Merit-based Incentive Payment System (MIPS)

2023 Quality Performance Category Quick Start Guide: Traditional MIPS

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Purpose: This resource focuses on the quality performance category under traditional MIPS, providing the high-level requirements and practical information about quality measure selection, data collection, and submission for the 2023 performance period for individual, group, virtual group, and Alternative Payment Model (APM) Entity participation. This resource doesn't address quality requirements under the MIPS Value Pathways (MVPs) or APM Performance Pathway (APP).

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How to Use this Guide

How to Use This Guide

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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.

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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

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What is the MIPS Quality Performance Category?

The quality performance category measures your performance on clinical practices and patient outcomes. The quality measures are tools that help us assess healthcare processes, outcomes, and patient experiences to ensure they align with our quality goals for healthcare.

Traditional MIPS Performance Category Weights in 2023:
Individual, Group, and Virtual Group Participation

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

Traditional MIPS Performance Category Weights in 2023:
APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
55%	0%	15%	30%

Overview

What's New with Quality Under Traditional MIPS in 2023?

Updates to Quality Measure Inventory

- We added 9 new quality measures (including 1 new administrative claims measure), removed 11 quality measures from traditional MIPS, and partially removed 2 quality measures (removed from traditional MIPS but retained for MVPs).
- There were also 76 existing quality measures with substantive changes, 5 of which won't have a historical benchmark because the changes were so significant that we can't compare the 2023 measure specification to the 2021 measure specification.
- For more information on these measures, please review the Appendix.

For the 2023 performance period, **the data completeness threshold remains 70%**; however, we finalized increasing the threshold to 75% for the 2024 and 2025 performance periods.

This resource examines quality performance category under traditional MIPS.

- For more information about the quality performance category **under the MVP**, please refer to the 2023 MVP Implementation Guide or Explore MVPs webpage.
- For more information about the quality performance category **under the APP**, please refer to the APP Quality Requirements webpage.

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What's New with Quality Under Traditional MIPS in 2023? (Continued)

Updates to Measure Scoring

- We're removing the 3-point floor for measures that can be reliably scored against a benchmark (i.e., those that meet the data completeness and case minimum criteria). These measures will receive 1-10 points.
- We're removing the 3-point floor for measures without a benchmark, even when the data completeness and case minimum criteria are met (except for small practices). These measures will receive zero points; however, small practices will continue to earn 3 points.
- We're removing the 3-point floor for measures that don't meet the case minimum criteria (except for small practices). These measures will receive zero points; however, small practices will continue to earn 3 points.

Note: These policies don't apply to new measures during the first 2 performance periods available for reporting.

Beginning with the 2023 performance period, we'll score administrative claims measures exclusively against performance period benchmarks.

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Get Started with Quality for Traditional MIPS in 5 Steps

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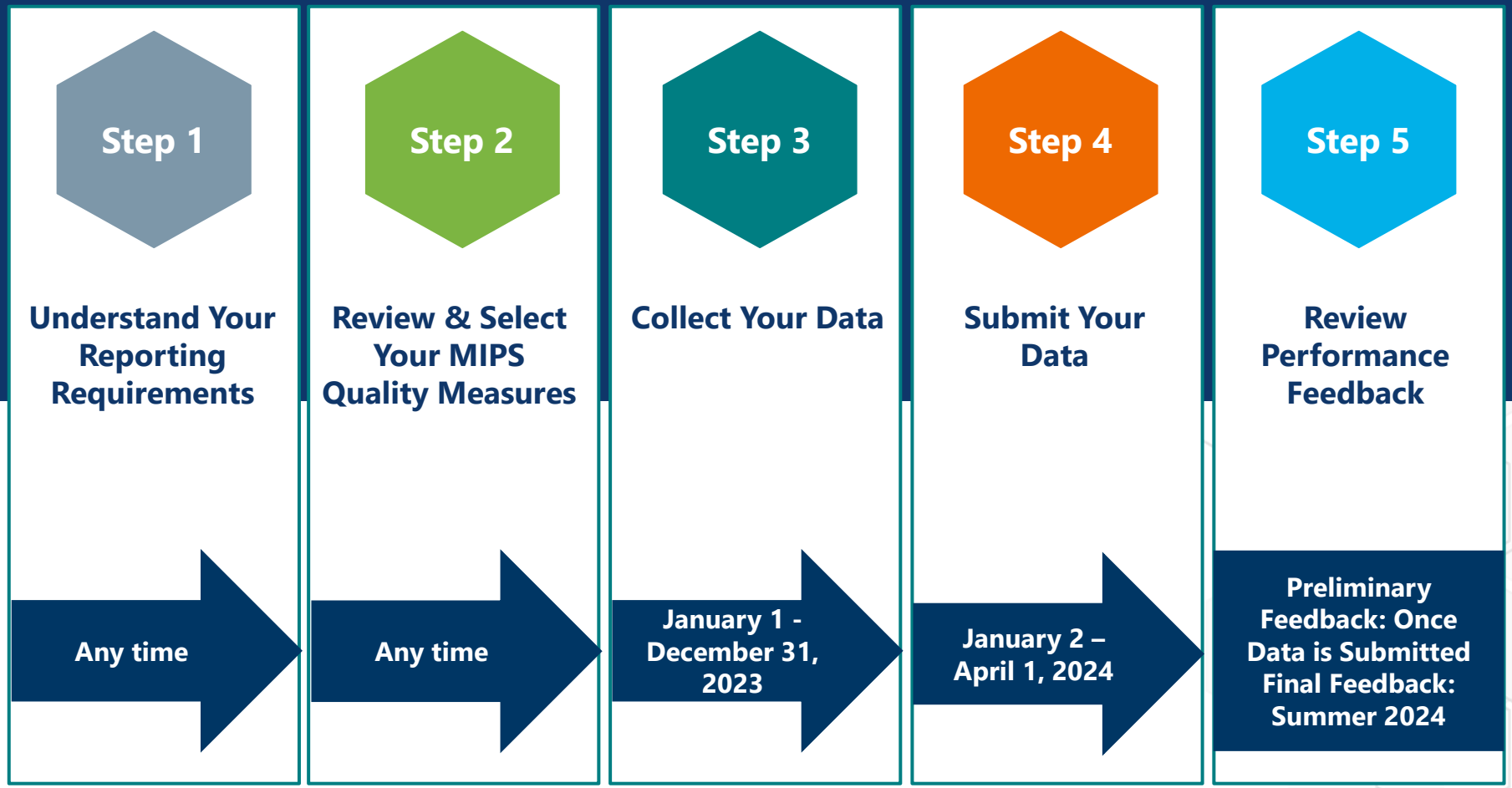

Get Started with Quality for Traditional MIPS in 5 Steps

Step 1. Understand Your Reporting Requirements

The quality performance category has a **12-month performance period** (January 1 – December 31, 2023), which means you must collect data for each measure for the full calendar year.

To meet the quality performance category requirements under traditional MIPS, you must report:

6 Quality Measures	OR	A Defined Specialty Measure Set
Including at least one outcome measure or high priority measure in absence of an applicable outcome measure.		(if the measure set has fewer than 6 measures, you need to submit all measures within that set).

Did you know? Facility-based clinicians, groups, and virtual groups whose assigned facility has a Fiscal Year (FY) 2024 Hospital Value-Based Purchasing (VBP) Program score may have the option to use their Hospital VBP Program score for the quality and cost performance categories. For more information on facility-based measurement, please refer to the 2023 Facility-Based Measurement Quick Start Guide.

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Step 2. Review & Select Your MIPS Quality Measures

There are 198 MIPS quality measures available to report for the 2023 performance period, as well 266 Qualified Clinical Data Registry (QCDR) measures approved outside the rulemaking process. The MIPS quality measures are available through different collection types. Some collection types give you an opportunity to work with a third party intermediary such as a Qualified Registry to collect and submit your data, while other collection types allow you to report measures yourself.

The table on the following pages walks you through the different collection types and provides links to the measure specifications that are available within the Quality Payment Program Resource Library. The 2023 MIPS quality measures will be available on the Explore Measures & Activities website in early 2023.

If you plan to work with a QCDR or Qualified Registry, check the 2023 Qualified Postings linked in the table on the following pages to see which measures they support.

Helpful Hints

- **Reminder: There are no bonus points available for reporting additional outcome and high priority measures or measures that meet end-to-end electronic reporting criteria.**
- Use the 2023 Quality Measures List to identify:
  - The available collection type(s) for each measure.
  - Measure type (outcome, patient experience, etc.).
  - Specialty sets associated with each measure.
- Specialty Measure guides will be released in early 2023 to aid in measure and activity selection for clinicians who practice in various specialties.

Get Started with Quality for Traditional MIPS in 5 Steps

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Step 2. Review & Select Your MIPS Quality Measures (Continued)

Did you know?

- **Collection Type** refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. Follow the measure specifications that correspond with how you choose to collect your quality data.
    - For example: You're looking for a quality measure to report on the Use of High-Risk Medications in the Elderly. This measure is available as both a MIPS Clinical Quality Measure (CQM) and Electronic Clinical Quality Measure (eCQM) (distinct specifications). You would use the measure specification that corresponds with how you choose to collect your data.
- You can report measures from multiple collection types to meet quality reporting requirements.

Collection Type	Quality Measures Available for 2023	What Do You Need to Know about This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2023 eCQM specifications 2023 eCQM flows eCQM Implementation and Preparation Checklists	You can report eCQMs if you use technology that has the 2015 Edition Cures Update Certified Electronic Health Record Technology (CEHRT) certification from the Office of the National Coordinator for Health Information Technology (ONC) by the time eCQM data is generated for submission. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. Please refer to the Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) website to verify.

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Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2023	What Do You Need to Know about This Collection Type?
Electronic Clinical Quality Measures (eCQMs) (continued)		If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure.
MIPS Clinical Quality Measures (MIPS CQMs)	2023 Clinical Quality Measure Specifications and Supporting Documents 2023 Qualified Clinical Data Registries Qualified Posting 2023 Qualified Registries Qualified Posting	MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you choose this collection type, you may choose to work with a QCDR, Qualified Registry, Health IT vendor, or you can submit them yourself. MIPS CQMs can be reported in combination with Medicare Part B claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
Qualified Clinical Data Registry (QCDR) Measures	2023 QCDR Measure Specifications 2023 Qualified Clinical Data Registries Qualified Posting	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures, which are approved along with the entity during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that feel relevant to their practice. You'll need to work with a QCDR to report these measures on your behalf. QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.

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Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2023	What Do You Need to Know about This Collection Type?
Medicare Part B Claims Measures	2023 Medicare Part B Claims Specifications and Supporting Documents 2023 Part B Claims Reporting Quick Start Guide	Medicare Part B claims measures are reported with the clinician's individual (rendering) NPI when reporting as a group, virtual group, or APM Entity. Medicare Part B claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
Consumer Assessment of Healthcare Providers and Systems (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, virtual groups, and APM Entities can register between April 3, 2023, and June 30, 2023, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience of care within a group, virtual group, or APM Entity. This survey measure must be administered by a CMS-approved survey vendor. This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.

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Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Measure Title	Case Minimum	Clinician Requirement	Who's Eligible to Receive Scoring on this Measure?
Administrative Claims Measures	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Eligible Clinician Groups	200 cases	>= 16 clinicians	• Groups • Virtual Groups • APM Entities
	Risk-Standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System	25 cases This measure has a 3-year performance period (October 1, 2020 – September 30, 2023)	None	• Individuals • Groups • Virtual Groups • APM Entities
	Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	18 cases	>= 16 clinicians	• Groups • Virtual Groups • APM Entities
	Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	21 cases	>= 1 cardiologist	• Individuals • Groups • Virtual Groups • APM Entities

Get Started with Quality for Traditional MIPS in 5 Steps

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures)

You should start data collection on **January 1, 2023**, to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive **0 points** for the measure, unless you're a small practice, in which case you'll receive 3 points.

The **data completeness requirement remains 70%** for the 2023 performance period. Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the eligible population (denominator).

Note: The data completeness requirement will increase to 75% for the 2024 and 2025 performance periods.

Selectively reporting data that misrepresents your performance in a disingenuous manner, commonly referred to as **"cherry-picking,"** results in data that aren't true, accurate, or complete and may subject you to audit.

If you're working with a third party intermediary to collect and submit data, make sure you work with them throughout the year on data collection.

Aggregation of Data using an EHR

If you transition from one EHR system to another EHR system during the performance period, you should aggregate the data from the previous EHR system and the new EHR system into one report for the full 12 months prior to submitting the data. If a full 12 months of data is unavailable (for example, if aggregation isn't possible), your data completeness must reflect the 12-month period.

During the 2023 performance period, 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 before the eCQM data is generated for submission.

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Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures) (Continued)

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
  - These errors include, but are not limited to:
    - Changes to the active status of codes.
    - The inadvertent omission of codes.
    - The inclusion of inactive or inaccurate codes.
- Updates to ICD-10 codes during the performance period.
  - We finalized that we would publish a list of measures requiring 9 months of data on the Quality Payment Program Resource Library by October 1st of the performance period if technically feasible, but no later than the beginning of the data submission period (for example, January 2, 2024, for the 2023 performance period).
- Clinical guideline changes.
- Updates to measure specifications during the performance period.

If there were no concerns with potential patient harm and **9 consecutive months of data available, the measure will have a truncated performance period to the 9 consecutive months**.

If there isn't 9 consecutive months of data available, the **measure will be suppressed from scoring**, earning 0 achievement points (numerator) and reducing the total measure achievement points by 10 (denominator) for each measure submitted that is impacted.

Get Started with Quality for Traditional MIPS in 5 Steps

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Step 4. Submit Your Data

We'll assess your performance on the data you submit.

The data submission period will begin on **January 2, 2024**, and end **April 1, 2024**. If reporting Medicare Part B claims, submission will be continuous throughout the performance period.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Individual, Group, Virtual Group, or APM Entity Representative)	Medicare Part B claims Measures (small practice only)	Through your routine Medicare Part B billing practices	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2024)
	eCQMs	Sign in to the QPP website and upload a QRDA III 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 the QPP website and upload a QRDA III or QPP JSON file **OR** Use the QPP Submission 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	Following data collection (standardized annual timeframe)

Get Started with Quality for Traditional MIPS in 5 Steps

Step 4. Submit Your Data (Continued)

Did you know?

The level at which you participate in MIPS (individual, group, or virtual group) generally applies to all performance categories. We won't combine data submitted at the individual, group, and/or virtual group level into a single final score.

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all performance categories as a group.
- If data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all performance categories, but your MIPS payment adjustment will be based on the higher score.

NEW: When participating in MIPS at the APM Entity level, the APM Entity will submit quality measures and improvement activities, and now may choose to report Promoting Interoperability data at the APM Entity level. However, APM Entities will still have the option to report this performance category at the individual and group level.

Note: We'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data for another category as a group (signaling their intent to participate as a group).

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Step 5. Review Your Performance Feedback

- Preliminary scoring information will be available beginning **January 2, 2024**, once data has been submitted.
- We anticipate your final score preview will be available in **early Summer 2024**, and final performance feedback including payment adjustments will be available in **late Summer 2024**.
- You can review your performance feedback by signing in to QPP website.

Did you know?

Small practices (15 or fewer clinicians, reporting individually, as a group, virtual group, or APM Entity) that submit at least one quality measure will continue to earn 6 bonus points, which will be added to their quality performance category score.

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Help and Version History

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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
12/27/2022	Original Posting.

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Appendix

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Appendix A: Measures Finalized for Addition in the CY2023 Quality Payment Program Final Rule

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
485	MIPS CQM	Patient-Reported Outcome-based Performance	Psoriasis – Improvement in Patient-Reported Itch Severity
486	MIPS CQM	Patient-Reported Outcome-based Performance	Dermatitis – Improvement in Patient-Reported Itch Severity
487	MIPS CQM	Process	Screening for Social Drivers of Health
488	MIPS CQM eCQM	Process	Kidney Health Evaluation
489	MIPS CQM	Process	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
490	MIPS CQM	Process	Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors
491	MIPS CQM	Process	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma
492	Administrative Claims	Outcome	Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System
493	MIPS CQM	Process	Adult Immunization Status

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Appendix B: Measures Finalized for Removal in the CY2023 Quality Payment Program Final Rule

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
076	MIPS CQM Medicare Part B Claims	Process	Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections
119	MIPS CQM eCQM	Process	Diabetes: Medical Attention for Nephropathy
258	MIPS CQM	Outcome	Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)
265	MIPS CQM	Process	Biopsy Follow-Up
323	MIPS CQM	Efficiency	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)
375	eCQM	Process	Functional Status Assessment for Total Knee Replacement
425	MIPS CQM	Process	Photodocumentation of Cecal Intubation
455	MIPS CQM	Outcome	Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)
460	MIPS CQM	Patient-Reported Outcome-Based Performance	Back Pain After Lumbar Fusion
469	MIPS CQM	Patient-Reported Outcome-Based Performance	Functional Status After Lumbar Fusion
473	MIPS CQM	Patient-Reported Outcome-Based Performance	Leg Pain After Lumbar Fusion

Appendix

Appendix C: Measures Finalized for Partial Removal (Removed from Traditional MIPS; Retained for MVPs) in the CY2023 Quality Payment Program Final Rule

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
110	Medicare Part B Claims, eCQM and MIPS CQM	Process	Preventive Care and Screening: Influenza Immunization
111	Medicare Part B Claims, eCQM and MIPS CQM	Process	Pneumococcal Vaccination Status for Older Adults

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Appendix D: Measures Finalized with Substantive Changes in the CY2023 Quality Payment Program Final Rule, Resulting in No Historical Benchmark for the 2023 Performance Period

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
145	Medicare Part B claims MIPS CQM	Process	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
277	MIPS CQM	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis
459	MIPS CQM	Patient Reported Outcome-based Performance	Back Pain After Lumbar Surgery
461	MIPS CQM	Patient Reported Outcome-based Performance	Leg Pain After Lumbar Surgery
471	MIPS CQM	Patient Reported Outcome-based Performance	Functional Status After Lumbar Surgery