Quality Payment PROGRAM

Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) Final Rule Fact Sheet and Policy Comparison Table

Quality Payment Program Policy Overview

We noted with the release of the CY 2024 PFS Notice of Proposed Rulemaking (NPRM) that we were looking forward to getting the Quality Payment Program (QPP) back on track with the trajectory we had planned before the public health emergency (PHE). We're finalizing policies that emphasize continuity, and further support digital measurement and interoperability. We're also continuing the development and maintenance of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs).

The following are highlights of policies **finalized** in the CY 2024 PFS Final Rule:

- We **finalized** 5 new MVPs, and modifications to the previously finalized MVPs.
  - There will be a total of 16 MVPs available for reporting in the 2024 performance period.

- We **finalized** a 180-day (minimum) performance period for the Promoting Interoperability performance category.
  - This change promotes continuity across the Centers for Medicare & Medicaid Services (CMS) programs, aligning with the Medicare Promoting Interoperability Program.

- We **finalized** the Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) collection type for Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) meeting the reporting under the APM Performance Pathway (APP).

The following are highlights of policies **not finalized** in the CY 2024 PFS Final Rule:

- We didn't finalize any policies that would result in an increase to the performance threshold.
  - The **performance threshold will remain 75 points** for the 2024 performance period.

- We didn't finalize an increase to the data completeness threshold for the 2027 performance period.

- We didn't finalize our proposal to make Qualifying Alternative Payment Model (APM) Participant (QP) determinations at the individual clinician level.
    - We'll continue to make these determinations at the APM Entity level for the 2024 performance period.

For more information on the specific policies finalized in the CY 2024 PFS Final Rule, please refer to:

- **2024 QPP Final Rule MVP Guide (PDF)**
- **2024 Medicare Shared Savings Program Policies Fact Sheet (PDF)**
- **QPP Policy Comparison Table** (next section in this document)
- **2024 PFS Final Rule: FAQs about QPP Policies (ZIP)**

QPP Policy Comparison Table: Current Policies vs Policies Finalized in the CY 2024 PFS Final Rule

MIPS Overview

The following table outlines finalized policies that are applicable to one or more MIPS reporting options. There are 3 MIPS reporting options available:

- Traditional MIPS
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

Refer to the 2024 Finalized MVPs Guide for information about the MVPs finalized for the 2024 performance period.

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
Quality Performance Category			
Quality Measures	**Quality Measure Inventory** There are 198 quality measures available for the 2023 performance period, excluding Qualified Clinical Data Registry (QCDR) measures.	**Quality Measure Inventory** We finalized changes to the quality measures inventory resulting in a total of 198 quality measures for the 2024 performance period. Note that QCDR measures are approved outside the rulemaking process and aren't included in this total. These changes reflect: • Addition of 11 quality measures, including 1 composite measure and 6 high priority measures, of which 4 are patient-reported outcome measures. (See Appendix B).	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
	• Registered dieticians or nutrition professionals Automatic reweighting applies to MIPS eligible clinicians, groups, and virtual groups with the following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practice	ASC-based, hospital-based, and non-patient facing clinicians and groups, along with clinicians in a small practice, will continue to be automatically reweighted.	
Performance Period	The performance period is a minimum of **90 continuous days** within the calendar year.	We finalized the **increase** of the performance period to a minimum of **180 continuous days** within the calendar year. • This ensures that the MIPS Promoting Interoperability performance category continues to align with the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals.	• **Traditional MIPS** • **MVPs** • **APP**
Measures	**Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion** The current exclusion is available if a clinician or group "writes fewer than 100 permissible prescriptions during the performance period"	**Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion** We finalized the modification of this exclusion to the following:	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
		• "Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period." The current exclusion is too broad and doesn't necessarily accommodate clinicians who don't electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.	
Measure Points	**Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure** For the 2022 and 2023 performance periods a "yes" or a "no" response fulfills the SAFER Guide measure.	**Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure** We finalized our proposal to require a "yes" response on the attestation for the SAFER Guide measure beginning with the CY 2024 performance period. • Clinicians only need to review the High Priority Practices SAFER guide.	• **Traditional MIPS** • **MVPs** • **APP**
Final Scoring			
Facility-Based Scoring	A facility-based score, if available, would be assigned to clinicians participating as a subgroup.	We finalized a clarification that we won't calculate a facility-based score at the subgroup level. • There's isn't a facility-based MVP. • Facility-based scores are only calculated as part of a final score in traditional MIPS* which isn't an available reporting option for subgroups.	• **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
		*A facility-based clinician or group can still report an MVP or the APP. In this instance we would: • Calculate one final score in traditional MIPS using facility-based measurement, and • Calculate one final score from MVP or APP reporting, and • Assign the higher of these final scores.	
Complex Patient Bonus	Beginning with the 2023 performance period, a complex patient bonus score will be added to the subgroup's final score.	We finalized the addition of § 414.1365(e)(4)(i) to clarify that **beginning with the 2023 performance period**, subgroups will receive their affiliated group's complex patient bonus, if available.	• **MVPs**
Performance Category Reweighting	For an MVP Participant that is a subgroup, any reweighting applied to its affiliated group will also be applied to the subgroup. • If reweighting isn't applied to the affiliated group, the subgroup may request reweighting independent of the affiliated group through a MIPS extreme and uncontrollable circumstances exception application.	We finalized that subgroups will only receive reweighting based on any reweighting applied to its affiliated group. • Under current policy, we're only able to review and approve a subgroup's reweighting request after we confirmed an affiliated group didn't submit a reweighting request or if any reweighting was applied to the affiliated group. • Therefore, a subgroup wouldn't know of its reweighting status until later in the performance period.	• **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
		• We believe this delayed review of a subgroup's reweighting application disrupts the capability of a subgroup to determine its reweighting status and data submission needs.	
Performance Threshold	As required by statute, beginning with the 2022 performance year/2024 payment year, we must set the performance threshold as either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. We continued to use the **mean final score from the 2017 performance year/2019 MIPS payment year** to establish the performance threshold for the 2023 MIPS performance period/2025 MIPS payment year. • The performance threshold is set at **75 points**.	No changes to the performance threshold for the 2024 performance period. • **The performance threshold will remain 75 points.** We didn't finalize our proposal to use the mean of final scores from the 2017 – 2019 performance periods to set the MIPS performance threshold, which would have increased the performance threshold to 82 points.	• **Traditional MIPS** • **MVPs** • **APP**
Targeted Review	**Targeted Review Timeline** There is a 60-day period during which clinicians, groups, virtual groups and APM Entities can request a targeted review.	**Targeted Review Timeline** Beginning with the 2024 performance period, the **targeted review submission period will open upon release of MIPS final scores and remain open for 30 days after MIPS payment adjustments are released.**	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)

	• The 60-day period begins on the day CMS makes MIPS payment adjustment information available.	• This will maintain an approximately 60-day period for requesting a targeted review:
		  ○ 30 days **before** payment adjustments are released.
		  ○ 30 days **after** payment adjustments are released.
		
		This updated timeline will allow us to ensure that we have completed adjudicating targeted reviews and have a finalized list of Qualifying APM Participants (QPs) by October 1 so that accurate payments reflective of performance across QPP (that is, MIPS payment adjustments and the Qualifying APM conversion factor) can be implemented as of January 1 of the payment year.	

	Targeted Review Documentation/Information Requests If CMS requests additional information under the targeted review process, the additional information must be provided to and received by CMS within 30 days of receipt of such request.	**Targeted Review Documentation/Information Requests** If CMS requests additional information under the targeted review process, the additional information must be provided to and received by CMS **within 15** days of receipt of such request. This policy will also support our ability to finalize scores and QP status by October 1.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
	Targeted Review Requests Targeted reviews may be submitted by or on behalf of individual clinicians, groups and APM Entities.	**Targeted Review Requests** We finalized t that subgroups and virtual groups will be added to the list of entities that may submit a request for a targeted review for the MIPS payment adjustment factor beginning with the 2023 performance period.	• **MVPs (subgroups)** • **Traditional MIPS (virtual groups)**
Third Party Intermediaries			
Health Information Technology (IT) Vendors	Health IT vendors are a category of third party intermediaries, authorized to submit data on behalf of MIPS eligible clinicians. • Health IT vendors are required to support data submission for all performance categories in traditional MIPS. • Beginning with the 2023 performance period, Health IT vendors must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. • Health IT vendors may also support the APP.	We finalized the **elimination of the health IT vendor category of third party intermediaries**, beginning with the CY 2025 performance period, to remove gaps in third party intermediary requirements and improve data integrity. To submit data on behalf of clinicians, a health IT vendor will need to meet the requirements of and self-nominate to become a qualified registry or QCDR. They can continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.	• **Traditional MIPS** • **MVPs** • **APP**
Qualified Clinical Data Registries (QCDRs)	**Self-Nomination and Approval Policies** We refer you to § 42 CFR 414.1400(b)(2) and § 42 CFR 414.1400(b)(3) for information about	**Self-Nomination and Approval Policies** We finalized the following policies related to the self-nomination and approval process for QCDRs and	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
and Qualified Registries	previously finalized policies related to self-nomination requirements and approval criteria.	qualified registries, including: • Updating self-nomination requirements to require that QCDRs and qualified registries must include MVP titles and measure and activity identifiers for the improvement activities and Promoting Interoperability performance categories. Specifying requirements for a simplified self-nomination form to existing Qualified Clinical Data Registries (QCDRs) and qualified registries in good standing. • Adding “measures submitted after self-nomination” to our list of reasons for rejecting a QCDR measure. • Implementing a requirement that QCDRs publicly post their approved measure specifications through the duration of the performance period and associated submission period. • Specifying the required sampling methodology for third party intermediary data validation audits. • Requiring QCDRs and qualified registries to attest to the accuracy of their information in qualified postings. • Requiring QCDRs and qualified registries to attest that they can provide CMS with access to review the data, upon request.	

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
	Support of MVPs Beginning with the 2023 performance period, QCDRs and qualified registries must support MVPs that are applicable to the MVP participants on whose behalf they submit MIPS data. QCDRs and qualified registries may also support the APP. Third party intermediaries who support MVPs are required to support all measures and activities available in the MVP across the quality, improvement activities, and Promoting Interoperability performance categories. The exceptions to this requirement are the cost measures, population health measure, QCDR measures and the CAHPS for MIPS Survey measure.	**Support of MVPs** Given that many third party intermediaries may not support measures for clinicians in all specialty areas that might report a MVP, we clarified that a QCDR or a qualified registry must support all measures and improvement activities available in the MVP with 2 exceptions: 1. If an MVP includes several specialties, then the QCDR or qualified registry is only expected to support the measures that are pertinent to the specialty of their clinicians. 2. QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR doesn't own the QCDR measures in the MVP, the QCDR can only support the QCDR measures if they have the appropriate permissions.	• **MVPs**
	Remedial Action and Termination Policies We may take remedial action if we determine that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, has submitted a false certification, or	**Remedial Action and Termination Policies** We finalized the following policies related to third party intermediaries: • CMS will indicate in the public qualified postings that a third party intermediary has been placed on remedial action or terminated.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY	Applicable MIPS Reporting Option(s)
	has submitted data that are inaccurate, unusable, or otherwise compromised. We may immediately or with advance notice terminate a third party intermediary for one or more of the following reasons: • CMS has grounds to impose remedial action. • CMS hasn't received a corrective action plan (CAP) within the specified time-period or the CAP is not accepted by CMS. • The third party intermediary fails to correct the deficiencies or data errors by the date specified by CMS. A data submission that contains data inaccuracies affecting the third party intermediary's total clinicians may lead to remedial action/termination of the third party intermediary for future program year(s) based on CMS discretion.	• CMS can take remedial action, including termination, for third party intermediaries that fail to maintain up-to-date contact information. • Third party intermediaries will be required to notify CMS when a CAP has been successfully completed. • CMS can initiate termination of third party intermediaries that are on remedial action for two consecutive years.	

Advanced APMs Overview

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY
Advanced APMs	**Use of Certified Electronic Health Record Technology (CEHRT)** Our regulations at 42 C.F.R. § 414.1415 state that 75% of eligible clinicians in each participating APM Entity (for example, an ACO) must be required under the terms of the APM to use CEHRT in order for the APM to be an Advanced APM.	**Use of Certified Electronic Health Record Technology (CEHRT)** To be an Advanced APM, the APM must require the use of certified EHR technology, which means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM. We also proposed to remove the 75% numerical threshold, and simply have the APM require the use of CEHRT as defined in QPP regulations. We're finalizing this proposal with a one-year delay to the 2025 performance year.
APM Incentive	**QP Determinations**	**QP Determinations** **No change.**

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY
	For purposes of QP determination, we assess most eligible clinicians as a group at the APM Entity level.	We didn't finalize the proposal to make QP determinations at the individual eligible clinician level only, instead of the APM Entity level.
	QP and Partial QP Threshold Percentages The statutory QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer Option at 42 C.F.R. § 414.1430 provide the values for performance year 2022 and performance year 2023.	**QP and Partial QP Threshold Percentages** In accordance with the Consolidated Appropriations Act, 2023, the QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer Option are "frozen" for performance year 2023; in other words, the values remain unchanged from last year. Under current statute, the QP threshold percentages will increase beginning with the 2024 performance year. Medicare payments: • QP threshold increasing from 50% to 75% • Partial QP threshold increasing from 40% to 50% Medicare patients: • QP threshold increasing from 35% to 50% • Partial QP threshold increasing from 25% to 35%

POLICY AREA	EXISTING POLICY	CY 2024 FINALIZED POLICY
	APM Incentive Payment and Transition to Qualifying APM Conversion Factor For payment years 2019-2024, the APM Incentive Payment is equal to 5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period (the calendar year immediately preceding the payment year).	**APM Incentive Payment and Transition to Qualifying APM Conversion Factor** In accordance with amendments made by the Consolidated Appropriations Act, 2023, the APM Incentive Payment with respect to payment year 2025 is 3.5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period. After the 2023 performance year, the APM Incentive Payment will end. Instead, beginning for the 2024 performance year, QPs will receive a higher Medicare Physician Fee Schedule (PFS) update ("qualifying APM conversion factor") of 0.75% compared to non-QPs, who will receive a 0.25% Medicare PFS update, which will result in a differentially higher PFS payment rate for eligible clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year.

Public Reporting via Doctors and Clinicians Care Compare Overview

POLICY AREA	EXISTING POLICY	CY 2023 FINALIZED POLICY
Public Reporting	**Telehealth Indicators** We publicly report a telehealth indicator, as applicable and technically feasible, on individual clinician profile pages for those clinicians furnishing covered telehealth services to help empower patients' healthcare decisions.	**Telehealth Indicators** We finalized the modification to existing policy about identifying telehealth services furnished to inform the public reporting of telehealth indicators on individual clinician profile pages: • Instead of using specific Place of Service (POS) and claims modifier codes such as POS code 02, 10, or modifier 95, to identify telehealth services through annual rulemaking, we'll use the most recent POS and claims modifier codes available as of the time the information is refreshed on clinician profile pages. This will give us more flexibility to ensure the accuracy of the telehealth indicator and reduce annual regulatory burden.
	Utilization Data We'll publicly report certain procedure information (utilization data) on individual clinician profile pages to aid patients in finding clinicians who may appropriately serve their needs. • Adding utilization data to clinician profile pages will allow patients to find clinicians who have performed specific types of procedures.	**Utilization Data** We finalized the modification to existing policies about publicly reporting procedure utilization data on individual clinician profile pages in the following ways:

POLICY AREA	EXISTING POLICY	CY 2023 FINALIZED POLICY
		• Providing additional procedure grouping flexibility for CMS to create clinically meaningful categories when one isn't available. • Publicly reporting Medicare Advantage (MA)[1] data, in addition to Medicare FFS utilization data counts, as appropriate and technically feasible, to address low volume counts and provide a more complete scope of a clinician's experience. • Removing the policy to publicly report on the Provider Data Catalog (PDC), a subset of procedures from the Medicare Public Use File (PUF) and instead, providing a single downloadable dataset reflecting the same utilization data that would appear on clinician profile pages. These policies address procedure category and procedure volume limitations, provide a more complete scope of a clinician's experience by adding MA data to procedure counts, align the data in the PDC with the procedural groupings shown on profile pages, and reduce redundancy with information already publicly available in the PUF.

[1] We're amending § 422.310(f)(3) to align the release of this MA data with the existing disclosure timelines on the Care Compare website, thereby providing patients with the necessary information for choosing a healthcare provider.

Contact Us

We will continue to provide support to clinicians who need assistance. While our support offerings reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance to help them successfully participate.

We also encourage clinicians to contact the QPP Service Center. Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History

Date	Change Description
11/06/2023	Updated Quality ID #s in Appendix B.
11/02/2023	Original posting.

Appendix A: Previously Finalized Policies for the 2024 Performance Period

The table below identifies policies finalized in the CY 2022 and 2023 PFS Final Rules that apply to the 2024 performance period.

Policy Area	Previously Finalized Policy Applicable to the 2024 Performance Period
Quality Performance Category	
Collection Types	The 2024 performance period will be the final performance year that the CMS Web Interface will be an available collection type for Shared Savings Program ACOs reporting quality measures under the APP.
Data Completeness	We previously finalized a 75% data completeness threshold for the 2024 performance period.
Promoting Interoperability Performance Category	
Public Health and Clinical Data Exchange Objective	There are 2 levels of active engagement which must be submitted for the Public Health and Clinical Data Exchange Objective measures. • "Pre-production and Validation" • "Validated Data Production"
Third Party Intermediaries	
Termination	Beginning with the 2024 performance period, CMS can terminate QCDRs or qualified registries that are required to submit participation plans as required under existing policy during the applicable self-nomination period (because they didn't submit any MIPS data for either of the 2 years preceding the applicable self-nomination period) and continue to not submit MIPS data to CMS for the applicable performance period.

Appendix B: New Quality Measures Finalized for the 2024 Performance Period and Future Years

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
495	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	The percentage of top-box responses among patients aged 18 years and older who had an ambulatory palliative care visit and report feeling heard and understood by their palliative care provider and team within 2 months (60 days) of the ambulatory palliative care visit.	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are finalizing this patient reported outcome measure because it will fill a gap within MIPS for patients in palliative care and captures the patient's experience and assesses communication and shared decision making with their clinician. Assessment of how well patients feel heard and understood complements and adds an important dimension to existing quality measures of care planning by including patient experience of care for this unique patient population.
496	Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive	Percentage of pregnant or postpartum patients who received a cardiovascular disease (CVD) risk assessment with a standardized instrument.	MIPS CQMs Specifications	Process	We are finalizing this measure because it fills a high priority clinical gap area in MIPS under the wellness and prevention domain for maternal health. This fully developed process measure will address care for pregnant/postpartum patients by assessing for a standardized CVD

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
	CVD Risk Assessment with a Standardized Instrument				risk assessment. While this measure was tested at the facility level, there is encounter level data element testing that adequately addresses the validity of the measure, additionally there is ongoing clinician level testing being completed.
497	Preventive Care and Wellness (composite)	Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), American Association of Clinical Endocrinology (AACE), and American College of Endocrinology (ACE).	MIPS CQMs Specifications	Process	We are finalizing this composite measure which is composed of seven current preventive care measures with age and sex appropriate preventive screenings and wellness services. This process measure creates a robust, broadly encompassing preventive care assessment. There is a performance gap based upon data submitted by the measure developer. Initially, the measure will be implemented as a weighted average analytic, representing performance for quality actions linked to positive patient outcomes. This measure addresses preventive care and wellness and will work to drive quality care by requiring a more

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
					comprehensive set of quality actions be completed.
498	Connection to Community Service Provider	Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.	MIPS CQMs Specifications	Process	We are finalizing this measure because it addresses CMS's identified social and economic determinants as both a measurement priority and gap. This measure is a central part of its Health Equity strategic plan pillar moving forward. This measure assesses patients who screen positive for one or more of the following Health related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety and had contact with a Community Service Provider (CSP), (defined as any independent, for-profit, non-profit, state, territorial, or local agency capable of addressing core or supplemental health-related social needs), for at least 1 of their HRSNs within 60 days after

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
					screening. This measure does contain an exclusion for patients to opt out of CSP. It is currently being utilized by CMS Accountable Health Communities program and leveraging the data and experience from the CMMI Accountable Health Community (AHC) model, which has screened nearly one million beneficiaries.
499	Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy	Percentage of patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) who, within seven (7) weeks following the date of injection, are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP =<25	MIPS CQMs Specifications	Process	We are finalizing this measure because it directly measures intraocular pressure (IOP) after corticosteroid injections. This measure addresses the MIPS priority area of patient safety. Currently there are no measures in MIPS that address the screening and plan of care for elevated IOP following intravitreal or periocular steroid therapy. This measure is important to provide measure options for retinal specialists.

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
		mm Hg for injected eye OR if the IOP was >25 mm Hg, a plan of care was documented.			
500	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks.	MIPS CQMs Specifications	Process	We are finalizing this measure because this measure addresses the appropriate screening and follow-up for patients with posterior vitreous detachment (PVD) and at risk of retinal tears, conditions that disproportionately affect an aging population that has an increased risk for retinal detachment. Prior to this measure, there were no measures in MIPS that address the appropriate screening and follow-up for patients with posterior vitreous detachment (PVD) and at risk of retinal tears. This measure is important to provide measure options for retinal specialists.

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
501	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) and acute vitreous hemorrhage in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks.	MIPS CQMs Specifications	Process	We are finalizing this measure because this measure addresses appropriate screening and follow-up for patients with PVD and at risk of retinal tears. Prompt treatment may minimize complications, such as retinal detachment, and improve a patient's quality of life. Prior to this measure and the measure above, there were no measures in MIPS that address the appropriate screening and follow-up for patients with posterior vitreous detachment (PVD) and at risk of retinal tears. This measure is important to provide measure options for retinal specialists.
502	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	The percentage of patients aged 18 and older with a mental and/or substance use disorder who demonstrated improvement or maintenance of functioning based on	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are finalizing this measure because it is comprehensive and inclusive of broad mental and/or substance use disorder and uses a measurement-based care framework for implementation across various settings and populations. This measure

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
		results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) or Sheehan Disability Scale (SDS) 30 to 180 days after an index assessment.			addresses a high priority specialty and high priority clinical condition that is not duplicative of any existing measure within MIPS.
503	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skills, and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM® performance measure (PAM®-PM) is the change in score on the PAM® from baseline to follow-up measurement.	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	We are finalizing this measure because this measure addresses chronic conditions and outcomes, both of which are high-priority areas for future measure consideration for MIPS. This PRO-PM provides a standardized method for clinicians to assess patient activation through the continuum of care. The Patient Activation Measure (PAM®) survey collects information directly from patients regarding their knowledge, skill, and confidence in managing their health and healthcare. This measure is not disease-specific and has been used with a wide variety of chronic

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
					conditions, as well as with people with no medical diagnosis.
504	Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk	Percentage of adults aged 18 years and older with suicidal ideation or behavior symptoms (based on results of a standardized assessment tool or screening tool) or increased suicide risk (based on the clinician's evaluation or clinician-rating tool) for whom a suicide safety plan is initiated, reviewed, and/or updated in collaboration between the patient and their clinician.	MIPS CQMs Specifications	Process	We are finalizing this measure because it focuses on a process where initiating and reviewing a suicide safety plan with a patient at risk of suicide is a proxy for the clinical outcome of a reduction in suicides, suicide attempts, and suicidal ideation. This measure addresses behavioral health and a high-priority area for MIPS. This measure compliments a related MIPS measure, Q370: Depression Remission at Twelve Months, as this measure distinguishes itself by focusing on a care process that is directly designed to mitigate suicide risk, as opposed to screening for it.
505	Reduction in Suicidal Ideation or Behavior Symptoms	The percentage of patients aged 18 and older with a mental and/or substance use disorder AND suicidal thoughts, behaviors or risk	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance	We are finalizing this measure because this measure focuses on mental health and substance use disorder (SUD) which are a CMS high-priority area for MIPS measure consideration. This PRO-

Quality ID #	Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
		symptoms who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale (C-SSRS) 'Screen Version' or 'Since Last Visit', within 120 days after an index assessment.		Measure (PRO-PM)	PM collects information related to a demonstration of a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale (C-SSRS) 'Screen Version' or 'Since Last Visit', within 120 days after an index assessment.

Appendix C: New Quality Measures Finalized for the 2025 Performance Period and Future Years

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)	This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible. This	eCQM Specifications	Intermediate Outcome	We are finalizing this eCQM **with a 1-year delay to CY 2025** because it adds an important outcome measure in the diagnostic radiology set and addresses patient safety within the scope of diagnostic radiology. This measure will fill a gap area in care for patients undergoing diagnostic CT imaging to assess actual radiation dosing, complementing the current MIPS measures that address radiation dosing utilization and documentation of dose lowering techniques or appropriateness of follow-up imaging. This measure will operationalize accessibility of data into electronic clinical data systems for increased efficiency.

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
	eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM. Additional details are included in the Guidance field.			

Appendix D: Quality Measure Removals Finalized for the 2024 Performance Period and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
014	MIPS CQM / Process	No	**Age-Related Macular Degeneration (AMD): Dilated Macular Examination:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity during one or more office visits within the 12 month performance period.	American Academy of Ophthalmology	End of Topped out Lifecycle.
093	MIPS CQM / Process	Yes	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngo-logy – Head and Neck Surgery	End of Topped out Lifecycle.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
107	eCQM / Process	No	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of all patient visits for those patients that turn 18 or older during the measurement period in which a new or recurrent diagnosis of major depressive disorder (MDD) was identified and a suicide risk assessment was completed during the visit.	Mathematica	Duplicative to new MUC2022-127: Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk measure being finalized for 2024.
110	Medicare Part B Claims Measure, eCQM, MIPS CQM / Process	No	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit during the measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization.	National Committee for Quality Assurance	Duplicative to measure Q493: Adult Immunization Status. Measure is being replaced by Q493: Adult Immunization Measure in all applicable MVPs.
111	Medicare Part B Claims Measure, eCQM, MIPS CQM / Process	No	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 66 years of age and older who have received a pneumococcal vaccine.	National Committee for Quality Assurance	Duplicative to measure Q493: Adult Immunization Status. Measure is being replaced by Q493: Adult Immunization Measure in all applicable MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
138	MIPS CQM / Process	Yes	**Melanoma: Coordination of Care:** Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	American Academy of Dermatology	End of Topped out Lifecycle.
147	Medicare Part B Claims Measure, MIPS CQM / Process	Yes	**Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy:** Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), etc.) that were performed.	Society of Nuclear Medicine and Molecular Imaging	End of Topped out Lifecycle.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
283	MIPS CQM / Process	No	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Academy of Neurology/American Psychiatric Association	End of Topped out Lifecycle.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
324	MIPS CQM / Efficiency	Yes	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment.	American College of Cardiology Foundation	Extremely Topped Out.[2]

[2] This inverse, non-process measure meets the criteria of an "extremely topped out measure" (83 FR 59763) – a measure with an average/mean performance within the 98th to 100th percentile range (2nd or lower percentile range for an inverse measure). For the 2023 performance period, the average/mean performance rate is 0.81% for this measure. While this measure is considered "extremely topped out," it doesn't meet the criteria of a "topped out non-process measure" (defined at 42 CFR 415.1305) – a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles (25th and 10th percentiles for an inverse measure) are within 2 standard errors. We note that it's possible for a measure to be "extremely topped out" without being "topped out" due to the different methodologies used for determining each status. A measure that is "extremely topped out" may be proposed for removal regardless of whether or not it's in the midst of the 4-year topped out measure lifecycle (83 FR 59763).

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
391	MIPS CQM / Process	Yes	**Follow-Up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are submitted: • The percentage of discharges for which the patient received follow-up within 30 days after discharge • The percentage of discharges for which the patient received follow-up within 7 days after discharge.	National Committee for Quality Assurance	Attribution/Burden
402	MIPS CQM / Process	No	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance	Duplicative to measure Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

Appendix E: Quality Measure Removals Finalized for the 2025 Performance Period and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
436	Medicare Part B Claims Measure, MIPS CQM / Process	No	**Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques:** Percentage of final reports for patients aged 18 years and older undergoing computed tomography (CT) with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control. • Adjustment of the mA and/or kV according to patient size. • Use of iterative reconstruction technique.	American College of Radiology/ American Medical Association/ National Committee for Quality Assurance	Duplicative to new MUC2022-007: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) measure being proposed for 2024.

Appendix F: Quality Measure Removals from Traditional MIPS (Retained for MVPs) Finalized for the 2024 Performance Period and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Partial Removal
112	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	No	**Breast Cancer Screening** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	National Committee for Quality Assurance	A more robust and comprehensive measure is finalized under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we finalized removal of this measure from traditional MIPS and finalized retention of this measure for use in relevant MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Partial Removal
113	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	No	**Colorectal Cancer Screening** Percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance	A more robust and comprehensive measure is finalized under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we finalized removal of this measure from traditional MIPS and finalized retention of this measure for use in relevant MVPs.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Partial Removal
128	Medicare Part B Claims Measure, MIPS CQM, eCQM / Process	No	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters.	Centers for Medicare & Medicaid Services	A more robust and comprehensive measure is finalized under the Preventive Care and Wellness (composite) and the clinical concept of this measure is included as one of the components. However, the clinical concept of this measure is appropriate and applicable for some MVPs; therefore, we finalized removal of this measure from traditional MIPS and finalized retention of this measure for use in relevant MVPs.

Appendix G: New Improvement Activities Finalized for the 2024 Performance Period and Future Years

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
IA_PM_22	Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services	Establish policies and procedures to improve practice capacity to increase HIV prevention screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities: • Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening; • Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or • Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV	Medium / Population Management

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
		testing processes, universal HIV screening, and PrEP initiation.	
IA_MVP	Practice-Wide Quality Improvement in MIPS Value Pathways	Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity. Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following: • Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice; • Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff; • Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives;	High / N/A

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
		• Designate regular team meetings to review data and plan improvement cycles with defined, iterative goals as appropriate; or • Promote transparency and engage patients and families by sharing practice-level quality of care and patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data. Optional activities related to this activity (but do not count towards completion of this IA) include the following: • Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and	

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
		• Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	
IA_PM_23	Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines	Incorporate the Cervical Cancer Screening and Management (CCSM) Clinical Decision Support (CDS) tool within the electronic health record (EHR) system to provide clinicians with ready access to and assisted interpretation of the most up-to-date clinical practice guidelines in CCSM to ensure adequate screening, timely follow-up, and optimal patient care. The CCSM CDS helps ensure that patient populations receive adequate screening and management, according to evidence-based recommendations in the United States Preventive Services Task Force (USPSTF) screening and American Society for Colposcopy and Cervical Pathology (ASCCP) management guidelines for cervical cancer. The CCSM CDS integrates into the clinical workflow a clinician-facing dashboard to support the clinician's awareness and adoption of and preventive care for cervical cancer,	High / Population Management

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
		including screening and any necessary follow-up treatment. The CCSM CDS is fully conformant with the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, so it can be used with any Office of the National Coordinator for Health Information Technology (ONC) certified EHR platform. The CDS Hooks and SMART-on-FHIR interoperability interface standards provide two ways to integrate with the clinical workflow in a way that complements existing displays and information pre-visit, during visit, and for post-visit follow-up. CCSM CDS helps the clinician evaluate the patient's clinical data against existing guidance and displays patient-specific recommendations.	
IA_BMH_14	Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in patient care plans.	High / Behavioral and Mental Health

Activity ID	Activity Title	Activity Description	Activity Weight / Subcategory
IA_BMH_15	Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to treatment and/or referral to appropriate social services, and document this in patient care plans.	High / Behavioral and Mental Health

Appendix H: Improvement Activities Finalized for Removal for the 2024 Performance Period and Future Years

Activity ID	Activity Title and Description	Activity Weight / Subcategory
IA_BMH_6	Implementation of co-location PCP and MH services	Medium / Behavioral and Mental Health
IA_BMH_13	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder	Medium / Behavioral and Mental Health
IA_ PSPA_29	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	High / Patient Safety and Practice Assessment