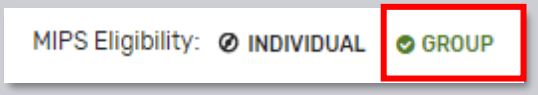
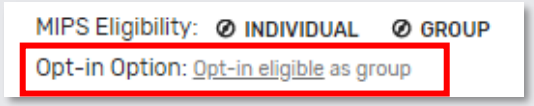
There are 2 ways that you can find your practice's current **group-level eligibility status** on the QPP website. Final eligibility will be available in December 2023.

Option 1. Enter the National Provider Identifier (NPI) of any clinician in your practice into our QPP Participation Status Tool.

a) Click on "PY 2023" if the display hasn't begun to default to the "2023 Participation Status" tab.

b) Find your practice on the list of the clinician's "Associated Practices" and look for the "Group" indicator of MIPS eligibility.

c) Your practice has the option to participate as a group and earn a MIPS payment adjustment if there is a green check mark next to "Group", or if there is text indicating that the practice is opt-in eligible as a group.

You See	This Means
	Your practice can choose to participate as a group, and the MIPS eligible clinicians in the group will receive a MIPS payment adjustment if you submit data as a group. (This includes clinicians who aren't individually eligible.)
	Your practice can choose to participate as a group and can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group's submission (i.e., choose to do nothing, opt-in, or voluntarily report). Learn more about opt-in eligible groups on slide 23
	Your practice can choose to voluntarily report, but your clinicians won't receive a MIPS payment adjustment.

Overview

Group Participation Frequently Asked Questions (Continued)

How do we know if our practice can participate as a group? (Continued)

Option 2. Sign in to the QPP website and navigate to "Eligibility & Reporting" on the left-hand navigation.

a) Make sure to select "2023" as the Performance Year at the top of the page.

b) Look for the indicator under your practice's name.

c) You have the option to participate as a group and earn a MIPS payment adjustment if you see text indicating that you are MIPS eligible or opt-in eligible as a group.

You See	This Means
	Your practice can choose to participate as a group, and all MIPS eligible clinicians who are eligible at the group level will receive a MIPS payment adjustment if you submit data as a group. (This includes clinicians who aren't individually eligible.)
	Your practice can choose to participate as a group and can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group's submission (i.e., choose to do nothing, opt-in, or voluntarily report). Learn more about opt-in eligible groups on slide 23.
	Your practice can choose to voluntarily report, but your clinicians won't receive a MIPS payment adjustment.

Overview

Group Participation Frequently Asked Questions (Continued)

If our practice is eligible as a group, are we required to participate as a group?

No. There is no requirement to participate as a group. If your practice is eligible at the group level, your practice has the option to participate as a group.

The next 2 examples show what you may see after entering your NPI into the QPP Participation Status Tool and explains what it means:

- If your practice chooses to participate as a group, the MIPS eligible clinicians who aren't eligible as individuals **will be included** in **MIPS** and receive a payment adjustment.

- If your practice chooses **not** to participate as a group, the MIPS eligible clinicians who are eligible as individuals **will need to participate** as individuals.

How MIPS Eligibility is Determined

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MIPS Eligible Clinician Types

If you're not one of the following clinician types, you're excluded from MIPS reporting:

[1] Includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry.
[2] With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

Overview

Group Participation Frequently Asked Questions (Continued)

Who are the MIPS Eligible Clinicians in our group? (Continued)

For group participation, a MIPS eligible clinician:

Is an eligible clinician type	AND	Enrolled as a Medicare provider prior to the performance year	AND	Isn't identified as a Qualifying APM Participant (QP)

When participating as a group, it is the group, and not each individual MIPS eligible clinician, that must exceed the low-volume threshold at the group level.

If we choose to report as a group, whose data do we need to include?

If you choose to participate in MIPS as a group, you'll need to collect and submit the available data from all the clinicians within your group as appropriate to the quality measures you select. **This includes data for clinicians that aren't eligible for MIPS or a MIPS payment adjustment.**

For improvement activities, each improvement activity for which groups attest must be performed by at least 50% of the clinicians billing under the group's TIN. Clinicians don't need to perform the activity concurrently, as long they each perform the activity for the required performance period (a continuous 90-day period during the calendar year, unless otherwise specified in the activity description).

For the quality, cost, and improvement activities performance categories, performance is measured across all clinicians in the group, including those that aren't MIPS eligible clinicians. For the Promoting Interoperability performance category, groups are required to submit the data collected in Certified Electronic Health Record Technology (CEHRT) on behalf of their MIPS eligible clinicians.

Overview

Group Participation Frequently Asked Questions (Continued)

Which clinicians in our practice are eligible for a payment adjustment based on our group submission?

Clinicians that have reassigned billing rights to your TIN are eligible for a 2025 MIPS payment adjustment based on the group submission if they:

Are an eligible clinician type AND Enrolled as a Medicare provider before January 1, 2023 AND Aren't identified as a QP **OR** as a Partial QP who didn't elect to participate in MIPS (learn more)

MIPS eligible clinicians (meeting the criteria above) who didn't exceed the low-volume threshold at the individual level and those who start billing Medicare Part B claims under your TIN in the final 3 months of the MIPS performance year, between 10/1/2023 and 12/31/2023, are eligible for a MIPS payment adjustment based on the group's final score.

Your practice may choose to participate in MIPS as a group and the MIPS eligible clinicians within the practice may also choose to participate as individuals. If the MIPS eligible clinicians within your practice exceed the low-volume threshold at the individual level or elect to opt-in as individuals, they'll be evaluated for 2 final scores: one from their individual participation and one from the group participation. They'll receive the higher final score and associated MIPS payment adjustment when billing Medicare Part B claims under your practice's TIN in the 2025 payment year.

Overview

Group Participation Frequently Asked Questions (Continued)

How is a group different from a virtual group?

There are several distinctions between a group and a virtual group including the following: the number of TINs involved in the group or virtual group, the need to submit your participation choice to CMS in advance of the start of the 2023 performance year, and the way in which clinicians are assessed, scored, and receive a MIPS payment adjustment.

Group	Virtual Group
1) A group is defined as a single TIN with 2 or more eligible clinicians (including at least 1 MIPS eligible clinician) as identified by their NPI who have reassigned their Medicare billing rights to the TIN.	1) A virtual group is defined as a combination of 2 or more **TINs** assigned to 1 or more solo practitioners (who are also MIPS eligible clinicians) or to 1 or more groups consisting of 10 or fewer eligible clinicians (including at least 1 MIPS eligible clinician), or both.
2) There is no requirement for a practice to alert CMS of their intent to participate as a group in advance of data submission.	2) Clinicians that wish to form a virtual group must submit an election prior to the start of the 2023 performance year. The virtual group election period for the 2023 performance year closed on December 31, 2022.
3) MIPS eligible clinicians in a group can also participate in MIPS as individuals or as part of an APM Entity; clinicians who participate in multiple ways will receive the highest final score attributed to them under their associated TIN/National Provider Identifier (NPI) combination.	3) MIPS eligible clinicians in a virtual group will receive the virtual group's final score and receive a MIPS payment adjustment based on the virtual group's final score, even if data are submitted at the group, individual or APM Entity level.

Want more information on virtual groups? Additional information on virtual group participation in MIPS is available in the 2023 Virtual Group Toolkit (ZIP).

Overview

Group Participation Examples

Example 1: A practice has 4 physicians on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A enrolled in Medicare during the performance year.
- Clinician B enrolled in Medicare prior to the performance year but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D each enrolled in Medicare prior to the performance year and exceed the low-volume threshold as individuals at this practice.

For the 2023 performance year, the practice:

- Participates in MIPS at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 physicians as appropriate to the measures selected. For improvement activities, 2 physicians would need to complete the same activity during the performance year for the group to attest.

The group earns a final score that corresponds to a +1.2% MIPS payment adjustment based on their 2023 performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by **Clinicians B, C, and D** in the 2025 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- Clinician A isn't eligible to receive a MIPS payment adjustment because the clinician was newly enrolled in Medicare.

Overview

Group Participation Examples (Continued)

Example 2: A practice has a clinical pharmacist (Clinician A) and 3 physicians (Clinicians B, C, and D) on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A is a clinical pharmacist which isn't a MIPS eligible clinician type.
- Clinician B is a MIPS eligible clinician type but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D are MIPS eligible clinician types and exceed the low-volume threshold as individuals at this practice.

For the 2023 performance year, the practice:

- Participates at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 clinicians as appropriate to the measures selected. For improvement activities, 2 clinicians would be required to attest to completing the same activity during the performance year.

The group earns a final score that corresponds to a +0.5% MIPS payment adjustment based on their 2023 performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by **Clinicians B, C and D** in the 2025 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- The payment adjustment won't be applied to Clinician A because she isn't a MIPS eligible clinician type.

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Eligibility & Participation

Eligibility & Participation

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Impact of Low-Volume Threshold on Eligibility

TIP: One professional claim line with positive allowed charges is considered one covered professional service.

How do you determine if our practice is eligible to participate in MIPS as a group?

We look at your Medicare Part B claims from two 12-month segments, called the MIPS Determination Period, to evaluate the total volume of care your practice provides to Medicare patients.

Segment 1
October 1, 2021 – September 30, 2022

AND

Segment 2
October 1, 2022 – September 30, 2023

During each segment, we look to see if you and your practice exceed the low-volume threshold criteria:

Charges: Bill more than $90,000 for Medicare Part B covered professional services under the Physician Fee Schedule (PFS)

AND

Patient Count: See more than 200 Medicare Part B patients

AND

Covered Services: Provide more than 200 covered professional services to Medicare Part B patients

To be eligible for MIPS, your practice must exceed all 3 of the **low-volume threshold** criteria during both 12-month segments of the MIPS Determination Period. Your practice may be eligible to opt-in to participate in MIPS as a group if you exceed some, but not all, of the low-volume threshold criteria.

Did you know? If your practice is newly formed or has otherwise established a new TIN between October 1, 2022, and September 30, 2023, we'll only evaluate your eligibility during segment two.

Eligibility & Participation

Impact of Low-Volume Threshold on Eligibility (Continued)

What does it mean if our group is "opt-in eligible"?

If your group is otherwise eligible for MIPS and exceeds 1 or 2, but not all 3 low-volume threshold criteria, you are **opt-in eligible.**

If the group is opt-in eligible, you can:

Do nothing. Your group isn't required to participate in MIPS.

OR

Elect to opt-in. If your group decides to opt-in, the group will submit data at the group level, receive performance feedback, and the MIPS eligible clinicians within the group will receive a MIPS payment adjustment in 2025.

OR

Elect to voluntarily report. If your group wants to participate in MIPS but doesn't want its clinicians to receive a MIPS payment adjustment in 2025, the group can voluntarily report data and receive limited performance feedback.

The election to opt-in (or voluntarily report) to MIPS for the 2023 performance year is irreversible. If you are considering this option, be sure to explore program requirements to ensure that you're prepared to collect and report on data needed to demonstrate successful performance in 2023.

Eligibility & Participation

Impact of Low-Volume Threshold on Eligibility (Continued)

How do we elect to opt-in or voluntarily report?

Opt-in eligible groups that want to submit data must submit an election before data can be submitted. Groups can submit this election themselves by signing in to the QPP website during the submission period and choosing to opt-in or voluntarily report.

Alternately, if you're working with a Qualified Registry or QCDR, the third party intermediary can submit this election on your behalf before submitting your data. (The 2022 MIPS Opt-In and Voluntary Reporting Election Guide (PDF) reviews what this process looked like for the 2022 performance year; at this time, we don't anticipate significant changes to this process.)

Voluntary Reporting

If your group chooses to voluntarily report, your group will receive performance feedback based on the measures and activities for which the group submitted data. This can help to inform the group's potential future MIPS participation. If you submit data, you'll receive performance feedback, but the group's clinicians won't receive a MIPS payment adjustment.

You can voluntarily report if you're identified as either MIPS exempt or as opt-in eligible for the 2023 performance year. Groups identified as opt-in eligible will need to submit their election before data can be submitted; groups identified as MIPS exempt can simply submit their data.

Reminder: slides 11-12 explain how to tell what your practice's group participation options are in MIPS.

Eligibility & Participation

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Impact of Low-Volume Threshold on Eligibility (Continued)

Understanding Participation Options: Eligible Groups vs. Opt-in Eligible Groups and Group Voluntary Reporting

	Your group is eligible and chooses to submit data as a group	Your group is opt-in eligible and elects to opt-in	Your group voluntarily reports
Is the group required to make an active election indicating the chosen participation option?	NO	YES	YES, if you are opt-in eligible. NO, if your group isn't MIPS eligible.
Will the group receive performance feedback?	YES	YES	YES (no feedback on cost measures, Medicare Part B Claims quality measures, or administrative claims measures).
Will the MIPS eligible clinicians in the group receive a positive, neutral, or negative payment adjustment?	YES	YES	NO
Is the group's data eligible to be published in the Doctors & Clinicians section of Medicare Care Compare, formerly known as Physician Compare?	YES	YES	YES (but, able to opt-out of public reporting during preview period).
Will the group's quality measure submissions be used to establish historical MIPS measure benchmarks for future program years?	YES	YES	NO

Reminder: Clinicians who are MIPS eligible as individuals must report or be subjected to a negative payment adjustment. They may report individually, or as a group (if eligible), or both.

Eligibility & Participation

Quality Payment PROGRAM

Impact of Low-Volume Threshold on Eligibility (Continued)

Can our group's eligibility change?

Yes, eligibility can change once we reconcile eligibility results from the 2 segments of the MIPS Determination Period. This information will be added to the QPP website December 2023. If your group falls below all 3 elements of the low-volume threshold in either segment, your group will be ineligible to participate in MIPS as a group, except as voluntary reporters.

If you're currently eligible as a group, your group could:	If you're currently opt-in eligible as a group, your group could:	If you're currently ineligible as a group:
• Remain eligible; • Become opt-in eligible; or • Become ineligible (can still voluntarily report).	• Remain opt-in eligible; or • Become ineligible (can still voluntarily report).	• Your group will remain ineligible (can still voluntarily report).

Helpful hint: When you sign in to check your group's eligibility status, you can also view individual eligibility for the clinicians in your practice.

When you sign in before eligibility is updated in December 2023:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2021, to Sept. 30, 2022, and received by CMS by October 30, 2022.

When you sign in after eligibility is updated in December 2023:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2022, to Sept. 30, 2023, and received by CMS by October 30, 2023.
- If you have clinicians who participate in a MIPS APM, you may also see clinicians who didn't bill Medicare Part B claims but were identified as part of your practice on an APM participation list.

Did You Know?

It's possible for a practice to be opt-in eligible or ineligible as a group AND for a clinician in the practice to be individually eligible and required to participate in MIPS.

This can happen when a group falls below the low-volume threshold in the first segment and a new clinician joins in the second segment and exceeds the low-volume threshold.

Eligibility & Participation

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Quick Reference: Special Status Designations

Can our group's eligibility change?

We determine if a group qualifies for most special statuses by reviewing Medicare Part B claims data from the two 12-month segments of the MIPS Determination Period.

The following table outlines special status designations and their impact on group reporting requirements for the 2023 performance year.

If a group has a "special status", this will be indicated on the Special Statuses webpage of the QPP website.

Sign in to the QPP website and navigate to the "Eligibility & Reporting" webpage.

Or check the QPP Participation Status NPI Lookup Tool.

(Click **Expand** next to the clinician's name and scroll down to 'Practice Level' in the Other Factors section.)

Special Status	Description	Impact to MIPS Reporting and Scoring
Ambulatory Surgical Center (ASC)-based	All MIPS eligible clinicians associated with your practice are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Hospital-based	More than 75% of the clinicians associated with your practice are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Non-patient Facing	More than 75% of the clinicians billing under your practice's TIN meet the definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points). Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.

Eligibility & Participation

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Quick Reference: Special Status Designations (Continued)

Special Status	Description	Impact to MIPS Reporting and Scoring
Facility-based	75% or more of the clinicians in the TIN are facility-based as individuals. Groups are assigned to the facility at which the plurality of clinicians in the TIN were assigned as individuals. **Note:** We don't evaluate clinicians and groups for the facility-based status in the 2nd segment of the MIPS Determination Period. The facility-based status and assigned facility currently displayed on the QPP website will be updated if the assigned facility doesn't receive a Fiscal Year (FY) 2024 Hospital Value Based Purchasing (VBP) Program score. We won't know if a facility has a FY 2024 score until late 2023.	Your group may qualify to receive scores for the quality and cost performance categories based on your assigned facility's FY 2024 Hospital VBP Program score. *To receive facility-based scoring as a group, your group must submit group level data for the improvement activities and/or Promoting Interoperability performance category(ies) to signal your intent to participate as a group.
Health Professional Shortage Area (HPSA)	More than 75% of the clinicians in the TIN are in an area designated as an HPSA.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points).

Eligibility & Participation

Quick Reference: Special Status Designations (Continued)

Special Status	Description	Impact to MIPS Reporting and Scoring
Small Practice	There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.	Your group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points instead of 20 points). Groups who submit at least 1 quality measure will also receive 6 bonus points for the quality performance category. You'll continue to receive 3 points (instead of zero) for quality measures that don't meet data completeness or case minimum requirements, or that can't be reliably scored against a benchmark. View Appendix D for additional information on the redistribution policies that apply to small practices.
Rural	More than 75% of the clinicians billing under the practice's TIN are in a ZIP code designated as rural using the most recent Federal Office of Rural Health Policy (FORHP) ZIP code file.	Each submitted improvement activity will earn double points (e.g., a high-weighted activity will earn 40 points instead of 20 points).

Quality Performance Category

Quality Performance Category

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Overview

The quality performance category assesses health care processes, outcomes, and patient experiences of their care. This category accounts for 30% of your final score, unless you qualify for reweighting in another performance category.

Measure Selection

How many quality measures do we need to select?

You will need to:

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

OR

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

Where can I find information on the 2023 quality measures?

You can find measure descriptions, specifications and benchmarks on the Explore Measures & Activities tool on the QPP website.

For a complete list of measures, see the 2023 MIPS Quality Measures List (XLSX). For tips on choosing quality measures and information about scoring, review the 2023 Quality User Guide (PDF).

Helpful Hints:

- Make sure you've selected the 2023 performance year.
- Search by key words or terms applicable to the care you provide.

Quality Performance Category

Measure Selection (Continued)

Does our group have to report quality data if we're a facility-based practice?

If your group is identified by CMS as having a facility-based special status and if your group's assigned facility has a FY 2024 Hospital VBP Program score, your group can use that score for the quality performance category in lieu of submitting quality measures. (Please remember that the facility-based status is predictive until late 2023 when the FY 2024 scores are available.)

However, **groups must submit data for the improvement activities and/or Promoting Interoperability performance categories** to qualify for facility-based scoring. This data submission alerts us of your group's intent to participate as a group.

Keep in mind:

- We won't know if your group's assigned facility has a FY 2024 Hospital VBP Program score until the end of the performance year – at this point, we'll remove the facility-based status from any clinician or group assigned to a facility without a FY 2024 score.
- You can still submit quality measures. We'll calculate 2 final scores – 1 with facility-scoring and 1 without – and assign the higher final score to the group.
- Please review the 2023 Facility-Based Measurement Quick Start Guide (PDF) for more information.

Quality Performance Category

Collection Types

What do we need to know about collection types?

A collection type is a set of quality measures with the same data completeness criteria and specifications that follow a consistent format. There are 5 collection types, or ways you can collect and submit your quality measures to CMS. They include:

1. Electronic Clinical Quality Measures (eCQMs)
2. MIPS Clinical Quality Measures (MIPS CQMs)
3. Qualified Clinical Data Registry (QCDR) Measures
4. Medicare Part B Claims Measures
5. CAHPS for MIPS Survey Measure

Additionally, 4 MIPS quality measures are automatically evaluated and calculated through administrative claims if minimum requirements are met. Note: these administrative claims measures **don't count** as 1 of the 6 measures required to meet quality reporting requirements.

Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population and can choose from one or more collection types for a single quality performance category score.

For example, a small practice could:

Report **2 Medicare Part B claims** measures throughout the performance period.

+

Work with a QCDR to collect and report **2 eCQMs** and **2 QCDR measures** on their behalf during the 2023 submission period.

=

All **6 of these measures** would contribute to a single quality performance category score for the group.

Quality Performance Category

Quality Payment PROGRAM

Collection Types (Continued)

The table below walks through the different collection types, provides links to the 2023 measure specifications and provides helpful hints.

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2023	What You Need to Know
eCQMs	2023 eCQM Specifications (ZIP)	• Groups can report eCQMs if they use technology that has been certified to the 2015 Edition Cures Update certification criteria by the Office of the National Coordinator for Health Information Technology (ONC) by the time the eCQM data is generated for submission. • Groups can report their eCQMs themselves or work with a third party intermediary to report these measures on their behalf. • eCQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
Medicare Part B Claims Measures	2023 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP)	• Only small practices (15 or fewer clinicians) can report Medicare Part B claims measures. • When reporting as a group, claims measures must still be reported with the clinician's individual (rendering) NPI. Don't report claims measures with the group's organizational NPI. • We'll only calculate a quality score for groups based on individual claims data if group-level data is submitted for the improvement activities and/or Promoting Interoperability performance categories. • Claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure. • Review the 2023 Part B Claims Reporting Quick Start Guide (PDF) for more information.

Quality Performance Category

Quality Payment PROGRAM

Collection Types (Continued)

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2023	What You Need to Know
MIPS CQMs	2023 Clinical Quality Measure Specifications and Supporting Documents (ZIP)	• Groups can report their MIPS CQMs themselves or work with a third party intermediary to collect and report these measures on their behalf. • MIPS CQMs can be reported in combination with Medicare Part B claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
QCDR Measures	2023 QCDR Measure Specifications (XLSX)	• Groups will need to work with a CMS-approved QCDR to report these measures on their behalf. • QCDR measures can be a great option for groups that provide specialized care or who have trouble finding MIPS measures that feel relevant to their practice. • QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.
CAHPS for MIPS Survey Measure	2023 CAHPS for MIPS Survey Overview Fact Sheet (available on the Quality Payment Program Resource Library in March 2023)	• Groups (with 2 or more eligible clinicians) that wish to administer the CAHPS for MIPS Survey must register with a CMS-approved vendor-between April 3, 2023, and June 30, 2023. • The CAHPS for MIPS Survey assesses patients' experiences of care within a group. This measure is most appropriate for groups that provide primary care services. • This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.

Quality Performance Category

Collection Types (Continued)

What do we need to know about collection types? (Continued)

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

NEW: Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System (MIPS) (ZIP)

- This measure will have a case minimum of 21 cases and will only apply to groups or virtual groups with at least 1 cardiologist.

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP)

- This measure will have a case minimum of 18 cases and will only apply to groups or virtual groups with at least 16 clinicians.

Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment Program (MIPS) Groups (ZIP)

- This measure will have a case minimum of 200 cases and will only apply to groups or virtual groups with at least 16 clinicians.

Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (ZIP)

- This measure will have a case minimum of 25 cases and will apply to groups or virtual groups.
- This measure will have a 3-year performance period (consecutive 36-month timeframe) that will start on October 1, 2020 (3 years prior to the performance year), and end on September 30, 2023 (current performance year), and proceed with a 3-month numerator assessment period.

Quality Performance Category

Data Collection & Submission

How much data do we need to collect?

There is a **12-month performance period** for the quality performance category, which means that your group must collect data for each quality measure from January 1 – December 31, 2023. To meet data completeness requirements, you should start data collection on January 1, 2023. If you fail to meet data completeness requirements, you'll receive zero points for the measure, unless you're a small practice, in which case you'll receive 3 points.

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

- **For Medicare Part B claims measures**, we identify the eligible denominator patient population based on your submitted Medicare Part B claims. Small practices choosing to report Medicare Part B claims measures submit data for their quality measures at the Medicare patient level.
- **For eCQMs, MIPS CQMs, and QCDR measures**, you (or your third party intermediary) identify the eligible population (include data from all-payers) in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications. Quality measure data (numerators, denominators, etc.) are aggregated for all the clinicians in the group, as applicable to the measure, not just the MIPS eligible clinicians in the practice.
- Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking), wouldn't be considered true, accurate, or complete and may subject you to audit.

Quality Performance Category

Data Collection & Submission (Continued)

EHR-based Quality Reporting

- If you transition from one electronic health record (EHR) system to another during the performance period, you should aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month reporting period prior to submitting the data.
- If your practice uses multiple EHR systems for clinicians billing under the same TIN, you'll also need to aggregate data into a single report prior to submitting the data. For cases in which there are more than one EHR systems being used under a single TIN during the 2023 performance year and 12 months of data isn't available, you're required to submit as much data as possible. During the 2023 performance year, the EHR system(s) may use the functionality of 2015 Edition CEHRT for eCQMs; however, the submitting EHR system must be certified to the 2015 Edition Cures Update criteria before the eCQM data is generated for submission.

International Classification of Diseases 10th Revision (ICD-10) Updates

- Each year, the Value Set Authority Center (VSAC) releases updates to ICD-10 coding that take effect October 1st.
- We'll identify the measures that are significantly impacted by these updates in the 2023 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released by October 1 of the performance period if technically feasible, but no later than the beginning of the data submission period. Measures that are significantly impacted by ICD-10 updates will have a 9-month performance period, ending September 30, before the ICD-10 code changes take effect.
- Other measures may be impacted by these code changes, but not significantly enough to shorten the performance period. You should continue to report these measures according to the specification, reporting on encounters that use the codes identified in the measure's 2023 specification. You won't report on encounters that use updated codes not identified in the measure's 2023 specification.

Measures Affected by Significant Changes during the Performance Period

- In addition to ICD-10 coding changes, a measure could be impacted by errors found in the finalized measure specifications or changes to the clinical guidelines. For more information about how these changes may impact measure scoring and performance, please see the 2023 Quality User Guide.

Quality Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

How do we submit our data?

Data will generally be submitted during the 2023 submission period, January 2 – April 1, 2024. Some data can be submitted by the group while other data must be submitted by a third party intermediary. The table below outlines the different submission types available for the quality performance category.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Practice/Group representative)	Medicare Part B Claims Measures (Only for Small Practices)	Through your routine Medicare Part B claims billing practices.	Throughout the performance period, with dates of service in calendar year 2023. Claims must be processed by your Medicare Administrative Contractor (MAC) and received by CMS by March 1, 2024.
	eCQMs	Sign in to the QPP website and upload a QRDA III file or a QPP JSON file.	January 2 – April 1, 2024
	MIPS CQMs	Sign in to the QPP website and upload a QPP JSON file.	January 2 – April 1, 2024
Third Party Intermediaries (QCDRs, Qualified Registries, and Health IT Vendors)	eCQMs MIPS CQMs QCDR Measures	Sign in to QPP website and upload a QRDA III or QPP JSON file. **OR** Use the QPP Submissions Application Programming Interface (API).	January 2 – April 1, 2024
CMS-Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of the QPP website.	Early 2024, following data collection (standardized annual timeframe).

Cost Performance Category

Cost Performance Category

Quality Payment PROGRAM

Overview

The cost performance category measures Medicare payments made for care provided to patients and accounts for 30% of your group's final score, unless you qualify for reweighting in another performance category.

Measure Review

For the 2023 performance year, there are 25 cost measures:

- The Total per Capita Cost (TPCC) measure;
- The Medicare Spending per Beneficiary Clinician (MSPB Clinician) measure;
- 15 Procedural Episode-based measures;
- 6 Acute Inpatient Medical Condition Episode-based measures; and
- 2 Chronic Condition Episode-based measures.

Your group won't choose measures for the cost performance category in traditional MIPS. We look at your group's claims data to determine which of these measures apply to you.

Where can I find information on the 2023 cost measures?

You can find the measure descriptions, specifications ("Cost Measure Information Forms"), and code lists on the Explore Measures & Activities Tool on the QPP website. For more information about this performance category, refer to the 2023 Cost Performance Category Quick Start Guide.

Helpful Hint: Make sure you've selected the 2023 performance year.

Data Collection & Submission

How do we submit our data?

There are no data submission requirements for the cost performance category. We use Medicare claims data to calculate your group's performance on cost measures.

We'll calculate cost measure performance on behalf of all clinicians in your group – including those who aren't eligible to participate in MIPS.

Each measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

You'll only be scored for the cost measures for which you meet the case minimum. If your group doesn't meet the case minimum for any of the available cost measures, the 30% weight for the performance category will be reallocated to other performance categories.

- Appendix C provides additional information on the redistribution of performance category weights view (**small practices** should review Appendix D).

Quality Payment
PROGRAM

Improvement Activities Performance Category

Improvement Activities Performance Category

Quality Payment PROGRAM

Overview

The improvement activities performance category measures participation in activities that improve clinical practice and generally accounts for 15% of your group's final score.

Activity Selection

View Appendix D for more information on performance category weighting for small practices.

How many improvement activities do we need to perform and submit?

Most groups will need to implement and attest to between 2 and 4 activities to receive the maximum 40 points in this performance category. Each improvement activity is classified as either medium-weighted (10 points) or high-weighted (20 points).

Groups that are identified as non-patient facing, rural, HPSA, or a small practice earn **twice the points** for each activity and will need to implement and attest to 1 high-weighted or 2 medium-weighted activities to receive the maximum 40 points.

A certified or recognized patient-centered medical home or comparable specialty practice will receive full credit in this category if the following requirements are met:

At least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.

AND

The group must attest to their status as a certified or recognized patient-centered medical home or comparable specialty practice during the 2023 submission period.

Where can I find information on the 2023 improvement activities?

You can find activity descriptions and weights on the Explore Measures & Activities Tool on the QPP website.

Helpful Hints:

- Make sure you've selected the 2023 performance year.
- Search by key words or terms applicable to the care you provide.

Improvement Activities Performance Category

Data Collection & Submission

What are the requirements for a group to attest to having completed an improvement activity?

A group can attest to an activity when at least 50% of the clinicians in the practice perform the activity. Clinicians must perform the activity for a continuous 90-day period during calendar year 2023 unless a different performance period is specified in the activity description. However, clinicians in the group don't have to perform the activity concurrently and don't have to be eligible for MIPS to be included in the 50% threshold.

QPs are excluded from MIPS and aren't required to report on any MIPS performance category. If your group includes some clinicians who participate in an Advanced APM and have QP status, they don't count toward the requirement that 50% of clinicians in the group perform the activity. However, you can include them in the 50% if they choose to perform the activity.

Example. Practice A has 4 clinicians and is reporting as a group. Clinician 1 and Clinician 2 are QPs, Clinician 3 and Clinician 4 aren't.

- If Clinicians 1 and 2 (the QPs) don't perform the activity, the group will meet the 50% threshold and can attest to the activity as long as **either** Clinician 3 or Clinician 4 perform the activity.
- If Clinicians 1 and 2 (the QPs) perform the activity, the group will meet the 50% threshold and can attest to the activity even if **neither** Clinician 3 nor Clinician 4 perform the activity.

Improvement Activities Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

How do we submit our data?

You can attest to your improvement activities yourself or use a third party intermediary to submit improvement activity data on your behalf during the 2023 submission period, January 2 – April 1, 2024. The table below outlines the different submission types available for the improvement activities performance category.

QCDRs and Qualified Registries generally must support all performance categories to be approved by CMS. However, if you're working with a QCDR or Qualified Registry, you should verify that they can support and submit your selected improvement activities.

Who	How
You (practice/group representative)	Sign in to the QPP website and attest to the activities you've implemented.
You (practice/group representative) or a third party intermediary	Sign in to the QPP website and upload a file with your activity attestations.
Third party intermediary	Perform a direct submission on your behalf, using our submissions API.

Quality Payment
PROGRAM

Promoting Interoperability Performance Category

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Overview

The Promoting Interoperability performance category promotes patient engagement and the electronic exchange of health information using CEHRT. This performance category accounts for 25% of your group's final score.

Measure Review

View the following fact sheets for additional information on the new Promoting Interoperability measure and revised attestation statement:

- 2023 High Priority Practices SAFER Guide Fact Sheet (PDF)
- 2023 Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Fact Sheet (PDF)

Which Promoting Interoperability measures do we have to report?

The 2023 Promoting Interoperability performance category focuses on 4 objectives:

- e-Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

Within these objectives, there are 6 to 7 required measures (dependent upon which measure(s) you choose to report for the HIE objective) in addition to the Security Risk Analysis measure, High Priority Practices Guide of the SAFER Guides measure, Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation (formerly called the information blocking attestation), and ONC Direct Review attestation. Some of these measures have exclusions; if you qualify, you can claim (submit) the exclusion instead of reporting the measure.

Your group may qualify for an exception or reweighting of this performance category.

Where can I find information about the 2023 Promoting Interoperability measures?

You can find measure specifications, exclusion information, and details about the attestations on the Explore Measures & Activities Tool on the QPP website.

Helpful Hint: Make sure you've selected the 2023 performance year.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission

You must use CEHRT to collect your Promoting Interoperability performance category data. MIPS eligible clinicians must use electronic health record (EHR) technology certified to the 2015 Edition Cures Update certification criteria for the 2023 performance year.

The 2015 Edition Cures Update CEHRT functionality must be in place by the first day of your MIPS Promoting Interoperability performance period.	Your EHR technology must be certified by ONC to the 2015 Edition Cures Update criteria by the **last day of your performance period.**	MIPS eligible clinicians must use the 2015 Edition Cures Update CEHRT functionality for the **full** Promoting Interoperability performance period.	If your practice has several EHRs and not all are certified to the 2015 Edition Cures Update, you'll submit only the data collected in the 2015 Edition Cures Update CEHRT.

How much data do we need to collect?

Groups need to report the data collected in their 2015 Edition Cures Update CEHRT for all required measures (or meet and claim an exclusion, if applicable) for a minimum of a continuous 90-day period during the 2023 calendar year.

If your practice is participating as a group or virtual group:

- You'll aggregate the measure numerators and denominators for all MIPS eligible clinicians with data in your 2015 Edition Cures Update CEHRT. You can submit a "yes" for the 2 required measures in the Public Health and Clinical Data Exchange objective as long as one MIPS eligible clinician is in active engagement with each registry.

Reminder:

A group is considered hospital-based and eligible for reweighting when **more than 75%** of the clinicians billing under the practice's TIN meet the definition of hospital-based.

The hospital-based status is different than the facility-based status which has implications for quality reporting. Learn more about facility-based reporting.

Groups are only required to submit data from their MIPS eligible clinicians for this performance category.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

How does reweighting of the Promoting Interoperability performance category apply to groups?

A group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when:

- The group is identified on the QPP Participation Status Lookup Tool as hospital-based, ASC-based, non-patient facing, or a small practice at the practice level; **OR**
- The group's MIPS eligible clinicians qualify individually for reweighting based on their clinician type, special status, or approved significant hardship exception. If any MIPS eligible clinician within the group doesn't qualify for reweighting, the group **must submit** Promoting Interoperability data.

If the group qualifies for reweighting but submits any data in this performance category, the group will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the final score.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

When reporting as a group, do we need to include data from MIPS eligible clinicians who individually qualify for reweighting?

Yes. When submitting data as a group for the Promoting Interoperability performance category, the group should combine all their MIPS eligible clinicians' data. This includes the data of **MIPS eligible clinicians who may qualify for a reweighting** of the Promoting Interoperability performance category when submitting data individually**.**

If these MIPS eligible clinicians are part of the group and have data in the group's CEHRT, their data should be included in the group's data submission, and they'll be scored on the Promoting Interoperability performance category like the other MIPS eligible clinicians in the group.

The following types of MIPS eligible clinicians and special statuses qualify for an automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when reporting MIPS data individually.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

What if clinicians in the group are facing a significant hardship? There may be circumstances, out of your control, that make it difficult for you to meet the MIPS requirements.

Groups can submit a **Promoting Interoperability Hardship Exception** application when their entire practice:

- Has decertified EHR technology (impacting all MIPS eligible clinicians).
- Has insufficient internet connectivity (impacting all MIPS eligible clinicians).
- Faces extreme and uncontrollable circumstances (impacting all MIPS eligible clinicians) such as disaster, practice closure, severe financial distress or vendor issues.
- Lacks control over the availability of CEHRT (impacting all MIPS eligible clinicians).

Simply lacking the required 2015 Edition Cures Update CEHRT doesn't qualify the MIPS eligible clinician or group for re-weighting.

If **each** of the MIPS eligible clinicians in a group faces a significant hardship and **qualifies as an individual** for reweighting the Promoting Interoperability performance category, the group may submit an application to have their Promoting Interoperability performance category score be reweighted to 0%. If approved, the group will have their Promoting Interoperability performance category score reweighted to 0% and the category weight will be reallocated to the quality or improvement activities performance categories.

If **any** MIPS eligible clinician within the group **doesn't qualify** for a significant hardship exception (or doesn't otherwise qualify for reweighting), the group can't apply to have their Promoting Interoperability performance category reweighted to 0% and will need to submit data for this performance category, submitting all available measure data in their CEHRT.

Submit your 2023 Promoting Interoperability Performance Category Hardship Exception application by January 2, 2024. (Your application must be approved by CMS to qualify for reweighting.)

NOTE: Groups that have been approved for a hardship exception but submit any data in this performance category, will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the group's final score.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

What data do we have to submit?

In order to receive a score greater than zero for the Promoting Interoperability performance category, your group must:

- Collect your data in EHR technology with 2015 Edition Cures Update CEHRT functionality (certified by the last day of the performance period) for a minimum of any continuous 90-day period in 2023;
- Submit a "yes" to the Actions to Limit or Restrict Interoperability of CEHRT Attestation (formerly named Prevention of Information Blocking);
- Submit a "yes" to the SAFER Guides attestation measure. (A "no" will also satisfy this measure.) Additional information is available on the SAFER Guides webpage on HealthIT.gov;
- Submit a "yes" to the ONC Direct Review Attestation;
- Submit a "yes" that you have completed the Security Risk Analysis measure in 2023;
- Report the 6 to 7 required measures or claim their exclusion(s); and
  - For measures that require a numerator and denominator (as defined in the measure specifications), you must submit at least a '1' in the numerator;
- Provide your EHR's CMS identification code from the Certified Health IT product List (CHPL), available on HealthIT.gov.

Promoting Interoperability Performance Category

Quality Payment PROGRAM

Data Collection & Submission (Continued)

How do we submit our data?

You can submit your group's Promoting Interoperability data yourself or use a third party intermediary to submit data on your behalf during the 2023 submission period, January 2 – April 1, 2024. The table below outlines the different submission types available for the Promoting Interoperability performance category.

QCDRs and Qualified Registries generally must support all performance categories to be approved by CMS, though some are exempt from supporting the Promoting Interoperability performance category based on the types of clinicians they support. If you're working with a QCDR or Qualified Registry, verify whether they can support and submit your Promoting Interoperability measures.

Who	How
You (practice/group representative)	Sign in to the QPP website and attest to (manually enter) your Promoting Interoperability data.
You (practice/group representative) or a third party intermediary	Sign in to the QPP website and upload a file with your data.
Third party intermediary	Perform a direct submission on your behalf, using our submissions API.

Quality Payment
PROGRAM

Scoring & Payment Adjustments

Scoring & Payment Adjustments

Overview

How is our group's data scored?

For practices that choose to participate at the group level, group performance is assessed and scored at the practice (TIN) level across all 4 MIPS performance categories for the 2023 performance year.

Each category is scored based on the aggregated (group-level) data submitted or collected on your group's behalf.

How are payment adjustments applied?

Each MIPS eligible clinician participating in MIPS at the group level will receive a payment adjustment in the 2025 payment year based on the group's performance in 2023. MIPS payment adjustments will be applied on a claim-by-claim basis to covered professional services furnished by MIPS eligible clinicians under the Physician Fee Schedule.

MIPS eligible clinicians who submit data as a part of a group **AND** individually will be evaluated as an individual and as a group for all performance categories. We'll take the higher of the 2 final scores and apply the MIPS payment adjustment associated with it.

When the practice (TIN) participates as a group,

- Any individual (NPI) included in the TIN who is excluded from MIPS because they aren't a MIPS eligible clinician type or are identified as a new Medicare-enrolled clinician, a QP, or Partial QP **won't** receive a MIPS payment adjustment, regardless of their MIPS participation.
- Clinicians who are below the low-volume threshold as individuals, but otherwise eligible for MIPS, **will** receive a MIPS payment adjustment when reporting as a group provided no other exclusions apply to them.

Scoring & Payment Adjustments

Overview

What happens if a clinician joins our group after September 30 of the performance year?

We finalized the following policies for clinicians who start billing Medicare Part B claims at a practice (TIN) between October 1 and December 31 of the performance year:

- When the practice participates as a group, these clinicians will receive the group's final score and associated payment adjustment unless they are otherwise excluded (see the answer to the previous question).
- These clinicians will receive a neutral payment adjustment if the practice doesn't report as a group.

What happens if a clinician leaves our group during the performance year?

When submitting data as a group, your practice will report aggregated data from the clinicians billing under your TIN as appropriate to the measures and activities you select. This may include data from clinicians who left your practice prior to the end of the 2023 performance year.

Even if a MIPS eligible clinician left your practice, the clinician will still receive a final score and payment adjustment based on your practice's performance which may follow the clinician to any new practice (TIN) they join for the 2025 payment year.

Quality Payment
PROGRAM

Help and Version History

Help and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

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

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

Help and Version History

Version History

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

Date	Description
03/27/2023	Original Posting.

Appendices

Appendix A

Quality Payment PROGRAM

Group Participation Timeline (Traditional MIPS)

Participation and data submission deadlines for the 2023 performance year are included in the chart below. You can also visit the performance year 2023 timeline on the QPP website.

Below are some key dates for MIPS group participation in traditional MIPS:

Dec. 2022	Jan. 1, 2023	Apr. 3, 2023	Spring 2023	June 30, 2023
Initial 2023 performance year eligibility available. **DO NOW:** Check preliminary eligibility on the QPP website.	2023 MIPS performance year begins. **DO NOW:** Review collection types and available quality measures so you can start collecting quality data.	Registration period begins for the CAHPS for MIPS Survey. **DO NOW:** Create a QPP account (ZIP) and request the Security Official role for your practice if you don't have QPP credentials and your group wants to register.	MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exception application window opens. **DO NOW:** Review information about exception applications on the QPP website.	Registration deadline for CAHPS for MIPS Survey. **DO NOW:** Complete your registration before 8 p.m. ET.

Appendix A

Quality Payment PROGRAM

Group Participation Timeline (Traditional MIPS) (Continued)

Below are some key dates for MIPS group participation in traditional MIPS:

Oct. 3, 2023	Dec. 2023	Dec. 31, 2023	Jan. 2, 2024	Jan. 2, 2024 – April 1, 2024	Summer 2024	Jan 1, 2025
Last day to start a 90-day performance period for Promoting Interoperability and improvement activities. **DO NOW:** Start performing your measures and implementing activities if you haven't already.	2023 performance year eligibility finalized. **DO NOW:** Check final eligibility on the QPP Participation Status Tool.	2023 MIPS performance year ends. **DO NOW:** Prepare for data submission.	MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exceptions application window closes. **DO NOW:** Complete and submit your application by 8 p.m. ET (if applying).	MIPS data submission period for the 2023 performance year. **DO NOW:** Create a QPP account and request a role for your practice so you can submit data or review data submitted on your behalf.	MIPS Performance feedback will be available. **DO NOW:** Sign in to the QPP website to review your performance feedback and associated payment adjustment for your clinicians.	MIPS payment adjustments for the 2023 performance year go into effect. **DO NOW:** Review the MIPS payment adjustment applied to covered professional services furnished by your MIPS eligible clinicians on your remittance advance.

Appendix B

Data Submission Checklists (Traditional MIPS)

Once your practice has decided to participate as a group, you'll need to make some decisions about the ways you'll collect and submit your aggregated data for each of the performance categories requiring data submission.

- If your practice submits any data as a group, you'll be evaluated for all performance categories as a group.
- There is no checklist for the cost performance category because there are no data submission requirements. We collect and calculate your cost data for you.

Appendix B

Quality Payment PROGRAM

Quality Performance Category Submission Checklist (Traditional MIPS)

❑ **Determine whether your practice may qualify for facility-based measurement:**

- Sign in to the QPP website to find out if your practice is currently identified as facility-based at the group level.
- Review the 2023 Facility-Based Measurement Quick Start Guide (PDF).
- Verify your facility-based status in fall/late 2023.

❑ **If your practice isn't facility-based, or is facility-based but chooses to collect and submit additional quality measures, you'll need to:**

- Select your measures and collection type(s):
  - If you're a small practice reporting any Medicare Part B claims measures, begin adding quality data codes (QDCs) to your clinicians' claims in January 2023.
  - If applicable, register to administer the CAHPS for MIPS Survey by June 30, 2023.
    - If you're administering the CAHPS for MIPS Survey, review the list of 2023 CMS-approved survey vendors. We anticipate this list will be available on the QPP Resource Library in summer 2023.
  - If reporting eCQMs, talk to your CEHRT vendor to make sure:
    - Your data can be aggregated to and exported at the TIN-level.
    - Your EHR is certified by ONC to the 2015 Edition Cures Update CEHRT criteria by the end of the performance period.
  - If reporting MIPS CQMs, review the 2023 QCDR Qualified Postings (XLSX) to find a QCDR that supports the measures you've selected or the 2023 Qualified Registries Qualified Postings (XLSX) to find a Qualified Registry.
  - If reporting QCDR measures, review the 2023 QCDR Qualified Postings (XLSX) to find a QCDR that has been approved for QCDR measures that are relevant for your practice.

Appendix B

Quality Performance Category Submission Checklist (Traditional MIPS) (Continued)

- ❑ **Make your data available to a third party intermediary as appropriate.**
- ❑ **Create a QPP account and connect to your organization (if you haven't already) so you can:**
  - **Sign In and Upload** your eCQM data in a CMS-approved file format.
  - Review the data submitted on your behalf during the submission period.
  - Review your performance on claims measures submitted throughout the performance period.

Improvement Activities Category Submission Checklist (Traditional MIPS)

- ❑ **Determine whether your group qualifies for double points for each activity.**
- ❑ **Review and select your activities.**
- ❑ **Identify the clinicians who will implement the activities:**
  - Each activity must be implemented by at least 50% of the clinicians in the group.
  - Activities don't need to be performed concurrently, but each clinician must perform the activity for a minimum of 90 continuous days during calendar year 2023, unless otherwise specified in the activity description.
- ❑ **Decide whether you'll work with a third party intermediary to submit data for you:**
  - If you decide to work with a QCDR, review the 2023 QCDR Qualified Postings (XLSX) and find one that supports your desired activity.
  - If you decide to work with a Qualified Registry, review the 2023 Qualified Registries Qualified Postings (XLSX) and find one that supports your desired activity.
  - While you (or a third party intermediary) don't have to submit any supporting documentation when you attest to completing an improvement activity, you must keep documentation of the efforts your group undertook to meet the improvement activity for 6 years subsequent to submission. Review the 2023 MIPS Data Validation Criteria (ZIP) for additional information.

Appendix B

Improvement Activities Category Submission Checklist (Traditional MIPS) (Continued)

- ❑ **Make your data available to a third party intermediary, as appropriate.**
- ❑ **Create a QPP account and connect to your organization (if you haven't already) so you can:**
  - **Sign In and Upload** your activity data in a CMS-approved file format.
  - **Sign In and Attest** to your activities (providing 'Yes' values to the activities you've performed).
  - Review the data submitted on your behalf during the submission period.

Promoting Interoperability Performance Category Submission Checklist (Traditional MIPS)

- ❑ **Determine whether your group qualifies for reweighting. If your group doesn't qualify for reweighting in this category, or does qualify but is able to collect and submit the Promoting Interoperability measures, you'll need to:**
  - **Determine your performance period:**
    - A minimum of a continuous 90-day period in 2023.
    - Your EHR must have 2015 Edition Cures Update CEHRT functionality in place by the first day of your performance period.
    - Your EHR must be **certified by ONC** to the 2015 Edition Cures Update certification criteria by the **last day of your performance period**.
  - **Perform your annual Security Risk Analysis (ZIP).**
  - **Decide whether you'll work with a third party intermediary to submit data for you:**
    - If you decide to work with a QCDR, review the 2023 QCDR Qualified Postings (XLSX). Note that there are some exceptions for whether QCDRs will support the Promoting Interoperability performance category.
    - If you decide to work with a Qualified Registry, review the 2023 Qualified Registries Qualified Postings (XLSX). Note that there are some exceptions for whether Qualified Registries will support the Promoting Interoperability performance category.
    - If you decide to extract your measures directly from your CEHRT, talk to your CEHRT vendor to make sure your data can be aggregated to and exported at the TIN-level.

Appendix B

Promoting Interoperability Performance Category Submission Checklist (Traditional MIPS) (Continued)

- **Make your data available to a third party intermediary, as appropriate (including your EHR's CMS Certification ID).**
- **Create a QPP account and connect to your organization (if you haven't already) so you can:**
  - **Sign In and Attest** to your Promoting Interoperability data (reporting aggregated numerators and denominators, or 'Yes/No' values, as appropriate for measures and required attestation statements).
  - **Sign In and Upload** your Promoting Interoperability data in a CMS-approved file format.
  - Review the data submitted on your behalf during the submission period.

Appendix C

Quality Payment PROGRAM

2023 Performance Year Performance Category Weight Redistribution Policies

Attention: If you are a small practice, please review Appendix D for the redistribution policies that apply to you.

Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Reweighting Needed				
General weighting for all 4 performance categories	**30%**	**30%**	**15%**	**25%**
Reweight 1 Performance Category				
No Cost	55%	0%	15%	30%
No Promoting Interoperability	55%	30%	15%	0%
No Quality	0%	30%	15%	55%
No Improvement Activities	45%	30%	0%	25%
Reweight 2 Performance Categories				
No Cost **and** No Promoting Interoperability	85%	0%	15%	0%
No Cost **and** No Quality	0%	0%	15%	85%
No Cost **and** No Improvement Activities	70%	0%	0%	30%
No Promoting Interoperability **and** No Quality	0%	50%	50%	0%
No Promoting Interoperability **and** No Improvement Activities	70%	30%	0%	0%
No Quality **and** No Improvement Activities	0%	30%	0%	70%

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix D

Quality Payment PROGRAM

Final Score Calculation – 2023 Performance Year Performance Category Weight Redistribution Policies for Small Practices

We've updated the performance category redistribution policies for small practices **to more heavily weight the improvement activities performance category** when other performance categories are reweighted.

Standard weighting for small practices **(Promoting Interoperability automatically reweighted)**

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

When both the **cost** and the **Promoting Interoperability** performance categories are reweighted:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
50% of MIPS Score	0% of MIPS Score	50% of MIPS Score	0% of MIPS Score

Appendix D

Final Score Calculation – 2023 Performance Year Performance Category Weight Redistribution Policies for Small Practices (Continued)

NOTE: The following scenarios apply to all participating in MIPS, not just small practices.

When both the **quality** and the **Promoting Interoperability** performance categories are reweighted:

Quality	Cost	Improvement Activities	Promoting Interoperability
0% of MIPS Score	50% of MIPS Score	50% of MIPS Score	0% of MIPS Score

When **no** performance categories are reweighted (this means you submitted Promoting Interoperability data):

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