Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Notice of Proposed Rule Making

Quality Payment Program (QPP) Policy Proposals Overview

We recognize the challenges faced by many across the country over the past two years. As we move forward together and look to the future of the Quality Payment Program (QPP), the Centers for Medicare & Medicaid Services (CMS) remains committed to promoting more meaningful participation for clinicians and ensuring our policies continue to drive us toward value and improved health outcomes for patients. To further these goals under the Merit-based Incentive Payment System (MIPS), we're focusing our proposals on continuing to develop new MIPS Value Pathways (MVPs) and refining the subgroup participation option. MVPs provide clinicians with the opportunity for more meaningful participation by reporting a more connected, cohesive set of measures and activities and allowing for comparative feedback that will be more beneficial to patients. We believe that subgroup reporting will allow comprehensive measurement of clinician performance in MIPS due to the ability for a cohort of clinicians to form subgroups and report on measures and activities relevant to the scope of care provided. We anticipate that subgroup reporting would allow CMS to capture clinician performance at a more granular level, provide performance feedback to clinicians relevant to their scope of care provided, and provide patients better data to make informed decisions about their care needs.

We're proposing limited changes in traditional MIPS to provide clinicians continuity and consistency while they gain familiarity with MVPs. For example, we're proposing to continue streamlining and strengthening our quality measure and improvement activities inventories, by proposing to remove duplicative and topped out measures, as well as those with limited adoption. Maintaining a quality measure inventory that drives quality outcomes for patients is a key goal of quality measure reporting. Meanwhile, the new and modified activities help fill some gaps we have identified in the Inventory and standardize language related to equity across the category.

We're also proposing several policies to reduce burden and facilitate participation in Alternative Payment Models (APMs). For example, we're proposing to permanently establish the 8% minimum Generally Applicable Nominal Risk standard for Advanced APMs, which is currently set to expire in 2024. We also previously finalized a policy to set a limit of 50 on the number of clinicians in an organization that participates in an Advanced APM through a Medical Home Model, using the Medical Home Model nominal financial risk criteria. At that time, we described the way in which we would identify APM Entities that meet this standard as looking for "APM Entities that participate in Medical Home Models and that have 50 or fewer eligible clinicians in the organization through which the entity is owned and operated." We defined organizational size as measured based on the size of the "parent organization" rather than the size of the APM Entity itself. In this notice of proposed rulemaking (NPRM), we're proposing to apply the 50 eligible clinician limit to the APM Entity participating in the Medical Home Model based on the TIN/NPIs

on the APM Entity's participation list. We are also proposing conforming changes to our Other Payer Advanced APM policies in these areas.

We're also issuing a number of Requests for Information (RFIs) to solicit feedback on the future of the QPP.

- **Payment Gap for QPs and Subsequent Transition to Enhanced Conversion Factor Updates RFI:** We're requesting information from interested parties about what, if anything, they would like to see CMS do in response to the transition from having a 5% lump sum APM Incentive Payment awarded to Qualifying APM Participants (QPs) in payment years 2019-2024 to having a 0.75% Conversion Factor update available to them in payment years 2026 onward. (There is no APM incentive authorized under MACRA for the 2023 performance year/2025 payment year.)

- **MIPS Quality Performance Category Health Equity RFI:** We included a MIPS health equity RFI on the development and implementation of health equity measures for the quality performance category as we seek to enhance and increase the number of measures in future years that address and/or incorporate factors pertaining to health equity. To further align policies specific to health equity and health disparities across programs, the Medicare Shared Savings Program also included an RFI regarding health equity in the proposed rule.

- **Developing Quality Measures that Address Amputation Avoidance in Diabetic Patients RFI:** We believe amputation avoidance in diabetic patients is a priority clinical topic, particularly in the measurement of underserved populations, as there are substantial equity concerns related to racial disparity in diabetes-related amputation. We seek input from stakeholders on identifying measure concepts on this topic that would lead to improved patient outcomes and proactive care in an attempt to avoid amputation.

- **QCDRs/QRs/Health IT Vendors Supporting all Measures in MVPs RFI:** In response to comments, questions and concerns from third party intermediaries, we're seeking feedback on whether third party intermediaries (e.g., Qualified Clinical Data Registries (QCDRs)) should have the flexibility to choose which measures they will support within the MVP and why through an RFI.

- **CME Organizations Submitting Improvement Activities for MVPs RFI:** We're seeking feedback on allowing Continuing Medical Education (CME) Organizations to directly submit improvement activities for MVPs; this would require the creation of a new type of third party intermediary. We're seeking feedback on the value of implementing policies to approve CME Organizations or accreditation entities as third party intermediaries, including whether accreditation entities serving as third party intermediaries could reduce clinician reporting burden.

- **Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) RFI:** We're requesting input on CMS' opportunities to incentivize participation in TEFCA through programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery. We're also interested in a potential role for TEFCA in payment and operations activities, such as submission of clinical documentation to support claims adjudication and prior authorization processes.

- **Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in the Quality Payment Program RFI:** We're building upon the FHIR RFI included in the CY 2022 PFS proposed rule to continue our engagement with interested parties on the topic of CMS' aim to move to digital quality measurement in the CY 2023 PFS proposed rule. We want to continue engaging with interested parties on the topics of (a) data standardization activities related to leveraging and advancing standards for digital data, and (b) approaches to transition to FHIR electronic clinical quality measure (eCQM) reporting, as initial steps in our transition to digital quality measurement.

- **Potential Transition to Individual QP Determination RFI:** We are requesting information from interested parties on a change in the way we make QP determinations, which would move to the individual level rather than the current APM Entity level. Our focus includes how we can best encourage specialists in Advanced APMs to participate in performance measurement.

For more information on the specific policies proposed in the CY 2023 PFS NPRM, please refer to:
- **MVPs Proposals Table** and **Proposed MVPs Guide** in the CY 2023 PFS QPP Proposed Rule Resources (ZIP)
- **CY 2023 QPP Policy Proposals Comparison Table** in the CY 2023 PFS QPP Proposed Rule Resources (ZIP)

Version History

Date	Change Description
7/8/2022	Updated to include link to CY 2023 PFS QPP Proposed Rule Resources zip file.
7/7/2022	Original version