Supporting Statement – Part A

Quality Payment Program/Merit-Based Incentive Payment System (MIPS)
CMS-10621, OMB 0938-1314

A. Background

The Merit-based Incentive Payment System (MIPS) is a program for certain eligible clinicians that makes Medicare payment adjustments based on performance on quality, cost and other measures and activities. MIPS and Advanced Alternative Payment Models (AAPMs) are the two paths for clinicians available through the Quality Payment Program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As prescribed by MACRA, MIPS focuses on the following performance areas: quality – a set of evidence-based, specialty-specific standards; improvement activities that focus on practice-based improvements; cost; and use of Certified Electronic Health Record Technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.

Under the AAPM path, eligible clinicians may become Qualifying APM Participants (QPs) and are excluded from MIPS. Partial Qualifying APM Participants (Partial QPs) may opt to report and be scored under MIPS. APM Entities and eligible clinicians must also submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination, as well as the payment amount and patient count information sufficient for us to make QP determinations by December 1 of the calendar year that is 2 years to prior to the payment year, which we refer to as the QP Determination Submission Deadline (82 FR 53886).

The implementation of MIPS requires the collection of quality, Promoting Interoperability, and improvement activities performance category data.[1] For the quality performance category, MIPS eligible clinicians, groups, and subgroups will have the option to submit data using various submission types, including Medicare claims, direct, log in and upload, and CMS-approved survey vendors.[2] For the improvement activities and Promoting Interoperability, clinicians, groups, and subgroups can submit data through direct, log in and upload, or log in and attest submission types. As finalized in the CY 2021 PFS final rule (85 FR 84860), for clinicians in APM Entities, the APM Performance Pathway will be available for both ACOs and non-ACOs to submit quality data. Due to data limitations and our inability to determine who would use the APM Performance Pathway versus the traditional MIPS submission mechanism for the CY 2023 performance period/2025 MIPS payment year, we assume ACO APM Entities will submit data through the APM Performance Pathway, using the CMS Web Interface option, and non-ACO APM Entities would participate through traditional MIPS, thereby submitting as an individual or group rather than as an entity. We note that the CMS Web Interface is available as a collection type/submission type through the CY 2024 performance period/2026 MIPS payment year only for clinicians in Shared Savings Program reporting the APM Performance Pathway.

[1] Cost performance category measures do not require the collection of additional data because they are derived from the Medicare Parts A and B claims.

[2] The use of CMS-approved survey vendors is not included in this PRA package. CMS has requested approval for the collection of CAHPS for MIPS data via CMS-approved survey vendors in a separate PRA package (OMB Control Number 0938-1222).

Beginning with January 1 of the CY 2023 performance period/2025 MIPS payment year, individual clinicians, groups, and APM Entities could choose to report the measures and activities in a MIPS Value Pathway (MVP). Beginning with the CY 2023 performance period/2025 MIPS payment year, clinicians could choose to participate as subgroups for reporting the measures and activities in an MVP. We note that the subgroup reporting option is not available for clinicians participating in traditional MIPS.

For the Promoting Interoperability performance category, in the CY 2023 PFS proposed rule, we are proposing an additional requirement for the Public Health and Clinical Data Exchange Objective. Specifically, in addition to submitting responses for the required measures and any optional measures a MIPS eligible clinician chooses to report, we propose to require MIPS eligible clinicians to submit their level of active engagement, either Pre-production and Validation or Validated Data Production, for each measure they report beginning with the CY 2023 performance period/2025 MIPS payment year.

For the improvement activities performance category, we are proposing changes to the improvement activities inventory for the CY 2023 performance period/2025 MIPS payment year and future years as follows: adding 4 new improvement activities; modifying 5 existing improvement activities; and removing 6 previously adopted improvement activities.

The implementation of MIPS requires the collection of additional data beyond performance category data submission. Additionally, there are information collections related to AAPMs. Please see sections 12 and 15 of the Supporting Statement for details.

We are requesting approval of 23 information collections associated with the CY 2023 PFS proposed rule as a revision to our currently approved information requests submitted under this package's control number (OMB 0938-1314, CMS-10621). CMS has requested approval of the collection of information associated with the CAHPS for MIPS survey under OMB control number 0938-1222 (CMS-10450). CMS has already received approval for collection of information associated with the virtual group election process under OMB control number 0938-1343 (CMS-10652).

The changes in this CY 2023 collection of information request are associated with our July 7, 2022 proposed rule (CMS-1770-P, RIN 0938-AU81).

Where updated data and assumptions were available for the CY 2023 PFS proposed rule, we have made adjustments to applicable ICRs. In aggregate, we estimate that the proposed policies will result in a net decrease in burden of 11,039 hours and $1,213,933 for the CY 2023 performance period/2025 MIPS payment year. In total, we estimate an increase in burden of 79,215 hours and $8,411,851 for the CY 2023 performance period/2025 MIPS payment year due to updated data and assumptions as well as proposed policies.

As discussed in sections 12 and 15 of this Supporting Statement, the proposed policies in the CY 2023 PFS proposed rule will result in a decrease in burden for the ICRs related to the data submission via the Medicare Part B Claims, MIPS CQM QCDR, and eCQM collection types for the quality performance category due to the proposed increase in the number of respondents submitting for the MVP quality performance category. We also estimate that the proposed policies in the CY 2023 PFS proposed rule will result in an increase in burden for the ICRs related to MVP registration, MVP quality submission, and data submission for the Promoting

Interoperability performance category. The remaining changes to our currently approved burden estimates are adjustments due to the use of updated data sources and assumptions.

We are also requesting to add one new ICR to capture the estimated burden for third party intermediary plan audits. We added the new ICR to distinctly capture the capture the burden for collection of information related to: (1) QCDR and qualified registry targeted audits as established under the conditions for approval at § 414.1400(b)(3)(vi) through (viii); and (2) all the requirements for remedial action and termination at § 414.1400(e). For simplicity, we capture the estimated burden for third party intermediaries to submit additional requirements for compliance with both the conditions of approval and remedial action and termination criteria under one ICR. We note that the proposed addition of this ICR is not due to proposed policy changes in this rule, but rather it is a change in our approach to representing the estimated burden for third party intermediaries in the CY 2022 PFS final rule (86 FR 65569 through 65576).

Overall, we estimate an increase of 21,053 responses, 79,215 hours, and $8,411,851.

B. Justification

1. Need and Legal Basis

Our authority for collecting this information is provided by Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015) which further amended section 1848 and 1833 of the Act, respectively.

Section 1848(q) of the Act requires the establishment of the MIPS beginning with payments for items and services furnished on or after January 1, 2019, under which the Secretary is required to: (1) develop a methodology for assessing the total performance of each MIPS eligible clinician according to performance standards for a performance period; (2) using the methodology, provide a final score for each MIPS eligible clinician for each performance period; and (3) use the final score of the MIPS eligible clinician for a performance period to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor for exceptional performance) to the MIPS eligible clinician for a performance period. Under section 1848(q)(2)(A) of the Act, a MIPS eligible clinician's final score is determined using four performance categories: (1) quality; (2) cost; (3) improvement activities, and (4) Promoting Interoperability. Section 1833(z) of the Act establishes incentive payments for clinicians who are qualifying participants in advanced APMs.

2. Information Users

CMS will use data reported or submitted by MIPS eligible clinicians as individual clinicians (both required and voluntary) or as part of groups, subgroups, virtual groups, or APM entities. CMS will use this data to assess MIPS eligible clinician performance in the MIPS performance categories, calculate the final score (including whether or not requirements for certain performance categories can be waived), and calculate positive and negative payment adjustments based on the final score, and to provide feedback to the clinicians. Information provided by third party intermediaries may also be used for administrative purposes such as determining third party intermediaries and QCDR measures appropriate for the MIPS program. Information provided by clinicians, professional societies, and other respondents will be used to consider

quality and Promoting Interoperability measures, improvement activities, and MVPs for inclusion in the MIPS program. Information provided by payers, APM Entities, and eligible clinicians will be used to determine which additional payment arrangements qualify as Other Payer Advanced APM models. In order to administer the Quality Payment Program, the data will be used by agency contractors and consultants and may be used by other federal and state agencies.

We also use this information to provide performance feedback to MIPS eligible clinicians and eligible entities. Clinicians and beneficiaries can view performance category data and final scores for a MIPS performance period/MIPS payment year on compare tools hosted by the U.S. Department of Health and Human Services. The data also may be used by CMS authorized entities participating in health care transparency projects. The data is used to produce the annual Quality Payment Program Experience Report which provides a comprehensive representation of the overall experience of MIPS eligible clinicians and subgroups of MIPS eligible clinicians.

Relevant data will be provided to federal and state agencies, Quality Improvement Networks, contractors supporting the Quality Payment Program, and parties assisting consumers, for use in administering or conducting federally funded health benefit programs, payment and claims processes, quality improvement outreach and reviews, and transparency projects. In addition, this data may be used by the Department of Justice, a court, or adjudicatory body, another federal agency investigating fraud, waste, and abuse, appropriate agencies in the case of a system breach, or the U.S. Department of Homeland Security in the event of a cybersecurity incident. Lastly, CMS has made available a Public Use File presenting a comprehensive data set on performance of all clinicians across all categories, measures, and activities for MIPS which will be updated annually.

3. Use of Information Technology

All the information collection described in this form is to be conducted electronically.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by the CMS external to MIPS.

With respect to participating in MIPS for MIPS APM participants, CMS has set forth requirements that encourage limiting duplication of effort, but in the interest of providing flexibility in reporting, we cannot ensure that duplication does not occur. In addition, as discussed in later sections, many APM Entities would not need to submit improvement activities because they will be reporting through the APM Performance Pathway (APP). For the CY 2023 performance period/2025 MIPS payment year, we assume that all MIPS APM models would qualify for the maximum improvement activities performance category score and the APM Entities reporting the APP would not need to submit any additional improvement activities. We assume ACO APM Entities would submit data through the APM Performance Pathway and non-ACO APM Entities would participate through traditional MIPS, thereby submitting as an individual or a group rather than as an APM entity.

5. Small Businesses

Because the vast majority of Medicare clinicians that receive Medicare payment under the PFS (approximately 95 percent) are small entities within the definition in the Regulatory Flexibility Act (RFA), HHS's normal practice is to assume that all affected clinicians are "small" under the RFA. In this case, most Medicare and Medicaid eligible clinicians are either non-profit entities or meet the Small Business Administration's size standard for small business. The CY 2023 PFS proposed rule's Regulatory Impact Analysis estimates that approximately 865,116 MIPS eligible clinicians will be subject to MIPS performance requirements.[3] The low-volume threshold is designed to limit burden to eligible clinicians who do not have a substantive business relationship with Medicare. We estimate that approximately 107,995 clinicians in eligible specialties will be excluded from MIPS data submission requirements because they do not have sufficient charges, services or beneficiaries under the PFS and thus do not meet opt-in volume criteria as either a group or individual. Additionally, we exclude 424,752 clinicians who are not MIPS eligible as individual clinicians and did not participate as a group but could elect to participate in MIPS through opting in or participating as a group. Further, we exclude an additional 207,477 clinicians who are either QPs, newly enrolled Medicare professionals (to reduce data submission burden to those professionals), or practice non-eligible specialties. Clinicians who do not meet the low-volume threshold, or who are newly enrolled Medicare clinicians may opt to submit MIPS data. Medicare professionals voluntarily participating in MIPS would receive feedback on their performance but would not be subject to payment adjustments.

In the Regulatory Impact Analysis section of the CY 2023 PFS proposed rule, we explain that we assume 865,116 MIPS eligible clinicians will submit data as individual clinicians, or as part of groups or as APM entities. Included in this number, we estimate 10,933 clinicians who exceeded at least one but not all low-volume threshold, elected to opt-in and submitted data in the CY 2019 performance period/2021 MIPS payment year would elect to opt-in to MIPS in the CY 2023 performance period/2025 MIPS payment year.

Additionally, we estimate that for the CY 2023 QP Performance Period between 144,700 and 186,000 eligible clinicians would become QPs, and therefore be excluded from MIPS.

6. Less Frequent Collection

Data on the quality, Promoting Interoperability, and improvement activities performance categories are collected from individual MIPS eligible clinicians or groups annually. If this information was collected less frequently, we will have no mechanism to: (1) determine whether a MIPS eligible clinician or group meets the performance criteria for a payment adjustment under MIPS; (2) calculate for payment adjustments to MIPS eligible clinicians or groups; and (3) publicly post clinician performance information on the compare tools hosted by the U.S. Department of Health and Human Services. We require additional data collections to be performed annually in order to allow us to determine which clinicians are required to report MIPS data.

[3] For further detail on MIPS exclusions, see Supporting Statement B and the Regulatory Impact Analysis Section of the CY 2023 PFS proposed rule.

Third party intermediaries are required to self-nominate annually. If qualified registries and QCDRs are not required to submit a self-nomination statement on an annual basis, we will have no mechanism to determine which registries and QCDRs will participate in submitting quality measures, improvement activities, or Promoting Interoperability measures, objectives and activities. As such, we would not be able to post the annual list of qualified registries which MIPS eligible clinicians use to select qualified registries and QCDRs to use to report quality measures, improvement activities, or Promoting Interoperability measures, objectives, and activities to CMS.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than 3 years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

Serving as the 60-day notice, the CY 2023 PFS proposed rule (CMS-1770-P, RIN 0938-AU81) published in the Federal Register on July 29, 2022 (87 FR 45860). Public comments must be received no later than 5 p.m. on September 6,2022.

9. Payments/Gifts to Respondents

We will use this data to assess MIPS eligible clinician performance in the MIPS performance categories, calculate the final score, and calculate positive and negative payment adjustments based on the final score. For the APM data collections, the Partial QP election will also be used to determine MIPS eligibility for receiving payment adjustments based on a final score. For the Other Payer Advanced APM determinations, no gift or payment is provided via MIPS; however, information from these determinations may be used to assess whether a clinician participating in Other Payer Advanced APMs meets the thresholds under the All-Payer Combination Option required to receive QP status and the associated APM incentive payment.

More detail on how the payments are calculated can be found in 42 CFR §414.1405 and §414.1450.

10. Confidentiality

Consistent with federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, any confidential information (as such terms are interpreted under the Freedom of Information Act and the Privacy Act of 1974) will be protected from release by CMS to the extent allowable by law and consistent with 5 U.S.C. 552a(b).

Quality Payment Program (QPP), System No. 09-70-0539 (February 14, 2018; 83 FR 6587).

11. Sensitive Questions

Other than requested proprietary information noted above in section 10, there are no sensitive questions included in the information request. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates

a. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2021 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage. The adjusted hourly wage is used to calculate the labor costs.

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Therefore, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method. With regard to respondents, we selected BLS occupations Billing and Postal Clerks, Computer Systems Analysts, Physicians (multiple categories), Medical and health services manager, and Licensed Practical Nurse based on a study (Casalino et al., 2016) that collected data on the staff in physician's practices involved in the quality data submission process.[4]

We previously used the BLS wage rate for "Physicians and Surgeons" (occupation code 29-1060) to estimate the burden for Physicians. In BLS' most recent set of occupational wage rates (dated May 2021), they have discontinued this occupation in their wage data. As a result, in order to estimate the burden for Physicians, we are using a rate of $259.98/hr which is the average of the mean wage rates for Anesthesiologists; Family Medicine Physicians; General

[4] Lawrence P. Casalino et al, "US Physician Practices Spend More than $15.4 Billion Annually to Report Quality Measures," Health Affairs, 35, no. 3 (2016): 401-406.

Internal Medicine Physicians; Obstetricians and Gynecologists; Pediatricians, General; Physicians, All Other; and Orthopedic Surgeons, Except Pediatric; Psychiatrists; Pediatric Surgeons; Surgeons, All Other; and Surgeons, Except Ophthalmologists [($318.44/hr + $226.86/hr + $232.88/hr + $284.82/hr + $190.80/hr + $222.60/hr + $294.44/hr + $240.16/hr + $279.14/hr + $286.34/hr + $283.20/hr) ÷ 11].

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr.)	Fringe Benefits and Overhead costs ($/hr)	Adjusted Hourly Wage ($/hr)
Anesthesiologists	29-1211	159.22	159.22	318.44
Billing and Posting Clerks	43-3021	20.55	20.55	41.10
Computer Systems Analysts	15-1211	49.14	49.14	98.28
Family Medicine Physicians	29-1215	113.43	113.43	226.86
General Internal Medicine Physicians	29-1216	116.44	116.44	232.88
Licensed Practical Nurse (LPN)	29-2061	24.93	24.93	49.86
Medical and Health Services Managers	11-9111	57.61	57.61	115.22
Obstetricians and Gynecologists	29-1218	142.41	142.41	284.82
Pediatricians, General	29-1221	95.40	95.40	190.80
Physicians, All Other; and Ophthalmologists, Except Pediatric	29-1228	111.30	111.30	222.60
Psychiatrists	29-1223	120.08	120.08	240.16
Surgeons, Except Ophthalmologists	29-1248	143.17	143.17	286.34

b. Framework for Understanding the Burden of MIPS Data Submission

Because of the wide range of information collection requirements under MIPS, Table 2 presents a framework for understanding how the organizations permitted or required to submit data on behalf of clinicians vary across the types of data, and whether the clinician is a MIPS eligible clinician or other eligible clinician voluntarily submitting data, MIPS APM participant, or an Advanced APM participant. As shown in the first row of Table 2, MIPS eligible clinicians and other clinicians voluntarily submitting data will submit data either as individuals, groups, or virtual groups for the quality, Promoting Interoperability, and improvement activities performance categories. Note that virtual groups are subject to the same data submission requirements as groups, and therefore, we will refer only to groups for the remainder of this section unless otherwise noted. Beginning with the CY 2023 performance period/2025 MIPS payment year, clinicians could also participate as subgroups for reporting measures and activities in an MVP. Because MIPS eligible clinicians are not required to submit any additional information for assessment under the cost performance category, the administrative claims data used for the cost performance category is not represented in Table 2.

For MIPS eligible clinicians participating in MIPS APMs, the organizations submitting data on behalf of MIPS eligible clinicians will vary between performance categories and, in some instances, between MIPS APMs. We previously finalized in the CY 2021 PFS final rule, for clinicians in APM Entities, the APM Performance Pathway (APP) is available for both ACO and non ACOs to submit quality data (85 FR 84859 through 84866). Due to data limitations and our inability to determine who would use the APP versus the traditional MIPS submission mechanism for the CY 2023 performance period/2025 MIPS payment year, we assume ACO APM Entities will submit data through the APM Performance Pathway, using the CMS Web

Interface option, and non-ACO APM Entities would participate through traditional MIPS, thereby submitting as an individual or group rather than as an entity. We also want to note that as finalized in the CY 2022 PFS final rule (86 FR 65259 through 65263), the CMS Web Interface collection type is available through the CY 2024 performance period/2026 MIPS payment year only for clinicians participating in the Shared Savings Program. Per section 1899 of the Act (42 U.S.C. 1395jjj), submissions received from eligible clinicians in ACOs are not included in burden estimates for this proposed rule because quality data submissions to fulfill requirements of the Shared Savings Program are not subject to the PRA.

For the Promoting Interoperability performance category, group TINs may submit data on behalf of eligible clinicians in MIPS APMs, or eligible clinicians in MIPS APMs may submit data individually. In the CY 2023 PFS proposed rule, we are proposing to introduce a voluntary reporting option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level beginning with the CY 2023 performance period/2025 MIPS payment year. For the improvement activities performance category, we will assume no reporting burden for MIPS APM participants because they will be reporting through the APM Performance Pathway. In the CY 2017 Quality Payment Program final rule, we described that for MIPS APMs, we compare the requirements of the specific MIPS APM with the list of activities in the improvement activities inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians (81 FR 77185). Although the policy allows for the submission of additional improvement activities if a MIPS APM receives less than the maximum improvement activities performance category score, to date all MIPS APM have qualified for the maximum improvement activities score. Therefore, we assume that no additional submission will be needed.

Eligible clinicians who attain Partial QP status may incur additional burden if they elect to participate in MIPS, which is discussed in more detail in the CY 2018 Quality Payment Program final rule (82 FR 53841 through 53844).

TABLE 2: Clinicians and Organizations Submitting MIPS Data on Behalf of Clinicians by Type of Data*

Clinicians and Organizations	Quality Performance Category Data	Promoting Interoperability Performance Category Data	Improvement Activities Performance Category Data	Other Data Submitted on Behalf of MIPS Eligible Clinicians
MIPS Eligible Clinicians and Other Eligible Clinicians Voluntarily Submitting MIPS Data, Participating in Shared Savings Program, and other MIPS APMs that use the APM Performance Pathway for model measures. (CMS Web Interface will be available to only clinicians in ACOs through the CY 2024 performance period/2026 MIPS payment year.)	As virtual group, group, subgroup, individual clinicians, or APM Entity.[a]	As virtual group, group, subgroup, individual clinicians, or APM Entity. Certain MIPS eligible clinicians are automatically eligible for a zero percent weighting for the Promoting Interoperability performance category (please refer to the CY 2020 PFS final rule for a summary of the finalized criteria (84 FR 63111)). Clinicians who submit an application and are approved for significant hardship or other exceptions are also eligible for a zero percent weighting. Each MIPS eligible clinician in the APM Entity reports data for the Promoting Interoperability performance category through either group TIN or APM Entity TIN or individual reporting. [The burden estimates for this proposed rule assume group TIN-level reporting].[b]	As virtual group, group, subgroup, or individual clinicians. MIPS APMs do not submit information. CMS will assign the same improvement activities performance category score to each APM Entity based on the activities involved in participation in the MIPS APM.[c]	Groups electing to use a CMS-approved survey vendor to administer CAHPS must register. MVP participants electing to submit data for the measures and activities in an MVP must register. Clinicians in MIPS APMs electing the APM Performance Pathway. (CMS Web Interface will be available to only clinicians in ACOs through the CY 2024 performance period/2026 MIPS payment year.) APM Entities will make Partial QP election for participating eligible clinicians. Virtual groups must register via email.[d]

* Because the cost performance category relies on administrative claims data, MIPS eligible clinicians are not required to provide any additional information, and therefore, the cost performance category is not represented in this table.

[a] Submissions by the ACO are not included in burden estimates for this final rule because quality data submissions to fulfill requirements of the Shared Savings Program are not subject to the PRA. Sections 1899 (42 U.S.C. 1395jjj)

state that the Shared Savings Program is not subject to the PRA.

[b] Promoting Interoperability data will be accepted at the group TIN, APM Entity level or as individuals. If group TIN, APM Entity TIN, and individual scores are available for the same APM Entity, CMS will use the higher score for each TIN/NPI. For multi-TIN APM Entities that do not submit data at the APM Entity level, the TIN/NPI scores are then aggregated for purposes of calculating the APM Entity score.

[c] The burden estimates for this final rule assume no improvement activities performance category reporting burden for APM participants because we assume the MIPS APM model provides a maximum improvement activity score. APM Entities participating in MIPS APMs receive an improvement activities performance category score of at least 50 percent (42 CFR 414.1380) and do not need to submit improvement activities data unless the CMS-assigned improvement activities scores are below the maximum improvement activities score.

[d] Virtual group participation is limited to MIPS eligible clinicians, specifically, solo practitioners and groups consisting of 10 eligible clinicians or fewer.

The policies finalized in the CY 2017 and CY 2018 Quality Payment Program final rules and CY 2019, 2020, and 2021 PFS final rules, and continued in the CY 2022 PFS final rule create some additional data collection requirements not listed in Table 2. These additional data collections consist of:

- Self-nomination of new and returning QCDRs
- Self-nomination of new and returning qualified registries
- Third party intermediary plan audits (New)
- Open Authorization Credentialing and Token Request Process
- Quality Payment Program Identity Management Application Process
- Reweighting Applications for Promoting Interoperability and Other Performance Categories
- Call for quality measures
- Nomination of new improvement activities
- Call for Promoting Interoperability measures
- Nomination of MVPs
- Opt out of performance data display on Physician Compare for voluntary reporters under MIPS
- Partial Qualifying APM Participant (Partial QP) election
- Other Payer Advanced APM determinations: Payer Initiated Process
- Other Payer Advanced APM determinations: Eligible Clinician Initiated Process
- Submission of Data for All-Payer QP Determinations Framework for Understanding the Burden of MIPS Data Submission

In the below tables that describe our calculations for each ICR throughout Section 12, due to burden for certain activities being estimated in fractions of hours, totals may not reflect the sum of individual rows due to rounding.

c. Burden for Third Party Reporting

In this rule, we propose changes in our existing approach to capture the estimated burden for third party intermediaries. In the CY 2022 PFS final rule, for the burden related to the third party intermediaries, we combined the burden associated with the submission of targeted audits, corrective action plans, participation plans and transition plans under the ICRs for QCDR and qualified registry self-nomination process (86 FR 65569 through 65573 and 86 FR 65573 through 65576). Specifically, we propose to separate the burden for submission of the targeted

audits and other plans listed above under the ICR for third party intermediary plan audits. We believe that the proposed change would more accurately capture the associated burden for the QCDR and qualified registry self-nomination process because not every QCDR and qualified registry that submits a self-nomination application would also submit a targeted audit, corrective action plan (CAP), participation plan, or a transition plan. This change is not due to any proposed policies related to third party intermediaries in this rule, rather it is a change in representing the estimated burden from adopted policies.

Under MIPS, the quality, Promoting Interoperability, and improvement activities performance category data may be submitted via relevant third-party intermediaries, such as qualified registries, QCDRs, and health IT vendors. Data on the CAHPS for MIPS survey, which counts as either one quality performance category measure, or towards an improvement activity, can be submitted via CMS-approved survey vendors. Entities seeking approval to submit data on behalf of clinicians as a qualified registry, QCDR, or survey vendor must complete a self-nomination process annually. The processes for self-nomination for entities seeking approval as qualified registries and QCDRs are similar with the exception that QCDRs have the option to nominate QCDR measures for approval for the reporting of quality performance category data. Therefore, differences between QCDRs and qualified registry self-nomination are associated with the preparation of QCDR measures for approval. The burden associated with qualified registry self-nomination and QCDR self-nomination and measure submission follow:

i. Burden for Qualified Registry Self-Nomination and other Requirements

Qualified registries interested in submitting MIPS data to us on their participants' behalf need to complete a self-nomination process to be considered for approval to do so (82 FR 53815).

Previously approved qualified registries in good standing (i.e., that are not on probation or disqualified) may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the applicable performance period. Qualified registries in good standing that would like to make minimal changes to their previously approved self-nomination application from the previous year, may submit these changes, and attest to no other changes from their previously approved qualified registry application for CMS review during the self-nomination period. The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period.

We estimate that 160 qualified registries will self-nominate during the CY 2022 self-nomination period for the CY 2023 performance period/2025 MIPS payment year. We assume that the staff involved in the qualified registry self-nomination process will continue to be computer systems analysts or their equivalent, who have an average labor rate of $98.28/hr. Using the unchanged estimated hourly burden per respondent ranging from 0.5 hours for the simplified self-nomination form to 2 hours for the full self-nomination form and accounting for the estimated increase in the number of qualified registries that would submit a self-nomination application, we estimate that the annual burden will range from 80 hours (160 qualified registries x 0.5 hr) at a cost of $7,862 (80 hr x $98.28/hr) to 320 hours (160 qualified registries x 2 hr) at a cost of $31,450 (320 hr x $98.28/hr) for the simplified and full self-nomination process, respectively (See table 3).

The burden associated with the qualified registry self-nomination process varies depending on the number of existing qualified registries that elect to use the simplified self-nomination process in lieu of the full self-nomination process as described in the CY 2018 Quality Payment Program final rule (82 FR 53815). The QPP Self-Nomination Form is submitted electronically using a web-based tool. We will be submitting a revised version of the form for approval under OMB control number 0938-1314 (CMS-10621). Qualified registries must comply with requirements on the submission of MIPS data to CMS. The burden associated with qualified registry submission requirements will be the time and effort associated with calculating quality measure results from the data submitted to the qualified registry by its participants and submitting these results, the numerator and denominator data on quality measures, the Promoting Interoperability performance category, and improvement activities data to us on behalf of their participants. We expect that the time needed for a qualified registry to accomplish these tasks will vary along with the number of MIPS eligible clinicians submitting data to the qualified registry and the number of applicable measures. However, we believe that qualified registries already perform many of these activities for their participants. Therefore, we believe the estimates discussed earlier and as shown in Table 3, the 320-hour estimate represents the upper bound for qualified registry burden, with the potential for less additional MIPS burden if the qualified registry already provides similar data submission services.

Based on these assumptions, we provide an estimate of the total annual burden associated with a qualified registry self-nominating to be considered for approval.

TABLE 3: Estimated Burden for Qualified Registry Self-Nomination

Burden and Respondent Descriptions	**Minimum Burden Estimate**	**Maximum Burden Estimate**
# of Qualified Registry Simplified Self-Nomination Applications submitted (a)	160	0
# of Qualified Registry Full Self-Nomination Applications submitted (b)	0	160
Total Applications (c)	**160**	**160**
Total Annual Hours Per Qualified Registry for Simplified Process (d)	0.5	0
Total Annual Hours Per Qualified Registry for Full Process (e)	0	2
Total Annual Hours for Self-Nomination for min. (f) = (a) * (d) and max. (b) * (e)	**80**	**320**
Cost Per Simplified Process Per Qualified Registry (@ computer systems analyst's labor rate of $98.28/hr) (g)	$49.14	0
Cost Per Full Process Per Qualified Registry (@ computer systems analyst's labor rate of $98.28/hr) (h)	0	$196.56
Total Annual Cost (i) = (a) * (g) (min.) and (b) * (h) (max.)	**$7,862**	**$31,450**

ii. Burden for QCDR Self-Nomination and Other Requirements[5]

QCDRs interested in submitting quality, Promoting Interoperability, and improvement activities performance category data to us on their participants' behalf will need to complete a self-nomination process to be considered for approval to do so.

Previously approved QCDRs in good standing (that are not on probation or disqualified) that wish to self-nominate using the simplified process can attest, in whole or in part, that their

[5] We do not anticipate any changes in the CEHRT process for health IT vendors as we transition to MIPS. Hence, health IT vendors are not included in the burden estimates for MIPS.

previously approved form is still accurate and applicable. Existing QCDRs in good standing that would like to make minimal changes to their previously approved self-nomination application from the previous year, may submit these changes, and attest to no other changes from their previously approved QCDR application. The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period (83 FR 59898).

We estimate that a total of 90 QCDRs would submit self-nomination applications during the CY 2022 self-nomination period for the CY 2023 performance period/2025 MIPS payment year.

QCDRs must calculate their measure results and also must possess benchmarking capabilities (for QCDR measures) that compare the quality of care a MIPS eligible clinician provides with other MIPS eligible clinicians performing the same quality measures. For QCDR measures, the QCDR must provide to us, if available, data from years prior (for example, 2017 data for the CY 2019 performance period) before the start of the performance period. In addition, the QCDR must provide to us, if available, the entire distribution of the measure's performance broken down by deciles. As an alternative to supplying this information to us, the QCDR may post this information on their website prior to the start of the performance period, to the extent permitted by applicable privacy laws. The time it takes to perform these functions may vary depending on the sophistication of the entity, but we estimate that a QCDR will spend an additional 1 hour performing these activities per measure. QCDRs are also required to link their QCDR measures as feasible to at least one of the following, at the time of self-nomination: (a) cost measures, (b) improvement activities, or (c) MIPS Value Pathways. We estimate that a QCDR will spend an additional 1 hour performing these activities per measure, on average.

We assume that the staff involved in the QCDR self-nomination process will continue to be computer systems analysts or their equivalent, who have an average labor rate of $98.28/hr. Using the unchanged estimated hourly burden per respondent ranging from 9.5 hours for the simplified self-nomination process to 11.5 hours for the full self-nomination process, and accounting for the estimated increase in the number of QCDRs that would submit a self-nomination application, we estimate that the annual burden will range from 855 hours (90 QCDRs x 9.5 hr) to 1,035 hours (90 QCDRs x 11.5 hr) at a cost ranging from $84,029 (855 hr x $98.28/hr) to $101,720 (1,035 hr x $98.28/hr) for the simplified self-nomination process and the full self-nomination process, respectively (See Table 4).

QCDRs must comply with requirements on the submission of MIPS data to CMS. The burden associated with the QCDR submission requirements will be the time and effort associated with calculating quality measure results from the data submitted to the QCDR by its participants and submitting these results, the numerator and denominator data on quality measures, the Promoting Interoperability performance category, and improvement activities data to us on behalf of their participants. We expect that the time needed for a QCDR to accomplish these tasks will vary along with the number of MIPS eligible clinicians submitting data to the QCDR and the number of applicable measures. However, we believe that QCDRs already perform many of these activities for their participants. Therefore, we believe the 1,035-hour estimate represents the upper bound of QCDR burden, with the potential for less additional MIPS burden if the QCDR already provides similar data submission services.

Based on the assumptions previously discussed, we provide an estimate of the total annual burden associated with a QCDR self-nominating to be considered for approval.

TABLE 4: Estimated Burden for QCDR Self-Nomination

Burden and Respondent Descriptions	Minimum Burden Estimate	Maximum Burden Estimate
# of QCDR Simplified Self-Nomination Applications submitted (a)	90	0
# of QCDR Full Self-Nomination Applications submitted (b)	0	90
Total Applications (c)	**90**	**90**
Total Annual Hours Per QCDR for Simplified Process (d)	9.5	0
Total Annual Hours Per QCDR for Full Process (e)	0	11.5
Total Annual Hours for Self-nomination (f) = (a) * (d) and (b) * (e)	**855**	**1,035**
Cost Per Simplified Process Per QCDR (@ computer systems analyst's labor rate of $98.28/hr) (g) = (d) * $98.28/hr	$933.66	0
Cost Per Full Process Per QCDR (@ computer systems analyst's labor rate of $98.28/hr) (h) = (e) * $98.28/hr	0	$1,130.22
Total Annual Cost (i) = (a) * (g) (min.) and (b)*(e) (max.)	**$84,029**	**$101,720**

iii. Third Party Intermediary Plan Audits

As discussed above in this section, we propose to add a new ICR to distinctly capture the burden for collection of information related to QCDR and qualified registry targeted audits at § 414.1400(b)(3)(vi) through (viii) and the requirements for remedial action and termination of third party intermediaries at § 414.1400(e) during the third party intermediary self-nomination process. We note that we capture the estimated burden for third party intermediaries to submit additional requirements for compliance with both the conditions of approval and remedial action and termination criteria under one ICR.

In the CY 2022 PFS final rule, we combined the burden associated with the submission of the targeted audits, corrective action plans, participation plans and transition plans with the ICR for QCDR self-nomination process and other requirements (86 FR 65569 through 65573) and the ICR for qualified registry self-nomination process and other requirements (86 FR 65573 through 65576). For the purposes of this ICR, we refer to these audits and plans collectively as "plan audits." For this proposed rule, we determined that it is necessary to separately estimate the burden for QCDR and qualified registry targeted audits from their self-nomination application burden because it would more accurately represent the burden.

(a) Targeted Audits

In the CY 2022 PFS final rule (86 FR 65547 through 65548), we finalized that beginning with the CY 2021 performance period/2023 MIPS payment year, the QCDR or qualified registry must conduct targeted audits in accordance with requirements at § 414.1400(b)(3)(vi). Consistent with our assumptions in the CY 2022 PFS final rule for the QCDRs (86 FR 65574) and qualified registries (86 FR 65571) that would submit targeted audits, we estimate that the time required for a QCDR or qualified registry to submit a targeted audit ranges between 5 and 10 hours for the simplified and full self-nomination process, respectively. We assume that the staff involved in submitting the targeted audits will continue to be computer systems analysts or their equivalent, who have an average labor rate of $98.28/hr.

Using the proposed adjustments to the number of QCDRs and qualified registries expected to submit self-nomination applications in the CY 2022 self-nomination period, we estimate that 70 third party intermediaries (20 QCDRs and 50 qualified registries) would submit targeted audits

for the CY 2023 performance period/2025 MIPS payment year. Using the unchanged currently approved time per respondent (86 FR 65572), we estimate the total impact associated with QCDRs and qualified registries completing targeted audits will range from 350 hours (70 respondents × 5 hours/audit) at a cost of $34,398 (70 respondents × $491.40/audit) to 700 hours (70 respondents × 10 hours/audit) at a cost of $68,796 (70 respondents × $982.80/audit) for the simplified and full self-nomination process, respectively (See Tables 5 and 6).

(b) Participation Plans

In the CY 2022 PFS final rule (86 FR 65546), we finalized requirements for approved QCDRs and qualified registries that have not submitted performance data to submit a participation plan as part of their self-nomination process. Consistent with our assumptions in the CY 2022 PFS final rule for the QCDRs (86 FR 65574) and qualified registries (86 FR 65571) that would submit participation plans, we estimate that it would take 3 hours for a QCDR or qualified registry to submit a participation plan during the self-nomination process. We assume that the staff involved in submitting a participation plan will continue to be computer systems analysts or their equivalent, who have an average labor rate of $98.28/hr.

We estimate that 29 third party intermediaries (10 QCDRs and 19 qualified registries) would submit participation plans for the CY 2023 performance period/2025 MIPS payment year. Therefore, we estimate the total impact associated with QCDRs and qualified registries to submit participation plans would be 87 hours (29 respondents × 3 hours/plan) at a cost of $8,550 (29 respondents × $294.84/plan) (See Tables 5 and 6).

(c) Corrective Action Plans (CAPs)

As described in § 414.1400(e)(1)(i) and (ii), the remedial actions CMS may take against a third party intermediary include requiring the third party intermediary to submit to CMS a CAP by a date specified by the agency and publicly disclosing an entity's data error rate on the CMS website until the data error rate falls below 3 percent. We estimate that 10 third party intermediaries would submit CAPs for the CY 2023 performance period/2025 MIPS payment year. Additionally, we estimate that it would take 3 hours for a QCDR or qualified registry to submit a participation plan. We assume that the staff involved in submitting the CAPs will continue to be computer systems analysts or their equivalent, who have an average labor rate of $98.28/hr. Therefore, we estimate the total impact associated with QCDRs and qualified registries to CAPs would be 30 hours (10 respondents × 3 hours/plan) at a cost of $2,948 (10 respondents × $294.84/plan) (See Tables 5 and 6).

(d) Transition Plans

In the CY 2020 PFS final rule (84 FR 63052 through 63053), we established a policy at § 414.1400(a)(4)(vi) that a condition of approval for the third party intermediary is to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan.

In the CY 2020 PFS final rule (84 FR 63115), we did not estimate the total burden associated with the development of CMS approved transition plans because of the uncertain, but low

frequency (less than 10 per year historically) with which third party intermediaries have elected to discontinue services during a performance period. Based on updated data received for the transition plans submitted by the registries and QCDRs beginning with the CY 2020 performance period/2022 MIPS payment year, we estimate to receive 15 transition plans from QCDRs and qualified registries for the CY 2023 performance period/2025 MIPS payment year. We estimate that it would take 1 hour for a computer system analyst or their equivalent at a labor rate of $98.28/hr to develop a transition plan on behalf of each QCDR or qualified registry during the self-nomination period. However, we are unable to estimate the burden for implementing the actions in the transition plan because the level of effort may vary for each QCDR or qualified registry. Therefore, we estimate the total impact associated with qualified registries completing transition plans is 15 hours (15 transition plans × 1 hour/plan) at a cost of $1,474 (15 hr × $98.28/hr).

TABLE 5: Estimated Number of Respondents to Submit Plan Audits

Burden and Respondent Descriptions	**# of Respondents**
# of Targeted Audits (a)	70
# of Participation Plans (b)	29
# of Corrective Action Plans (CAPs) (c)	10
# of Transition Plans (d)	15
Total Respondents (e) = (a) + (b) + (c) + (d)	**124**

For the CY 2023 performance period/2025 MIPS payment year, in aggregate, the proposed estimated annual burden for the simplified (or minimum) and full (or maximum) self-nomination process will range from 482 hours to 832 hours at a cost ranging from $47,371 (482 hr x $98.28 /hr) and $81,769 (832 hr x $98.28 /hr), respectively.

TABLE 6: Estimated Burden for Third Party Intermediary Plan Audits

Burden and Respondent Descriptions	**Minimum**	**Maximum**
# of Hours per Completion of Targeted Audit (a)	5	10
Total Annual Hours for Completion of 70 Targeted Audits (b)	**350**	**700**
# of Hours per Submission of Participation Plan (c)	3	3
Total Annual Hours for Submission of 29 Participation Plans (d)	**87**	**87**
# of Hours per Submission of CAP (e)	3	3
Total Annual Hours for Submission of 10 CAPs (f)	**30**	**30**
# of Hours per Submission of Transition Plan (g)	1	1
Total Annual Hours for Submission of 15 Transition Plans (h)	**15**	**15**
Total Annual Hours for Submission of Plan Audits (i) = (b) + (d) + (f) + (h)	**482**	**832**
Cost Per Targeted Audit (@ computer systems analyst's labor rate of $98.28/hr) (j) = (a) * $98.28/hr	$491.40	$982.80
Cost Per Participation Plan (@ computer systems analyst's labor rate of $98.28/hr) (k) = (c) * $98.28/hr	$294.84	$294.84
Cost per CAP (@ computer systems analyst's labor rate of $98.28/hr) (l) = (e) * $98.28/hr	$294.84	$294.84
Cost per Transition Plan @computer systems analyst's labor rate of $98.28/hr (m) = (g) * $98.28/hr	$98.28	$98.28
Total Annual Cost (n) = 70 * (j) + 29 * (k) + 10 * (l) + 15 * (m) (min) and 70 * (j) + 29 * (k) + 10 * (l) + 15 * (m) (max)	**$47,371**	**$81,769**

d. Burden Estimate for the Open Authorization (OAuth) Credentialing and Token Request Process

Beginning with the CY 2021 performance period/2023 MIPS payment year, the OAuth Credentialing and Token Request Process is available to all submitter types who are approved to submit data via the direct submission type. Individual clinicians or groups may submit their quality measures using the direct submission type via the MIPS CQM, QCDR or eCQM collection types as well as their Promoting Interoperability measures and improvement activities through the same direct submission type. The burden associated with this ICR belongs only to the application developer; QPP participants will not be required to do anything additional to submit their data. For third party intermediaries, OAuth Credentialing will allow QPP participants to use their own QPP credentials to login through the third-party intermediary's application to submit their data and view performance feedback from QPP. Entities that receive approval for their applications through this process will be able to provide QPP participants a more comprehensive and less administratively burdensome experience using the direct submission type.

Beginning with the CY 2023 performance period/2025 MIPS payment year, we made administrative changes in the process for interested parties to submit their application for OAuth credentialing and token process. Based on the changes to the workflows, the CMS Office of Information Technology (OIT) has centralized Okta Administrator privileges. In previous years, the Quality Payment Program maintained the privileges for Administrator roles. As a result of this change, interested parties that would submit their information for OAuth Credentialing and Token request process are now required to meet with both Quality Payment Program and OIT for final approvals to have their applications integrated with the CMS Okta production environment. Therefore, we propose to revise our estimates to reflect that it would now take 2 hours for a computer systems analyst (or their equivalent) at $98.28/hr to provide documentation and any follow-up communication via email.

As shown in Table 7, we are not making any changes to our currently approved estimate of 15 submitter types to complete this process for the CY 2023 performance period/2025 MIPS payment year. In aggregate, we estimate it would take 2 hours at $98.28/hr for a computer systems analyst (or their equivalent) to complete the process. We estimate an annual burden of 30 hours (15 vendors x 2 hrs) at a cost of $2,948 (30 hrs x $98.28/hr).

TABLE 7: Estimated Burden for the OAuth Credentialing and Token Request Process

Burden and Respondent Descriptions	**Burden Estimate**
# of Organizations (a)	15
Total Annual Hours Per Organization to Submit (b)	2
Total Annual Hours (c) = (a)*(b)	**30**
Cost Per Organization (@ computer systems analyst's labor rate of $98.28/hr.) (d)	$98.28/hr
Total Annual Cost (e) = (a)*(d)	**$2,948**

e. Burden Estimate for the Quality Performance Category

Under our current policies, two groups of clinicians must submit quality data under MIPS: those who submit as MIPS eligible clinicians and those who opt to submit data voluntarily but are not subject to MIPS payment adjustments. Clinicians are ineligible for MIPS payment adjustments if they are newly enrolled to Medicare; are QPs; are partial QPs who elect to not participate in MIPS; are not one of the clinician types included in the definition for MIPS eligible clinician; or do not exceed the low-volume threshold as an individual or as a group.

To determine which QPs should be excluded from MIPS, we used the Advanced APM payment and patient percentages from the APM Participant List for the third snapshot date for the CY 2021 QP performance period. From this data, we calculated the QP determinations as described in the Qualifying APM Participant (QP) definition at § 414.1305 for the CY 2023 QP performance period. Due to data limitations, we could not identify specific clinicians who have not yet enrolled in APMs, but who may become QPs in the CY 2023 performance period/2025 MIPS payment year (and therefore will no longer need to submit data to MIPS); hence, our model may underestimate or overestimate the number of respondents.

The burden associated with the submission of quality performance category data has some limitations. We believe it is difficult to quantify the burden accurately because clinicians and groups may have different processes for integrating quality data submission into their practices' workflows. Moreover, the time needed for a clinician to review quality measures and other information, select measures applicable to their patients and the services they furnish, and incorporate the use of quality measures into the practice workflows is expected to vary along with the number of measures that are potentially applicable to a given clinician's practice and by the collection type. For example, clinicians submitting data via the Medicare Part B claims collection type need to integrate the capture of quality data codes for each encounter whereas clinicians submitting via the eCQM collection types may have quality measures automated as part of their EHR implementation.

We believe the burden associated with submitting quality measures data will vary depending on the collection type selected by the clinician, group, or third-party. As such, we separately estimated the burden for clinicians, groups, and third parties to submit quality measures data by the collection type used. For the purposes of our burden estimates for the Medicare Part B claims, MIPS CQM and QCDR, and eCQM collection types, we also assume that, on average, each clinician or group will submit 6 quality measures. Additionally, we capture the burden for clinicians who choose to submit via these collection types for the quality performance category of MVPs. We finalized in the CY 2022 PFS final rule (86 FR 65411 through 65412) that except as provided in paragraph § 414.1365(c)(1)(i), an MVP Participant must select and report 4 quality measures, including 1 outcome measure (or, if an outcome measure is not available, 1 high priority measure, included in the MVP.

i. Burden for Quality Payment Program Identity Management Application Process

For an individual, group, or third party to submit MIPS quality, improvement activities, or Promoting Interoperability performance category data using either the log in and upload or the log in and attest submission type or to access feedback reports, the submitter must have a CMS

Healthcare Quality Information System (HCQIS) Access Roles and Profile (HARP) system user account. Once the user account is created, registration is not required again for future years.

Based on historical trends for the number of eligible clinicians, groups, or third parties that register for new accounts, we noticed that we inadvertently underestimated our assumptions in the CY 2022 PFS final rule (86 FR 65582). In order to accurately capture the incremental change in the number of respondents in previous years, we are using a rolling average of the number of respondents that would register for obtaining new accounts. Therefore, we are proposing to adjust our estimates from 3,741 to 6,500 for the number of respondents that would submit their information to obtain new user accounts in the HARP system for the CY 2023 performance period/2025 MIPS payment year. As shown in Table 8, it would take 1 hour at $98.28/hr for a computer systems analyst (or their equivalent) to obtain an account for the HARP system. In aggregate we estimate an annual burden of 6,500 hours (6,500 registrations x 1 hr/registration) at a cost of $638,820 (6,500 hr x $98.28/hr) or $98.28 per registration.

TABLE 8: Estimated Burden for Quality Payment Program Identity Management Application Process

Burden and Respondent Descriptions	**Burden Estimate**
# of New TINs completing the Identity Management Application Process (a)	6,500
Total Hours Per Application (b)	1
Total Annual Hours for completing the Identity Management Application Process (c) = (a)*(b)	**6,500**
Cost Per Application @ computer systems analyst's labor rate of $98.28/hr.) (d)	$98.28
Total Annual Cost for completing the Identity Management Application Process (e) = (a)*(d)	**$638,820**

ii. Burden for Quality Data Submission by Clinicians: Medicare Part B Claims-Based Collection Type

As noted in Table 9 based on CY 2019 performance period/2021 MIPS payment year data, we assume that 27,006 individual clinicians will collect and submit quality data via the Medicare Part B claims collection type, an increase of 1,579 from the currently approved estimate of 25,427 respondents based on more recent data and our methodology of accounting only for clinicians in small practices who submitted such claims data in the CY 2019 performance period/2021 MIPS payment year rather than all clinicians who submitted quality data codes to us for the Medicare Part B claims collection type.

As shown in Table 9, consistent with our currently approved per response time figures, we estimate that the burden of quality data submission using Medicare Part B claims will range from 0.15 hours (9 minutes) at a cost of $14.74 (0.15 hr x $98.28/hr) to 7.2 hours at a cost of $707.61 (7.2 hr x $98.28/hr). The burden will involve becoming familiar with MIPS quality measure specifications. We believe that the start-up cost for a clinician's practice to review measure specifications is 7 hours, consisting of 3 hours at $115.22/hr for a medical and health services manager, 1 hour at $259.98/hr for a physician, 1 hour at $49.86/hr for an LPN, 1 hour at $98.28/hr for a computer systems analyst, and 1 hour at $41.10/hr for a billing and posting clerk. We are not revising our currently approved per response time estimates.

The estimate for reviewing and incorporating measure specifications for the claims collection type is higher than that of QCDRs/registries or eCQM collection types due to the more manual, and therefore, more burdensome nature of Medicare Part B claims measures.

As shown in Table 9, for the CY 2023 performance period/2025 MIPS payment year, considering both data submission and start-up requirements, the estimated time (per clinician) ranges from a minimum of 7.15 hours (0.15 hr + 7 hr) to a maximum of 14.2 hours (7.2 hr + 7 hr). In aggregate, the total annual time ranges from 193,093 hours (7.15 hr x 27,006 clinicians) to 383,485 hours (14.2 hr x 27,006 clinicians). The estimated annual cost (per clinician) ranges from $809.62 [(0.15 hr x $98.28/hr) + (3 hr x $115.22/hr) + (1 hr x $98.28/hr) + (1 hr x $49.86/hr) + (1 hr x $41.10/hr) + (1 hr x $259.98/hr)] to a maximum of $1,502.49 [(7.2 hr x $98.28/hr) + (3 hr x $115.22/hr) + (1 hr x $98.28/hr) + (1 hr x $49.86/hr) + (1 hr x $41.10/hr) + (1 hr x $259.98/hr)]. The total annual cost ranges from a minimum of $21,864,598 (27,006 clinicians x $809.62) to a maximum of $40,576,245 (27,006 clinicians x $1,502.49).

TABLE 9: Estimated Burden for Quality Performance Category: Clinicians Using the Claims Collection Type

Burden and Respondent Descriptions	**Minimum Burden Estimate**	**Median Burden Estimate**	**Maximum Burden Estimate**
# of Clinicians (a)	27,006	27,006	27,006
Hours Per Clinician to Submit Quality Data (b)	0.15	1.05	7.2
# of Hours Medical and health services manager Review Measure Specifications (c)	3	3	3
# of Hours Computer Systems Analyst Review Measure Specifications (d)	1	1	1
# of Hours LPN Review Measure Specifications (e)	1	1	1
# of Hours Billing Clerk Review Measure Specifications (f)	1	1	1
# of Hours Clinician Review Measure Specifications (g)	1	1	1
Annual Hours per Clinician (h) = (b)+(c)+(d)+(e)+(f)+(g)	7.15	8.05	14.2
Total Annual Hours (i) = (a)*(h)	**193,093**	**217,398**	**383,485**
Cost to Submit Quality Data (@ computer systems analyst's labor rate of $98.28/hr @ varying times) (j)	$14.74	$103.19	$707.61
Cost to Review Measure Specifications (@ medical and health services manager's labor rate of $115.22/hr @ 3 hr) (k)	$345.66	$345.66	$345.66

Burden and Respondent Descriptions	Minimum Burden Estimate	Median Burden Estimate	Maximum Burden Estimate
Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $98.28/hr @ 1 hr) (l)	$98.28	$98.28	$98.28
Cost to Review Measure Specifications (@ LPN's labor rate of $49.86/hr @1 hr) (m)	$49.86	$49.86	$49.86
Cost to Review Measure Specifications (@ billing clerk's labor rate of $41.10/hr @ 1 hr) (n)	$41.10	$41.10	$41.10
Cost to Review Measure Specifications (@ physician's labor rate of $259.98/hr @ 1 hr) (o)	$259.98	$259.98	$259.98
Total Annual Cost Per Clinician (p) = (j)+(k)+(l) +(m)+(n)+(o)	$809.62	$898.07	$1,502.49
Total Annual Cost (q) = (a)*(p)	**$21,864,598**	**$24,253,278**	**$40,576,245**

iii. Burden for Quality Data Submission by Individuals and Groups: MIPS CQM and QCDR Collection Types

Based on CY 2019 performance period/2021 MIPS payment year data, we assume that 37,306 individual clinicians and 10,278 groups and virtual groups will submit quality data for the MIPS CQM and QCDR collection types for the CY 2023 performance period/2025 MIPS payment year. Given that the number of measures required is the same for clinicians and groups, we expect the burden to be the same for each respondent collecting data via MIPS CQM or QCDR, whether the clinician is participating in MIPS as an individual or group.

Under the MIPS CQM and QCDR collection types, the individual clinician or group may either submit the quality measures data directly to us, log in and upload a file, or utilize a third-party intermediary to submit the data to us on the clinician's or group's behalf. We estimate that the burden associated with the QCDR collection type is similar to the burden associated with the MIPS CQM collection type; therefore, we discuss the burden for both together below. For MIPS CQM and QCDR collection types, we estimate an additional time for respondents (individual clinicians and groups) to become familiar with MIPS quality measure specifications and, in some cases, specialty measure sets and QCDR measures. Therefore, we believe that the burden for an individual clinician or group to review measure specifications and submit quality data totals 9.08 hours at a cost of $982.65 per response. This consists of 3 hours at $98.28/hr for a computer systems analyst (or their equivalent) to submit quality data along with 2 hours at $115.22/hr for a medical and health services manager, 1 hour at $98.28/hr for a computer systems analyst, 1 hour at $49.86/hr for a LPN, 1 hour at $41.10/hr for a billing clerk, and 1 hour at $259.98/hr for a physician to review measure specifications. Additionally, clinicians and groups who do not submit data directly will need to authorize or instruct the qualified registry or QCDR to submit quality measures' results and numerator and denominator data on quality measures to us on their behalf. We estimate that the time and effort associated with authorizing or instructing the quality

registry or QCDR to submit this data will be approximately 5 minutes (0.083 hours) at $98.28/hr for a computer systems analyst at a cost of $8.15 (0.083 hr x $98.28/hr). Overall, we estimate 9.083 hrs/response (3 hrs + 2 hrs + 1 hr + 1 hr + 1 hr + 1 hr + 0.083 hrs) at a cost of $982.65/response [(3 hr x $98.28/hr) + (2 hr x $115.22/hr) + (1 hr x $259.98/hr) + (1 hr x $98.28/hr) + (1 hr x $49.86/hr) + (1 hr x $41.10/hr) + (0.083 hr x $98.28/hr)].

As shown in Table 10, for the CY 2023 performance period/2025 MIPS payment year, in aggregate, we estimate a burden of 432,205 hours [9.083 hr/response x (37,306 clinicians submitting as individuals + 10,278 groups submitting via QCDR or MIPS CQM on behalf of individual clinicians or 47,584 responses)] at a cost of $46,758,418 (47,584 responses x $982.65/response).

TABLE 10: Estimated Burden for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group) Using the MIPS CQM and QCDR Collection Type

Burden and Respondent Descriptions	**Burden Estimate**
# of clinicians submitting as individuals (a)	37,306
# of groups submitting via QCDR or MIPS CQM on behalf of individual clinicians (b)	10,278
# of Respondents (groups and clinicians submitting as individuals) (c)=(a)+(b)	47,584
Hours Per Respondent to Report Quality Data (d)	3
# of Hours Medical and health services manager Review Measure Specifications (e)	2
# of Hours Computer Systems Analyst Review Measure Specifications (f)	1
# of Hours LPN Review Measure Specifications (g)	1
# of Hours Billing Clerk Review Measure Specifications (h)	1
# of Hours Clinician Review Measure Specifications (i)	
# of Hours Per Respondent to Authorize Qualified Registry to Report on Respondent's Behalf (j)	0.083
Annual Hours Per Respondent (k)= (d)+(e)+(f)+(g)+(h)+(i)+(j)	9.083
Total Annual Hours (l) = (c)*(k)	**432,205**
Cost Per Respondent to Submit Quality Data (@ computer systems analyst’s labor rate of $98.28/hr) (m)	$294.84
Cost to Review Measure Specifications (@ medical and health services manager's labor rate of $115.22/hr) (n)	$230.44
Cost Computer System’s Analyst Review Measure Specifications (@ computer systems analyst’s labor rate of $98.28/hr) (o)	$98.28
Cost LPN Review Measure Specifications (@ LPN's labor rate of $49.86/hr) (p)	$49.86
Cost Billing Clerk Review Measure Specifications (@ clerk’s labor rate of $41.10/hr) (q)	$41.10
Cost Physician Review Measure Specifications (@ physician’s labor rate of $259.98/hr) (r)	$259.98

Burden and Respondent Descriptions	Burden Estimate
Cost for Respondent to Authorize Qualified Registry/QCDR to Report on Respondent's Behalf (@ computer systems analyst's labor rate of $98.28/hr) (s)	$8.15
Total Annual Cost Per Respondent (t) = (m)+(n)+(o)+(p)+(q)+(r)+(s)	$982.65
Total Annual Cost (u) = (c)*(t)	**$46,758,418**

iv. Burden for Quality Data Submission by Clinicians and Groups: eCQM Collection Type

As noted in Table 11 below, based on data in the CY 2019 performance period/2021 MIPS payment year, we assume that 38,464 clinicians will submit eCQMs as individuals, and 7,296 groups and virtual groups will submit quality data using the eCQM collection type for the CY 2023 performance period/2025 MIPS payment year. We expect the burden to be the same for each respondent using the eCQM collection type, whether the clinician is participating in MIPS as an individual or group.

Under the eCQM collection type, the individual clinician or group may either submit the quality measures data directly to us from their eCQM, log in and upload a file, or utilize a third-party intermediary to derive data from their CEHRT and submit it to us on the clinician's or group's behalf.

To prepare for the eCQM collection type, the clinician or group must review the quality measures on which we will be accepting MIPS data extracted from eCQMs, select the appropriate quality measures, extract the necessary clinical data from their CEHRT, and submit the necessary data to a QCDR/qualified registry or use a health IT vendor to submit the data on behalf of the clinician or group. We assume the burden for collecting quality measures data via eCQM is similar for clinicians and groups who submit their data directly to us from their CEHRT and clinicians and groups who use a health IT vendor to submit the data on their behalf. This includes extracting the necessary clinical data from their CEHRT and submitting the necessary data to the QCDR/qualified registry.

We estimate that it will take no more than 2 hours at $98.28/hr for a computer systems analyst to submit the actual data file. The burden will also involve becoming familiar with MIPS submission. In this regard, we estimate it will take 6 hours for a clinician or group to review measure specifications. Of that time, we estimate 2 hours at $115.22/hr for a medical and health services manager, 1 hour at $259.98/hr for a physician, 1 hour at $98.28/hr for a computer systems analyst, 1 hour at $49.86/hr for an LPN, and 1 hour at $41.10/hr for a billing clerk. As shown in Table 11, we estimate a cost of $876.22/response [(2 hr x $98.28/hr) + (2 hr x $115.22/hr) + (1 hr x $259.98/hr) + (1 hr x $98.28/hr) + (1 hr x $49.86/hr) + (1 hr x $41.10/hr)].

As shown in Table 11, for the CY 2023 performance period/2025 MIPS payment year, we estimate a burden of 366,080 hours [8 hr x 45,760 (7,296 groups and 38,464 clinicians submitting as individuals)] at a cost of $40,095,827 (45,760 responses x $876.22/response).

TABLE 11: Estimated Burden for Quality Performance Category: Clinicians (Submitting Individually or as Part of a Group) Using the eCQM Collection Type

Burden and Respondent Descriptions	Burden estimate
# of Clinicians submitting as individuals (a)	38,464
# of Groups submitting via EHR on behalf of individual clinicians (b)	7,296
# of Respondents (groups and clinicians submitting as individuals) (c)=(a)+(b)	**45,760**
# of Hours Per Respondent to Submit MIPS Quality Data File to CMS (d)	2
# of Hours Medical and health services manager Review Measure Specifications (e)	2
# of Hours Computer Systems Analyst Review Measure Specifications (f)	1
# of Hours LPN Review Measure Specifications (g)	1
# of Hours Billing Clerk Review Measure Specifications (h)	1
# of Hours Clinicians Review Measure Specifications (i)	1
Annual Hours Per Respondent (j)=(d)+(e)+(f)+(g)+(h)+(i)	8
Total Annual Hours (k)=(c)*(j)	**366,080**
Cost Per Respondent to Submit Quality Data (@ computer systems analyst's labor rate of $98.28/hr) (l)	$196.56
Cost to Review Measure Specifications (@ medical and health services manager's labor rate of $115.22/hr) (m)	$230.44
Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $98.28/hr) (n)	$98.28
Cost to Review Measure Specifications (@ LPN's labor rate of $49.86/hr) (o)	$49.86
Cost to Review Measure Specifications (@ clerk's labor rate of $41.10/hr) (p)	$41.10
Cost to Review Measure Specifications (@ physician's labor rate of $259.98/hr) (q)	$259.98
Total Cost Per Respondent (r)=(l)+(m)+(n)+(o)+(p)+(q)	$876.22
Total Annual Cost (s) = (c)*(r)	**$40,095,827**

f. ICRs Regarding Burden for MVP Reporting

In the CY 2022 PFS final rule, we finalized the implementation of voluntary MIPS Value Pathways (MVP) and subgroup reporting for eligible clinicians beginning with the CY 2023 performance period/2025 MIPS payment year. Therefore, clinicians participating in MIPS would have the option to voluntarily submit data using MVPs starting with the CY 2023 performance period/2025 MIPS payment year. Additionally, clinicians participating in MIPS through reporting MVPs could also choose to form subgroups beginning with the CY 2023 performance period/2025 MIPS payment year. The MVPs would include the Promoting Interoperability performance category as a foundational element and incorporate population health claims-based measures, as feasible, along with the relevant measures and activities in the quality, cost and improvement activities performance categories. We estimate that the clinicians choosing to participate in MIPS for reporting MVPs would need to select from a reduced inventory of measures and activities for the quality and improvement activities performance categories. This reduction in burden is described in the quality, improvement activities and Promoting

Interoperability performance categories sections below. The following ICRs reflect the burden associated with the first year of data collection related to the implementation of MVPs and subgroup reporting in the CY 2023 performance period/2025 MIPS payment year as described in the CY 2022 PFS final rule.

For the ICRs related to MVP participants, we used the MIPS submission data from the CY 2019 performance period/2021 MIPS payment year. In Appendix 3: MVP Inventory of the CY 2023 PFS proposed rule, we propose to revise 6 of the 7 MVPs finalized in Appendix 3: MVP Inventory of the CY 2022 PFS final rule (86 FR 65998 through 66031). Specifically, these revisions are based on the proposed removal of certain improvement activities, the addition of other relevant existing quality measures for MVP participants to select from, and the proposed addition of the ONC direct review attestation requirement in the Promoting Interoperability performance category to all previously finalized MVPs. Additionally, we propose 5 new MVPs for the CY 2023 performance period/2025 MIPS payment year. If the proposed 5 new MVPs are finalized, MVP participants would have a total of 12 MVPs available for the CY 2023 performance period/2025 MIPS payment year. Due to the availability of new MVPs and addition of relevant quality measures to existing MVPs, we expect an increase in the number of MVP participants. Therefore, we estimate that 12 percent of the clinicians would participate in MVP reporting in the CY 2023 performance period/2025 MIPS payment year.

i. Burden for MVP Registration: Individuals, Groups and APM Entities

Beginning with the CY 2023 performance period/2025 MIPS payment year, clinicians interested in participating in MIPS through MVP reporting would be required to complete an annual registration process described in the CY 2022 PFS final rule (86 FR 65589 through 65590). At the time of registration, MVP participants would need to select a specific MVP, a population health measure and if administrative claims measures are included in the selected MVP, the MVP participants would also need to choose an applicable administrative claims measure in the MVP. In Table 12 below, we continue to estimate that the registration process for clinicians choosing to submit MIPS data for the measures and the activities in an MVP would require 0.25 hours of a computer systems analyst's time. We assume that the staff involved in the MVP registration process will mainly be computer systems analysts or their equivalent, who have an average labor cost of $98.28/hour.

Based on data from the CY 2019 performance period/2021 MIPS payment year, and accounting for the proposed changes to the existing MVPs and the addition of new MVPs, we estimate that 12 percent of the clinicians that currently participate in MIPS will submit data for the measures and activities in an MVP. For the CY 2023 performance period/2025 MIPS payment year, we assume that a total of 16,432 submissions would be received for the measures and activities included in MVPs. This total includes our estimate of 20 subgroup reporters that will also be reporting MVPs in addition to MVP reporters who currently participate in MIPS. Therefore, we assume that the total number of individual clinicians, groups, subgroups and APM Entities to complete the MVP registration process is 16,432. As shown in Table 12, we estimate that it would take 4,108 hours (16,432 respondents x 0.25 hr/registration) for individual clinicians, groups, subgroups, and APM Entities to complete the MVP registration process at a cost of $403,734 (4,108 hours x 98.28/hr) for the CY 2023 performance period/2025 MIPS payment year.

TABLE 12: Total Estimated Burden for MVP Registration (Individual clinicians, Groups, Subgroups and APM Entities)

Burden and Respondent Descriptions	Burden Estimate
Estimated # of Individual clinicians, groups, subgroups and APM Entities Registering (a)	16,432
Estimated Total Annual Burden Hours Per Registration (b)	0.25
Estimated Total Annual Burden Hours for MVP Registration (c) = (a) * (b)	**4,108**
Estimated Cost Per MVP (@ computer systems analyst's labor rate of $98.28/hr. (d)	$98.28
Estimated Total Annual Burden Cost for MVP Registration (e) = (c) * (d)	**$403,734**

ii. Burden for Subgroup Registration

In the CY 2022 PFS final rule, we also finalized to define a subgroup at § 414.1305 as a subset of a group, as identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician's NPI. In addition to the burden for MVP registration process described above in Table 12, clinicians who choose to form subgroups for reporting the MVPs would need to submit a list of each TIN/NPI associated with the subgroup and a plain language name for the subgroup in a manner specified by CMS, as described in the CY 2022 PFS final rule (86 FR 65415 through 65418). For the CY 2023 performance period/2025 MIPS payment year, we continue to estimate that clinicians would choose to form 20 subgroups for reporting the measures and activities in MVPs and that it would require a minimum of 0.5 hours per subgroup respondent to submit the finalized requirements for subgroup registration. As shown in Table 13 below, we assume that the staff involved in the subgroup registration process will mainly be computer systems analysts or their equivalent, who have an average labor cost of $98.28/hr. In aggregate, we estimate that it will take 10 hours (20 subgroups x 0.5 hr/subgroup) to complete the subgroup registration process at a cost of $983 (10 hours x 98.28/hr).

As subgroup participation option is only available to report MVPs, the burden associated with subgroup quality reporting will be included with the MVP quality reporting ICR. Burden associated with subgroup submissions for Promoting Interoperability and improvement activities will be included with those ICRs.

TABLE 13: Total Estimated Burden for Subgroup Registration

Burden and Respondent Descriptions	Burden Estimate
Estimated # of Subgroups Registering (a)	20
Estimated Total Annual Burden Hours Per Subgroup (b)	0.5
Estimated Total Annual Burden Hours for Subgroup Reporting (c) = (a) * (b)	**10**

Burden and Respondent Descriptions	Burden Estimate
Estimated Cost Per Subgroup (@ computer systems analyst's labor rate of $98.28/hr. (d)	$98.28
Estimated Total Annual Burden Cost for Subgroup Registration (e) = (c) * (d)	**$983**

iii. Burden for MVP Quality Performance Category Submission

In the CY 2022 PFS final rule (86 FR 65411 through 65415), we finalized that except as provided in paragraph § 414.1365(c)(1)(i), an MVP Participant must select and report 4 quality measures, including 1 outcome measure (or, if an outcome measure is not available, 1 high priority measure), included in the MVP. The decrease in the number of required measures in the quality performance category from 6 to 4 is a two-thirds reduction in the number of measures needed for eligible clinicians to submit data for the quality performance category in MVPs described in Appendix 3: MVP Inventory of the CY 2023 PFS proposed rule. Therefore, we continue to estimate that the time for submitting the measures in the MVP quality performance category will, on average, take two-thirds of the currently approved burden per respondent for the quality performance category as it does to complete a MIPS quality submission through the CQM, eCQM, and Claims submission types.

For the CY 2023 performance period/2025 MIPS payment year, we estimate that 12 percent of the clinicians who participated in MIPS for the CY 2019 performance period/2021 MIPS payment year, and 20 subgroups would submit data for the quality performance category of MVPs. As shown in Table 14, we estimate that approximately 3,683 clinicians would submit data for the MVP quality performance category using the Medicare Part B claims collection type; approximately 6,849 clinicians and 10 subgroups will submit data using MIPS CQM and QCDR collection type; and approximately 6,240 clinicians and 10 subgroups will submit data using eCQMs collection type. As shown in Table 14, for the clinicians, groups, and subgroups submitting data for the MVP quality performance category, we estimate a burden of 34,768 hours (9.44 hr x 3,683 clinicians) at a cost of $3,678,102 (3,683 respondents x 998.67/respondent) for the Medicare Part B claims collection type, 38,799 hours [5.97 hr x 6,499 (6,489 +10)] at a cost of $4,200,239 (6,499 x 646.29/respondent) for the MIPS CQM and QCDR collection type, and 33,125 hours [5.3 hr x 6,250 (6,240 +10) respondents] at a cost of $3,627,750 (6,250 x 580.44/respondent) for the eCQM collection types.

TABLE 14: Estimated Burden for Quality Performance Category Submission

Burden and Respondent Descriptions	eCQM Collection Type	CQM and QCDR Collection Type	Claims Collection Type
# of Submissions from pre-existing collection types (a)	6,240	6,489	3,683
# of Subgroup reporters (b)	10	10	0
Total MVP participants (c) = (a) + (b)	6,250	6,499	3,683
Hours Per Clinician to Submit Quality Data (d)	1.33	2	4.8
# of Hours Medical and Health Services Manager Review Measure Specifications (e)	1.33	1.33	2
# of Hours Computer Systems Analyst Review Measure Specifications (f)	0.66	0.66	0.66
# of Hours LPN Review Measure Specifications (g)	0.66	0.66	0.66
# of Hours Billing Clerk Review Measure Specifications (h)	0.66	0.66	0.66
# of Hours Physician Review Measure Specifications (i)	0.66	0.66	0.66
Annual Hours per Clinician Submitting Data for MVPs (j) = (d) + (e) + (f) + (g) + (h) + (i)	5.3	5.97	9.44
Total Annual Hours (k) = (c) * (j)	**33,125**	**38,799**	**34,768**
Cost to Submit Quality Data (@ computer systems analyst's labor rate of $98.28/hr @ varying times) (k)	$130.71	$196.56	$471.74
Cost to Review Measure Specifications (@ medical and health services manager's labor rate of $115.22/hr) (l)	$153.24	$153.24	$230.44
Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $98.28/hr) (m)	$64.87	$64.87	$64.87
Cost to Review Measure Specifications (@ LPN's labor rate of $49.86/hr) (n)	$32.91	$32.91	$32.91
Cost to Review Measure Specifications (@ billing clerk's labor rate of $41.10/hr) (o)	$27.12	$27.12	$27.12
Cost to Review Measure Specifications (@ physician's labor rate of $259.98/hr) (p)	$171.59	$171.59	$171.59
Total Annual Cost Per Clinician (q) = (k) + (l) + (m) + (n) + (o) + (p)	$580.44	$646.29	$998.67
Total Annual Cost (r) = (c) * (q)	**$3,627,750**	**$4,200,239**	**$3,678,102**

g. Burden Estimate for the Nomination of Quality Measures

Quality measures are selected annually through a call for quality measures under consideration, with a final list of quality measures being published in the Federal Register by November 1 of each year. As described in the CY 2017 Quality Payment Program final rule (81 FR 77137), we

will accept quality measures submissions at any time, but only measures submitted during the timeframe provided by us through the pre-rulemaking process of each year will be considered for inclusion in the annual list of MIPS quality measures for the performance period beginning two years after the measure is submitted. This process is consistent with the pre-rulemaking process and the annual call for measures, which are further described at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html.

As shown in Table 15, we are not making any changes to our currently approved estimate of 28 quality measure submissions. We continue to estimate that it would take approximately 5.5 hours per quality measure submission. This estimate includes 2.4 hours for the practice administrator at $115.22/hr and 1.1 hours at $259.98/hr for a clinician to identify, propose, and link the quality measure, and approximately 2 hours at $259.98/hr for a clinician to complete the Peer Review Journal Article Form.

As shown in Table 15, in aggregate we estimate an annual burden of 154 hours (28 submissions x 5.5 hr/submission) at a cost of $30,309 {28 submissions x [(2.4 hr x $115.22/hr) + (3.1 hr x $259.98/hr)]}.

TABLE 15: Burden Estimates for Call for Quality Measures

Burden and Respondent Descriptions	**Burden Estimate**
# of Organizations Nominating New Quality Measures (a)	28
# of Hours Per Medical and health services manager to Identify and Propose Measure (b)	2.4
# of Hours Per Clinician to Identify Measure (c)	1.1
# of Hours Per Clinician to Complete Peer Review Article Form (d)	2.00
Annual Hours Per Response (e)= (b) + (c) + (d)	5.50
Total Annual Hours (f) = (a)*(e)	**154**
Cost to Identify and Submit Measure (@practice administrator's labor rate of $115.22/hr.) * 2.4 hr (g)	$276.52
Cost to Identify Quality Measure and Complete Peer Review Article Form (@ physician's labor rate of $259.98/hr.) * 3.1 hr (h)	$805.93
Total Annual Cost Per Respondent (i)=(g)+(h)	$1,082.45
Total Annual Cost (j)=(a)*(i)	**$30,309**

h. Burden Estimate for the Promoting Interoperability Performance Category

For the CY 2023 performance period/2025 MIPS payment year, clinicians and groups can submit Promoting Interoperability data through direct, log in and upload, or log in and attest submission types. With the exception of submitters who elect to use the log in and attest submission type for the Promoting Interoperability performance category, which is not available for the quality performance category, we anticipate that individuals and groups will use the same data submission type for the both of these performance categories and that the clinicians, practice managers, and computer systems analysts involved in supporting the quality data submission will also support the Promoting Interoperability data submission process. The following burden estimates show only incremental hours required above and beyond the time already accounted for in the quality data submission process. Although this analysis assesses burden by performance category and submission type, we emphasize MIPS is a consolidated program and submission analysis, and decisions are expected to be made for the program.

i. Burden for Reweighting Applications for Promoting Interoperability and Other Performance Categories

As established in the CY 2017 and CY 2018 Quality Payment Program final rules, MIPS eligible clinicians who meet the criteria for a significant hardship or other type of exception may submit an application requesting a zero percent weighting for the Promoting Interoperability, quality, cost, and/or improvement activities performance categories under specific circumstances (81 FR 77240 through 77243, 82 FR 53680 through 53686, and 82 FR 53783 through 53785). Respondents who apply for a reweighting for the quality, cost, and/or improvement activities performance categories have the option of applying for reweighting for the Promoting Interoperability performance category on the same online form. We assume respondents applying for a reweighting of the Promoting Interoperability performance category due to extreme and uncontrollable circumstances will also request a reweighting of at least one of the other performance categories simultaneously and not submit multiple reweighting applications.

Table 16 summarizes the burden for clinicians to apply for reweighting the Promoting Interoperability performance category to zero percent due to a significant hardship exception or because of a decertification of an EHR. As finalized in the CY 2022 PFS final rule, small practices receive an automatic hardship exception beginning in the CY 2022 performance period/2024 MIPS payment year (86 FR 65486). Based on the number of reweighting applications received by March 31, 2022 for the CY 2021 performance period/2023 MIPS payment year, we assume 13,480 respondents (eligible clinicians or groups) will submit a request to reweight the Promoting Interoperability performance category to zero percent due to a significant hardship or EHR decertification and an additional 17,655 respondents will submit a request to reweight one or more of the quality, cost, Promoting Interoperability, or improvement activity performance categories due to an extreme or uncontrollable circumstance, for a total of 31,135 reweighting applications submitted. Similar to the data used to estimate the number of respondents in the CY 2021 PFS final rule, our respondent estimate includes a significant number of applications submitted as a result of a data issue CMS was made aware of and is specific to a single third-party intermediary. While we do not anticipate similar data issues to occur in each performance period, we do believe future similar incidents may occur and are electing to use this data without adjustment to reflect this belief. We note that our respondent estimate also includes reweighting applications submitted during the extended period ending March 31, 2022, due to the PHE for COVID-19. Of our total respondent estimate of 31,135, we estimate that 13,480 respondents (eligible clinicians or groups) will submit a request for reweighting the Promoting Interoperability performance category to zero percent due to extreme and uncontrollable circumstances, insufficient internet connectivity, lack of control over the availability of CEHRT, or because of a decertification of an EHR.

In the CY 2021 PFS final rule (85 FR 84984), we finalized that, beginning with the CY 2020 performance period/2022 MIPS payment year, APM Entities may submit an extreme and uncontrollable circumstances exception application for all four performance categories and applicable to all MIPS eligible clinicians in the APM Entity group. As previously discussed, due to data limitations and our inability to predict who would use the APM Performance Pathway versus the traditional MIPS submission mechanism for the CY 2023 performance period/2025 MIPS payment year, we assume ACO APM Entities will submit data through the APM Performance Pathway and non-ACO APM Entities would participate through traditional MIPS, thereby submitting as an individual or group rather than as an entity. Therefore, we limited our

analysis to ACOs that were eligible for an exception due to extreme and uncontrollable circumstances during the CY 2021 performance period/2023 MIPS payment year and elected not to report quality data. Based on this data, we estimate that 20 APM Entities will submit an extreme and uncontrollable circumstances exception application for the CY 2023 performance period/2025 MIPS payment year. Combined with our estimate of 31,135 eligible clinicians and groups, the total estimated number of respondents for the CY 2023 performance period/2025 MIPS payment year is 31,155.

The application to request a reweighting to zero percent only for the Promoting Interoperability performance category is a short online form that requires identifying the type of hardship experienced or whether decertification of an EHR has occurred and a description of how the circumstances impair the clinician or group's ability to submit Promoting Interoperability data, as well as some proof of circumstances beyond the clinician's control. The application for reweighting of the quality, cost, Promoting Interoperability, and/or improvement activities performance categories due to extreme and uncontrollable circumstances requires the same information apart from there being only one option for the type of hardship experienced. We continue to estimate it will take 0.25 hours at $98.28/hr for a computer system analyst to complete and submit the application. As shown in Table 16, we estimate an annual burden of 7,789 hours (31,155 applications x 0.25 hr/application) at an annual cost of $765,503 (7,789 hours x $98.28/hr).

TABLE 16: Estimated Burden for Reweighting Applications for Promoting Interoperability and Other Performance Categories

Burden and Respondent Descriptions	**Burden Estimate**
# of Eligible Clinicians and Groups Applying Due to Significant Hardship and Other Exceptions (a)	31,135
# APM Entities requesting Extreme and Uncontrollable Circumstances exception (b)	20
Total Respondents Due to Hardships, Other Exceptions and Hardships for Small Practices (c) = (a) + (b)	31,155
Hours Per Applicant per application submission (d)	0.25
Total Annual Hours (e)=(c)*(d)	**7,789**
Labor Rate for a computer systems analyst (f)	$98.28/hr
Total Annual Cost (g)=(e)*(f)	**$765,503**

ii. Burden for Submitting Promoting Interoperability Data

A variety of organizations will submit Promoting Interoperability data on behalf of clinicians. Clinicians not participating in a MIPS APM may submit data as individuals or as part of a group or a subgroup. In the CY 2017 Quality Payment Program final rule (81 FR 77258 through 77260, 77262 through 77264) and CY 2019 PFS final rule (83 FR 59822-59823), we established that eligible clinicians in MIPS APMs (including the Shared Savings Program) may report for the Promoting Interoperability performance category as an APM Entity group, individuals, or a group.

As shown in Table 17, based on data from the CY 2019 performance period/2021 MIPS payment year, we estimate that a total of 54,770 respondents consisting of 43,117 individual MIPS eligible clinicians, 11,633 groups and virtual groups, and 20 subgroups will submit Promoting Interoperability data for the CY 2023 performance period/2025 MIPS payment year.

Certain MIPS eligible clinicians will be eligible for automatic reweighting of the Promoting Interoperability performance category to zero percent, including MIPS eligible clinicians who are hospital-based, ambulatory surgical center-based, non-patient facing clinicians, physical therapists; occupational therapists; qualified speech-language pathologists or qualified audiologist; clinical psychologists; registered dieticians or nutrition professionals and clinical social workers. In the CY 2023 PFS proposed rule, we are proposing not to apply the automatic reweighting of the Promoting Interoperability performance category to nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. These estimates account for previously finalized reweighting policies including exceptions for MIPS eligible clinicians who have experienced a significant hardship and decertification of an EHR.

We assume that MIPS eligible clinicians previously scored under the APM scoring standard, as described in the CY 2020 PFS final rule, will continue to submit Promoting Interoperability data (84 FR 63006) in a similar way through the APP. Each MIPS eligible clinician in an APM Entity reports data for the Promoting Interoperability performance category through either their group TIN or individual reporting. In the CY 2023 PFS proposed rule, we are proposing to introduce a voluntary reporting option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level beginning with the CY 2023 performance period/2025 MIPS payment year. Sections 1899 of the Act (42 U.S.C. 1395jjj) state that the Shared Savings Program and the testing, evaluation, and expansion of Innovation Center models are not subject to the PRA. However, in the CY 2019 PFS final rule, we established that MIPS eligible clinicians who participate in the Shared Savings Program are no longer limited to reporting for the Promoting Interoperability performance category through their ACO participant TIN (83 FR 59822 through 59823). Burden estimates for this proposed rule assume group TIN-level reporting as we believe this is the most reasonable assumption for the Shared Savings Program, which requires that ACOs include full TINs as ACO participants. As we receive updated information which reflects the actual number of Promoting Interoperability data submissions submitted by Shared Savings Program ACO participants, we will update our burden estimates accordingly. In the CY 2023 PFS proposed rule, for the Public Health and Clinical Data Exchange Objective, in addition to submitting responses for the required measures and any optional measures a MIPS eligible clinician chooses to report, we propose to require MIPS eligible clinicians to submit their level of active engagement, either Pre-production and Validation or Validated Data Production, for each measure they report beginning with the CY 2023 performance period/2025 MIPS payment year. If the proposed requirement for MIPS eligible clinicians to submit their level of active engagement with each measure is finalized, we estimate that it would add an additional one minute (+0.02 hours) to the currently approved estimated time of 2.69 hours, resulting in a total estimated time of 2.71 hours (2.69 hrs + 0.02 hr), for clinicians to submit data for the Promoting Interoperability performance category. As shown in Table 17, the total burden estimate for submitting data on the specified Promoting Interoperability objectives and measures is estimated to be 148,427 hours (54,770 respondents x 2.71 incremental hours for a computer analyst's time above and beyond the physician, medical and health services manager, and computer system's analyst time required to submit quality data) and $14,587,406 (148,427 hrs x $98.28/hr)).

TABLE 17: Estimated Burden for Promoting Interoperability Performance Category Data Submission

Burden and Respondent Descriptions	Burden Estimate
Number of individual clinicians to submit Promoting Interoperability (a)	43,117
Number of groups to submit Promoting Interoperability (b)	11,633
Number of subgroups to submit Promoting Interoperability (c)	20
Total (d) = (a) + (b) + (c)	54,770
Total Annual Hours Per Respondent (e)	2.71
Total Annual Hours (f) = (d) * (e)	**148,427**
Labor rate for a computer systems analyst to submit Promoting Interoperability data (g)	$98.28/hr
Total Annual Cost (h) = (f) * (g)	**$14,587,406**

i. Burden Estimate for the Nomination of Promoting Interoperability Measures

Promoting Interoperability measures may be submitted via the Call for Promoting Interoperability Performance Category Measures Submission Form that includes the measure description, measure type (if applicable), reporting requirement, and CEHRT functionality used (if applicable). We are not finalizing any changes to that form.

Unchanged from our currently approved estimate, we estimate 10 responses will be submitted for new Promoting Interoperability measures, based on the number of submissions received for the CY 2021 nomination period. We estimate it will take 0.5 hours per organization to submit an activity to us, consisting of 0.3 hours at $115.22/hr for a medical and health services manager to make a strategic decision to nominate that activity and submit an activity to us via email and 0.2 hours at $259.98/hr for a clinician to review the nomination. As shown in Table 18, we estimate an annual burden of 5 hours (10 proposals x 0.5 hr/response) at a cost of $866 (10 x [(0.3 h x $115.22/hr) + (0.2 hr x $259.98/hr)].

TABLE 18: Estimated Burden for Call for Promoting Interoperability Measures

Burden and Respondent Descriptions	Burden Estimate
# of Organizations Nominating New Promoting Interoperability Measures (a)	10
# of Hours Per Medical and health services manager to Identify and Propose Measure (b)	0.30
# of Hours Per Clinician to Identify Measure (c)	0.20
Annual Hours Per Respondent (d) = (b) + (c)	0.50
Total Annual Hours (e) = (a) * (d)	**5**
Cost to Identify and Submit Measure (@ medical and health services manager's labor rate of $115.22/hr.) (f)	$34.56
Cost to Identify Improvement Measure (@ physician's labor rate of $259.98/hr.) (g)	$51.99
Total Annual Cost Per Respondent (h) = (f) + (g)	$86.55
Total Annual Cost (i) = (a) * (h)	**$866**

j. Burden Estimate for the Submission of Improvement Activities Data

In order to determine MIPS APM scores, we assign improvement activities scores to APM participants in the APP based on the requirements of participation in APMs. To develop the

improvement activities score for MIPS APMs, we would compare requirements of the APM with the list of improvement activities measures for the applicable year and score those measures as they would otherwise be scored according to § 414.1355. In the event a MIPS APM participant does not actually perform an activity for which improvement activities credit would otherwise be assigned under this provision, the MIPS APM participant would not receive credit for the associated improvement activity. In the event that the assigned score does not represent the maximum improvement activities score, we specify that MIPS eligible clinicians reporting through the APP would have the opportunity to report additional improvement activities that then would be applied towards their scores. Our burden estimates assume there will be no improvement activities burden for MIPS APM participants electing the APP. We will assign the improvement activities performance category score at the APM Entity level.

A variety of organizations and in some cases, individual clinicians, will submit improvement activity performance category data. As finalized in the CY 2017 Quality Payment Program final rule (81 FR 77264), APM Entities only need to report improvement activities data if the CMS-assigned improvement activities score is below the maximum improvement activities score. Similar to our assumption in the CY 2018 Quality Payment Program final rule, our burden estimates assume that all MIPS APM models for the CY 2023 performance period/2025 MIPS payment year will qualify for the maximum improvement activities performance category score and, as such, APM Entities will not submit any additional improvement activities. (82 FR 53921 through 53922).

As represented in Table 19, based on CY 2019 performance period/2021 MIPS payment year data, we estimate that a total of 96,980 respondents consisting of 78,239 individual clinicians and 17,721 groups, and 20 subgroups will submit improvement activities during the CY 2023 performance period/2025 MIPS payment year. In addition, we have updated our estimates for the number of clinicians and groups that will submit improvement activities data based on projections of the number of eligible clinicians that were not QPs or members of an ACO in the CY 2019 performance period/2021 MIPS payment year but will be in the CY 2023 performance period/2025 MIPS payment year, and will therefore not be required to submit improvement activities data.

We continue to estimate that it would take 5 minutes (or 0.083 hours) for a computer system analyst at a labor rate of $98.28/hr to submit by logging in and manually attesting that certain activities were performed in the form and manner specified by CMS with a set of authenticated credentials. As shown in Table 19, we estimate an annual burden of 8,049 hours (96,980 responses x 0.083) at a cost of $791,056 (8,049 hrs x $98.28/hr) for the CY 2023 performance period/2025 MIPS payment year.

TABLE 19: Estimated Burden for Improvement Activities Submission

Burden and Respondent Descriptions	**Burden Estimate**
Total # of Respondents (Groups, Subgroups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the CY 2023 MIPS performance period (a)	96,980
Total Annual Hours Per Respondent (b)	0.083
Total Annual Hours (c)	**8,049**
Labor rate for a computer systems analyst to submit improvement activities (d)	$98.28/hr
Total Annual Cost (e) = (c) * (d)	**$791,056**

k. Burden Estimate for the Nomination of Improvement Activities

Interested parties are provided an opportunity to propose new activities formally via the Annual Call for Activities nomination form posted on the CMS website. For the CY 2023 performance period/2025 MIPS payment year, we continue to use our currently approved assumption that we will receive 31 nominations of new or modified activities which will be evaluated for the Improvement Activities Under Consideration (IAUC) list for possible inclusion in the CY 2023 Improvement Activities Inventory.

We continue to estimate that it would take 2.8 hours at $115.22/hr for a medical and health services manager or equivalent and 1.6 hours at $259.98 /hr for a physician to nominate an improvement activity. As shown in Table 20, we estimate an annual information collection burden of 136 hours (31 nominations x 4.4 hr/nomination) at a cost of $22,896 (31 x [(2.8 hr x $115.22/hr) + (1.6 hr x $259.98/hr)]).

TABLE 20: Burden Estimates for Nomination of Improvement Activities

Burden and Respondent Descriptions	**Burden Estimate**
# of Organizations Nominating New Improvement Activities (a)	31
# of Hours Per Medical and health services manager to Identify and Propose Activity (b)	2.8
# of Hours Per Clinician to Identify Activity (c)	1.6
Annual Hours Per Respondent (d) = (b) + (c)	4.4
Total Annual Hours (e) = (a) * (d)	**136**
Cost to Identify and Submit Activity (@ medical and health services manager's labor rate of $115.22/hr.) (f)	$322.61
Cost to Identify Improvement Activity (@ physician's labor rate of $259.98/hr.) (g)	$415.96
Total Annual Cost Per Respondent (h) = (f) + (g)	$738.57
Total Annual Cost (i) = (a) * (h)	**$22,896**

l. Nomination of MVPs

Beginning in CY 2021 for purposes of the CY 2022 policymaking, we stated interested parties should formally submit their MVP candidates utilizing a standardized template, which will be published in the QPP resource library for our consideration for future implementation. Interested parties should submit all information including a description of how their MVP abides by the MVP development criteria as described in the CY 2021 PFS final rule (85 FR 84849 through 84859) and provide rationales as to why specific measures and activities were chosen to construct the MVP. As MVP candidates are received, they will be reviewed, vetted, and evaluated by CMS and our contractors to determine if the MVP is feasible and ready for inclusion in the upcoming performance period.

For the CY 2023 performance period/2025 MIPS payment year, we are proposing to revise our estimate that 20 MVP nominations will be received, and we continue to estimate the time required to submit all required information is 12 hours per nomination. Similar to the call for quality measures, nomination of Promoting Interoperability measures, and the nomination of improvement activities, we assume MVP nomination will be performed by both practice administration staff, or their equivalents and clinicians. We estimate 7.2 hours at $115.22/hr for

a medical and health services manager or equivalent and 4.8 hours at $259.98/hr for a physician to nominate an MVP. As shown in Table 21, we estimate an annual burden of 240 hours (20 nominations x 12 hr/nomination) at a cost of $41,550 (20 x [(7.2 hr x $115.22/hr) + (4.8 hr x $259.98/hr)]).

TABLE 21: Estimated Burden for Nomination of MVPs

Burden and Respondent Descriptions	**Burden Estimate**
# of Nominations of New MVPs(a)	20
# of Hours Per Medical and Health Services Manager (b)	7.2
# of Hours Per Physician (c)	4.8
Annual Hours Per Respondent (d)= (b) + (c)	12
Total Annual Hours (e) = (a) * (d)	**240**
Cost to Nominate an MVP (@ medical and health services manager's labor rate of $115.22/hr) (f)	$829.58
Cost to Nominate an MVP (@ physician's labor rate of $259.98/hr) (g)	$1,247.90
Total Annual Cost Per Respondent (h) = (f) + (g)	$2,077.48
Total Annual Cost (i) = (a) * (h)	**$41,550**

m. Burden Estimate for the Cost Performance Category

The cost performance category relies on administrative claims data. The Medicare Parts A and B claims submission process (OMB control number 0938-1197; CMS-1500 and CMS-1490S) is used to collect data on cost measures from MIPS eligible clinicians. MIPS eligible clinicians are not required to provide any documentation by CD or hardcopy, including for the 10 episode-based measures we included in the cost performance category as discussed in the CY 2020 PFS final rule (84 FR 62959). Moreover, the policies of the CY 2022 PFS final rule do not result in the need to add or revise or delete any claims data fields. Therefore, we did not implement any new or revised collection of information requirements or burden for MIPS eligible clinicians resulting from the cost performance category.

n. Burden Estimate for Partial QP Elections

APM Entities may face a data submission burden under MIPS if they attain Partial QP status and elect to participate in MIPS. Advanced APM participants will be notified about their QP or Partial QP status as soon as possible after each QP determination. Where Partial QP status is earned at the APM Entity level, the burden of Partial QP election will be incurred by a representative of the participating APM Entity. Where Partial QP status is earned at the eligible clinician level, the burden of Partial QP election will be incurred by the eligible clinician. For the purposes of this burden estimate, we assume that all MIPS eligible clinicians determined to be Partial QPs will participate in MIPS.

As shown in Table 22, based on historical response rates in the CY 2021 performance period/2023 MIPS payment year, we estimate that a total of 287 respondents, 156 APM Entities and 131 individual eligible clinicians (representing approximately 7,182 Partial QPs) will make the election to participate as a Partial QP in MIPS. We continue to estimate it will take the APM Entity representative or eligible clinician 15 minutes (0.25 hr) to make this election. In aggregate, we estimate an annual burden of 72 hours (287 respondents x 0.25 hr/election) and $7,076 (72 hrs x $98.28/hr).

TABLE 22: Estimated Burden for Partial QP Election

Burden and Respondent Descriptions	Burden Estimate
# of respondents making Partial QP election (156 APM Entities, 131 eligible clinicians) (a)	287
Total Hours Per Respondent to Elect to Participate as Partial QP (b)	0.25
Total Annual Hours (c) = (a) * (b)	**72**
Labor rate for computer systems analyst (d)	$98.28/hr
Total Annual Cost (e) = (c) * (d)	**$7,076**

o. Burden Estimate for Other-Payer Advanced APM Determinations

i. Payer-Initiated Process

The All-Payer Combination Option is an available pathway to QP status for eligible clinicians participating sufficiently in Advanced APMs and Other Payer Advanced APMs. Payers seeking to submit payment arrangement information for Other Payer Advanced APM determination through the payer-initiated process are required to complete a Payer Initiated Submission Form, instructions for which is available at https://qpp.cms.gov/.

As shown in Table 23, based on the actual number of requests received for in the 2021 QP performance period, we continue to estimate that for the 2023 QP performance period, 15 payer-initiated requests for Other Payer Advanced APM determinations will be submitted (6 Medicaid payers, 6 Medicare Advantage Organizations, and 3 remaining other payers. We continue to estimate it will take 10 hours for a computer system analyst per arrangement submission. In aggregate, we estimate an annual burden of 150 hours (15 submissions x 10 hr/submission) and $14,742 (150 hr x $98.28/hr) for the CY 2023 performance period/2025 MIPS payment year.

TABLE 23: Estimated Burden for Other Payer Advanced APM Identification Determinations: Payer-Initiated Process

Burden and Respondent Descriptions	Burden Estimate
# of other payer payment arrangements (6 Medicaid, 6 Medicare Advantage Organizations, 3 remaining other payers) (a)	15
Total Annual Hours Per other payer payment arrangement (b)	10
Total Annual Hours (c) = (a) * (b)	**150**
Labor rate for a computer systems analyst (d)	$98.28/hr
Total Annual Cost (e) = (c) * (d)	**$14,742**

ii. Eligible Clinician Initiated Process

Under the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements have an opportunity to request that we determine for the year whether those other payer arrangements are Other Payer Advanced APMs. Eligible clinicians or APM Entities seeking to submit payment arrangement information for Other Payer Advanced APM determination through the Eligible Clinician-Initiated process are required to complete an Eligible Clinician Initiated Submission Form, instructions for which can be found at https://qpp.cms.gov/.

We are not making any changes to our currently approved estimates. As shown in Table 24, we estimate 15 other payer arrangements will be submitted by APM Entities and eligible Other Payer Advanced APM determinations in the CY 2023 performance period/2025 MIPS payment year. We estimate it would take 10 hours at $98.28/hr for a computer system analyst per arrangement submission. In aggregate, we estimate an annual burden of 150 hours (15 submissions x 10 hr/submission) at a cost of $14,742 (150 hr x $98.28/hr).

TABLE 24: Estimated Burden for Other Payer Advanced APM Determinations: Eligible Clinician Initiated Process

Burden and Respondent Descriptions	**Burden Estimate**
# of other payer payment arrangements from APM Entities and eligible clinicians	15
Total Annual Hours Per other payer payment arrangement (b)	10
Total Annual Hours (c) = (a) * (b)	**150**
Labor rate for a computer systems analyst (d)	$98.28/hr
Estimated Total Annual Cost (e) = (c) * (d)	**$14,742**

ii. Submission of Data for QP Determinations under the All-Payer Combination Option

APM Entities or individual eligible clinicians must submit payment amount and patient count information: (1) attributable to the eligible clinician or APM Entity through every Other Payer Advanced APM; and (2) for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician during the QP performance period. APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination.

We are not making any changes to our currently approved estimates. As shown in Table 25, we assume that 20 APM Entities, 448 TINs, and 83 eligible clinicians will submit data for QP determinations under the All-Payer Combination Option in CY 2023 performance period/2025 MIPS payment year. We continue to estimate it will take the APM Entity representative, TIN representative, or eligible clinician 5 hours at $115.22/hr for a medical and health services manager to complete this submission. In aggregate, we estimate an annual burden of 2,755 hours (551 respondents x 5 hr) at a cost of $317,431 (2,755 hr x $115.22/hr).

TABLE 25: Estimated Burden for the Submission of Data for All-Payer QP Determinations

Burden and Respondent Descriptions	Burden Estimate
# of APM Entities submitting data for All-Payer QP Determinations (a)	20
# of TINs submitting data for All-Payer QP Determinations (b)	448
# of eligible submitting data for All-Payer QP Determinations (c)	83
Total # of Respondents (d) = (a) + (b) + (c)	**551**
Hours Per respondent QP Determinations (e)	5
Total Hours (f) = (d) * (e)	**2,755**
Labor rate for a Medical and health services manager ($115.22/hr) (g)	$115.22/hr
Total Annual Cost (h) = (f) * (g)	**$317,431**

p. Burden Estimate for Voluntary Participants to Elect Opt-Out of Performance Data Display on Compare Tools

For the CY 2023 performance period/2025 MIPS payment year, we continue to estimate that 0.1 percent of the total clinicians and groups who will voluntarily participate in MIPS will also elect not to participate in public reporting. This results in a total of 38 (0.001 x 37,934 voluntary MIPS participants) clinicians and groups that will voluntarily opt-out of public reporting on Compare Tools. Voluntary MIPS participants are clinicians that are not QPs and are expected to be excluded from MIPS after applying the eligibility requirements set out in the CY 2019 PFS final rule but have elected to submit data to MIPS. We estimate clinicians who exceed one (1) of the low-volume criteria, but not all three (3), elected to opt-in to MIPS and submitted data in the CY 2019 performance period/2021 MIPS payment year will continue to do so in the CY 2023 performance period/2025 MIPS payment year.

As shown in Table 26, we estimate that it would take 0.25 hours at $98.28/hr for a computer system analyst to submit a request to opt-out. In aggregate, we estimate an annual burden of 10 hours (38 requests x 0.25 hr/request) at a cost of $983 (10 hr x $98.28/hr).

TABLE 26: Estimated Burden for Voluntary Participants to Elect Opt Out of Performance Data Display on Physician Compare

Burden and Respondent Descriptions	Burden Estimate
# of Voluntary Participants Opting Out of Physician Compare (a)	38
Total Annual Hours Per Opt-out Requester (b)	0.25
Total Annual Hours (c) = (a) * (b)	**10**
Labor rate for a computer systems analyst (d)	$98.28/hr
Total Annual Cost (e) = (c) * (d)	**$983**

q. Burden Estimate Summary

Table 27 below provide summaries of all burden estimates for each of the information collections included in this PRA for the CY 2023 performance period/2025 MIPS payment year.

TABLE 27: CY 2023 Performance Period/2025 MIPS Payment Year Burden Summary

Regulation Section(s) Under Title 42 of the CFR	Table No.	No. Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost ($/hr)	Total Cost ($)*
§414.1400 (Registry self- nomination)	3	160	160	2	320	98.28	31,450
§414.1400 (QCDR self-nomination)	4	90	90	11.5	1,035	98.28	101,720
§414.1400 (Third Party Intermediary Plan Audits)	6	124	124	Varies	832	98.28	81,769
Open Authorization Credentialing and Token Request Process	7	15	15	2	30	98.28	2,948
§414.1325 and 414.1335 (QPP Identity Management Application Process)	8	6,500	6,500	1	6,500	98.28	638,820
§414.1325 and 414.1335 [(Quality Performance Category) Claims Collection Type]	9	27,006	27,006	14.2	383,485	Varies (see table 9)	40,576,245
§414.1325 and 414.1335 [(Quality Performance Category) QCDR/MIPS CQM Collection Type]	10	47,584	47,584	9.083	432,205	Varies (see table 10)	46,758,418
§414.1325 and 414.1335 [(Quality Performance Category) eCQM Collection Type]	11	45,760	45,760	8.0	366,080	Varies (see table 11)	40,095,827
§ 414.1365 MVP Registration	12	16,432	16,432	0.25	4,108	98.28	403,734
§ 414.1365 Subgroup Registration	13	20	20	0.5	10	98.28	983
§ 414.1365 MVP Quality Submission	14	16,432	16,432	Varies	106,692	Varies (see table 14)	11,506,091

Regulation Section(s) Under Title 42 of the CFR	Table No.	No. Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost ($/hr)	Total Cost ($)*
[(Quality Performance Category) Call for Quality Measures]	15	28	28	5.5	154	Varies (see table 15)	30,309
§414.1375 and 414.1380[(PI Performance Category) Reweighting Applications for Promoting Interoperability and Other Performance Categories	16	31,155	31,155	0.25	7,789	98.28	765,503
§414.1375 [(PI Performance Category) Data Submission]	17	54,770	54,770	2.71	148,427	98.28	14,587,406
[(PI Performance Category) Call for Promoting Interoperability Measures]	18	10	10	0.5	5	Varies (see table 18)	866
§414.1360 [(Improvement Activities Performance Category) Data Submission]	19	96,980	96,980	0.083	8,049	98.28	791,056
§414.1360 [(Improvement Activities Performance Category) Nomination of Improvement Activities]	20	31	31	4.4	136	Varies (see table 20)	22,896
Nomination of MVPs	21	20	20	12	240	Varies (see table 21)	41,550
§414.1430 [Partial Qualifying APM Participant (QP) Election]	22	287	287	0.25	72	98.28	7,076
§414.1440 [Other Payer Advanced APM Identification: Payer Initiated Process]	23	15	15	10	150	98.28	14,742

Regulation Section(s) Under Title 42 of the CFR	Table No.	No. Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost ($/hr)	Total Cost ($)*
§414.1445 [Other Payer Advanced APM Identification: Clinician Initiated Process]	24	15	15	10	150	98.28	14,742
§414.1440 [Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option]	25	551	551	5	2,755	115.22	317,431
§414.1395 [(Physician Compare) Opt Out for Voluntary Participants]	26	38	38	0.25	10	98.28	983
TOTAL	**n/a**	**180,365****	**344,023**	**Varies**	**1,469,234**	**Varies**	**156,792,565**

*With respect to the PRA, the CY 2023 PFS proposed rule does not impose any non-labor costs. Due to burden for certain activities being estimated in fractions of hours, totals may not reflect the sum of individual rows due to rounding.
** Total number of unique respondents to quality, Promoting Interoperability, and improvement activity performance categories is calculated to be 149,081. With the exception of extreme and uncontrollable exception applications, we assume remaining number of applications for reweighting are included in this total. We also assume that all voluntary participants that opt out of Physician Compare are included in this total.

Information Collection Instruments/Instructions

Appendix A (See Tables 3, 4, 5, and 6): 2023 QCDR and Registry Self-nomination User Guide (New)

Appendix B (See Table 23): 2022 Submission Form for Other Payer Requests for Other Payer Advanced Alternative Payment Model Determinations (Payer Initiated Submission Form) (No change)

Appendix C (See Table 24): 2022 Submission Form for Eligible Clinician and APM Entity Requests for Other Payer Advanced Alternative Payment Model Determinations (Eligible Clinician Initiated Submission Form) (No change)

Appendix D (See Table 25): 2022 Submission Form for Requests for Qualifying Alternative Payment Model Participant (QP) Determinations under the All-Payer Combination Option (No change)

Appendix E (See Table 15): Measures under Consideration 2021 (for the 2023 performance period), Data Template for Candidate Measures (No change)

Appendix F (See Table 15): 2022 Peer Reviewed Journal Article Requirement Template (No change)

Appendix G (See Table 18): Promoting Interoperability Performance Category, 2022 Call for Measures Submission Form (No change)

Appendix H (See Table 20): Improvement Activities Performance Category, 2022 Call for Activities Submission Form (No change)

Appendix I (See Table 16): 2021 Hardship Exception Application Form (for the 2023 MIPS payment year) (No change)

Appendix J (See Table 16): 2021 Extreme and Uncontrollable Circumstances Application Form for the 2023 MIPS payment year (No change)

Appendix K (See Table 21): 2022 MVP Candidates: Instructions and Template (No change)

Appendix L (See Table 22): 2020 Partial QP Election Form (for the 2022 MIPS payment year) (No change)

13. Capital Costs

We finalized to sunset the CMS Web Interface measures as a collection type for groups and virtual groups with 25 or more eligible clinicians starting with the CY 2023 performance period/2025 MIPS payment year (86 FR 65258). We recognize that the finalized policy to sunset the CMS Web Interface for groups and virtual groups may be burdensome to current groups and virtual groups submitting quality data on CMS Web Interface measures. Such groups and virtual groups would need to select a different collection type/submission type and redesign their systems to be able to interact with the new collection type/submission type. Given that the Medicare Part B claims collection type is limited to small practices, the alternatives for these groups and virtual groups would be either the MIPS CQM, QCDR, or eCQM collection types. Given the size of the affected groups and virtual groups, we believe the majority are likely to already be using a QCDR, qualified registry, or CEHRT as part of their practice workflow. Of the 3,611 TINs comprised of 25 or more clinicians who submitted MIPS data via a collection type other than the CMS Web Interface, 56 percent reported via the MIP CQM and QCDR collection type and 44 percent reported via the eCQM collection type. For groups converting from Web Interface, there will be some non-recurring costs associated with modifying clinical and MIPS data reporting workflows to utilize an alternate collection type. For any remaining groups and virtual groups there will also be registry fees paid to a QCDR or qualified registry or the financial expense of purchasing/licensing and deploying a CEHRT system. Because we are unable to assess either the existing workflows of each individual group and virtual group or the decisions each group and virtual group will make in response to this policy, we cannot quantify the resulting economic impact. While there may be an initial increase in burden for current groups and virtual groups utilizing the CMS Web Interface measures having to transition to the utilization of a different collection type/submission type, we recognize that we would also be reducing reporting requirements. Groups and virtual groups would no longer have to completely report on all pre-determined CMS Web Interface measures and would be able to select their own measures (at least 6) to report.

Groups and virtual groups account for less than 20 percent of organizations utilizing the CMS Web Interface measures while ACOs participating in the Medicare Shared Savings Program and Next Generation ACO Model account for more than 80 percent. In assessing the utilization of the CMS Web Interface by groups and virtual groups, there has been a substantial decrease in

participation each year since the inception of MIPS in the CY 2017 performance period/2019 MIPS payment year. From 2017 to 2019, the number of groups eligible to report quality measures via the CMS Web Interface (groups registered to utilize the CMS Web Interface) decreased by approximately 45 percent. Similarly, the number of groups utilizing the CMS Web Interface as a collection type decreased by approximately 40 percent from 2017 to 2019 (85 FR 85020 through 85021).

14. Cost to Federal Government

Aside from program administrative and implementation costs, MIPS payment incentives and penalties are budget-neutral and present no cost to the federal government, with respect to the application of the MIPS payment adjustments.

In the CY 2021 PFS final rule (85 FR 84884 through 84885), we stated to consider agency-nominated improvement activities beginning with the CY 2021 performance period/2023 MIPS payment year and future years. As discussed in the CY 2021 PFS final rule (85 FR 85021), we are unable to estimate the number of improvement activity nominations we will receive. Therefore, we continue to assume it will require 3 hours at $60.53/hr for a GS-13 Step 5 to nominate an improvement activity for a total cost of $181.59 (3 hrs x $60.53/hr) per activity.

15. Program and Burden Changes

We have replaced Appendices A1 (2022 Qualified Registry Fact Sheet) and B1 (2022 QCDR Fact Sheet) and C1 (2022 QCDR Measure Submission Template) with Appendix A (2023 QCDR and Registry Self-nomination User Guide). We are also removing Appendix N1, which, in the 2022 MIPS PRA Package, included the registration guide for the Web Interface collection type, as the Web Interface collection type has sunset for the 2023 performance period. With the new Appendix A (2023 QCDR and Registry Self-nomination User Guide) replacing Appendices A1, B1, and C1 from the 2022 MIPS PRA package, and the removal of Appendix of N1 from the 2022 MIPS PRA package, our CY 2023 NPRM MIPS PRA package has three fewer appendices than the package from last year. We have re-lettered the remaining appendices such that the Appendices M1 and O1 from the 2022 MIPS PRA package are now Appendices K and L respectively.

The currently approved burden estimate for the policies and information collections in the CY 2022 performance period/2024 MIPS payment year was set forth in the CY 2022 PFS final rule. This burden is associated with the policies and information collections for the CY 2022 performance period/CY 2024 MIPS payment year and will no longer be collected by or reported from clinicians for the Quality Payment Program in the CY 2023 performance period/2025 MIPS payment year. Therefore, as shown in table 28, we subtracted this burden in our burden calculations for the CY 2023 performance periods/2025 MIPS payment year.

TABLE 28: Change in Burden for CY 2022 MIPS Performance Period/2024 MIPS Payment Year

	No. Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost ($/hr)	Total Cost ($)*
2022 MIPS Performance Period Burden Summary	(119,890)	(310,051)	Varies	(1,435,361)	Varies	(144,761,094)

The currently approved burden estimate for the policies and information collections in the CY 2023 performance period/2025 MIPS payment year was set forth in the CY 2022 PFS final rule. In table 29 below, we show how our currently approved estimates for the CY 2023 performance period/2025 payment year have changed due to new statutes and program adjustments set forth in the CY 2023 PFS proposed rule.

TABLE 29: Change in Burden for CY 2023 Performance Period/2025 MIPS Payment Year

Burden Type	Total Requested (A)	Change Due to New Statute (B)	Change Due to Program Discretion (C)	Change Due to Program Adjustment (D)	Total Currently Approved (E)
Total Responses	344,023	+2,034	0	+19,019	322,970
Total Time (hr)	1,469,234	-11,039	0	+90,254	1,390,019
Total Cost ($)	156,792,565	-1,213,933	0	+9,625,784	148,380,714

*+2,034 responses = -614 (Table 30F) -1,082 (Table 30G) - 1,040 (Table 30H) +2,736 (Table 30I) + 2,034 (Table 30K)
**-11,039 hours = -8,719 (Table 30F) -9,828 (Table 30G) – 8,320 (Table 30H) + 684 (Table 30I) + 14,048 (Table 30K) + 1,096 (Table 30N)

As shown above in table 29, the increase in 2,034 responses with a total decrease in burden of 11,039 hours at a cost of $1,213,933 due to new statutes (Column B) is due to the proposed requirement for clinicians to submit their level of active engagement for the Public Health and Clinical Data Exchange Objective, proposed addition of 5 new MVPs to the existing MVP Inventory resulting in an increase in the number of respondents registering for MVP reporting and an increase in the number of respondents submitting for the quality performance category of MVPs, and a decrease in the number of respondents submitting for the Medicare Part B Claims, MIPS CQM and QCDR, and eCQM collection types. The remaining changes due to program adjustment (Column D) are entirely due to availability of updated data and assumptions. Table series 30 below provides additional detail as to the changes in burden for each information collection.

TABLE 30A: Burden Reconciliation for Qualified Registry Self-Nomination

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	147	1	147	2	841	98.28	82,653
Proposed (See Table 3)	160	1	160	2	320	98.28	31,450
Adjustment	+13	No change	+13	No change	-521	No change	-51,203

TABLE 30B: Burden Reconciliation for QCDR Self-Nomination and QCDR Measure Submission

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	84	1	84	11.5	1,176	98.28	115,577
Proposed (See Table 4)	90	1	90	11.5	1,035	98.28	101,720
Adjustment	+6	No change	+6	No change	-141	No change	-13,857

TABLE 30C: Burden Reconciliation for Third Party Intermediary Plan Audits

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Proposed (See Table 6)	124	1	124	Varies	832	98.28	81,769
Adjustment	+124	No change	+124	Varies	+832	98.28	+81,769

TABLE 30D: Burden Reconciliation for Open Authorization Credentialing and Token Request Process

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	15	1	15	1	15	98.28	1,474
Proposed (See Table 7)	15	1	15	2	30	98.28	2,948
Adjustment	No change	No change	No change	+1	+15	No change	+1,474

TABLE 30E: Burden Reconciliation for Quality Payment Program Identity Management Application Process

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	3,741	1	3,741	1	3,741	98.28	367,665
Proposed (See Table 8)	6,500	1	6,500	1	6,500	98.28	638,820
Adjustment	+2,759	No change	+2,759	No change	+2,759	No change	+271,155

TABLE 30F: Burden Reconciliation for Quality Performance Category Claims Collection Type

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	25,427	1	25,427	14.2	361,063	Varies	38,203,813
Proposed (See Table 9)	27,006	1	27,006	14.2	383,485	Varies	40,576,245
Adjustment	+1,579	No change	+1,579	No change	+22,422	No change	+2,372,432

TABLE 30G: Burden Reconciliation for Quality Performance Category QCDR/MIPS CQM Collection Type

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	46,890	1	46,890	9.083	425,902	Varies	46,076,459
Proposed (See Table 10)	47,584	1	47,584	9.083	432,205	Varies	46,758,418
Adjustment	+694	No change	+694	No change	+6,303	No change	+681,959

TABLE 30H: Burden Reconciliation for Quality Performance Category eCQM Collection Type

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	43,773	1	43,773	8	350,184	Varies	38,354,778
Proposed (See Table 11)	45,760	1	45,760	8	366,080	Varies	40,095,827
Adjustment	+1,987	No change	+1,987	No change	+15,896	No change	+1,741,049

TABLE 30I: Burden Reconciliation for MVP Registration

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	12,917	0	12,917	0.25	3,229	98.28	317,346
Proposed (See Table 12)	16,432	1	16,432	0.25	4,108	98.28	403,734
Adjustment	+3,515	1	+3,515	No change	+879	98.28	+86,388

TABLE 30J: Burden Reconciliation for Subgroup Registration

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	20	1	20	0.5	10	98.28	983
Proposed (See Table 13)	20	1	20	0.5	10	98.28	983
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30K: Burden Reconciliation for MVP Quality Performance Category Submission

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	12,917	1	12,917	Varies	83,673	Varies	9,022,782
Proposed (See Table 14)	16,432	1	16,432	Varies	106,692	Varies	11,506,091
Adjustment	+3,515	No change	+3,515	No change	+23,019	No change	+2,483,309

TABLE 30L: Burden Reconciliation for Call for Quality Measures

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	28	1	28	5.5	154	Varies	30,309
Proposed (See Table 15)	28	1	28	5.5	154	Varies	30,309
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30M: Burden Reconciliation for Reweighting Applications for Promoting Interoperability and Other Performance Categories

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	42,827	1	42,827	0.25	10,707	98.28	1,052,284
Proposed (See Table 16)	31,155	1	31,155	0.25	7,789	98.28	765,503
Adjustment	-11,672	No change	-11,672	No change	-2,918	No change	-286,781

TABLE 30N: Burden Reconciliation for Promoting Interoperability Performance Category Data Submission

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	51,667	1	51,667	2.69	138,984	98.28	13,659,348
Proposed (See Table 17)	54,770	1	54,770	2.71	148,427	98.28	14,587,406
Adjustment	+3,103	No change	+3,103	+0.02	+9,443	No change	+928,058

TABLE 30O: Burden Reconciliation for Call for Promoting Interoperability Measures

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	10	1	10	0.5	5	Varies	866
Proposed (See Table 18)	10	1	10	0.5	5	Varies	866
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30P: Burden Reconciliation for Improvement Activities Submission

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	81,582	1	81,582	0.083	6,771	98.28	665,454
Proposed (See Table 19)	96,980	1	96,980	0.083	8,049	98.28	791,056
Adjustment	+15,398	No change	+15,398	No change	+1,278	No change	+125,602

TABLE 30Q: Burden Reconciliation for Nomination of Improvement Activities

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	31	1	31	4.4	136	Varies	22,896
Proposed (See Table 20)	31	1	31	4.4	136	Varies	22,896
Adjustment	No Change	No Change	No change	No change	No change	Varies	No change

TABLE 30R: Burden Reconciliation for Nomination of MVPs

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	25	1	25	12	300	Varies	51,937
Proposed (See Table 21)	20	1	20	12	240	Varies	41,550
Adjustment	-5	No change	-5	No change	-60	No change	-10,387

TABLE 30S: Burden Reconciliation for Partial QP Election

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	250	1	250	0.25	63	98.28	6,192
Proposed (See Table 22)	287	1	287	0.25	72	98.28	7,076
Adjustment	+37	No change	+37	No change	+9	No change	+884

TABLE 30T: Burden Reconciliation for Other Payer Advanced APM Identification: Other Payer Initiated Process

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	15	1	15	10	150	98.28	14,742
Proposed (See Table 23)	15	1	15	10	150	98.28	14,742
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30U: Burden Reconciliation for Other Payer Advanced APM Identification: Eligible Clinician Initiated Process

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	15	1	15	10	150	98.28	14,742
Proposed (See Table 24)	15	1	15	10	150	98.28	14,742
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30V: Burden Reconciliation for Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	551	1	551	5	2,755	115.22	317,431
Proposed (See Table 25)	551	1	551	5	2,755	115.22	317,431
Adjustment	No change	No change	No change	No change	No change	No change	No change

TABLE 30W: Burden Reconciliation for Voluntary Participants to Elect to Opt Out of Performance Data Display on Physician Compare

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	38	1	38	0.25	10	98.28	983
Proposed (See Table 26)	38	1	38	0.25	10	98.28	983
Adjustment	No change	No change	No change	No change	No change	No change	No change

Table 31 provides the reasons for changes in the estimated burden for proposed policies and information collections for the CY 2023 performance period/2025 MIPS payment year set forth in the CY 2023 PFS proposed rule. We have divided the reasons for our change in burden into those related to newly proposed policies and those related to updated data and methods for the CY 2023 performance period/2025 MIPS payment year burden set forth in the CY 2022 PFS final rule.

TABLE 31: Reasons for Change in Burden Compared to the Currently Approved CY 2023 Information Collection Burdens

Table in Collection of Information	Changes in burden due to proposed CY 2023 policies	Proposed Adjustments in burden continued from CY 2022 PFS final rule policies due to revised methods or updated data
Table 3: Qualified Registry Self-Nomination and Other Requirements	None	Increase in number of respondents due to updated assumptions. Decrease in the total number of hours due to restructuring the ICR.
Table 4: QCDR Self-Nomination and Other Requirements	None	Increase in number of respondents due to updated assumptions. Decrease in the total number of hours due to restructuring the ICR.
Table 6: Third Party Intermediary Plan Audits	None	New ICR. Increase in number of respondents and hours due to restructuring the burden for third party intermediaries to submit a targeted audit, CAP, transition plan, or a participation plan.

Table in Collection of Information	Changes in burden due to proposed CY 2023 policies	Proposed Adjustments in burden continued from CY 2022 PFS final rule policies due to revised methods or updated data
Table 7: Open Authorization Credentialing and Token Request Process	None	Increase in the number of hours due to changes in administrative workflow for the application process.
Table 8: Quality Payment Program Identity Management Application Process	None	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 9: Quality Performance Category Claims Collection Type	Decrease in number of respondents due to the proposed increase in the number of respondents submitting for the MVP quality performance category via the claims collection type.	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 10: Quality Performance Category QCDR/MIPS CQM Collection Type	Decrease in number of respondents due to the proposed increase in the number of respondents submitting for the MVP quality performance category via the QCDR and MIPS CQM collection type.	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 11: Quality Performance Category eCQM Collection Type	Decrease in number of respondents due to the proposed increase in the number of respondents submitting for the MVP quality performance category via the eCQM collection type.	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 12: MVP Registration	Increase in number of respondents due to proposed addition of 5 new MVPs.	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 13: Subgroup Registration	None	None
Table 14: MVP Quality Performance Category Submission	Increase in number of respondents due to proposed addition of 5 new MVPs.	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 15: Call for Quality Measures	None	None
Table 16: Reweighting Applications for Promoting Interoperability and Other Performance Categories	None	Decrease in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Tables 17: Promoting Interoperability Performance Category Data Submission	Increase in the number of hours due to the proposed requirement for clinicians to submit their level of active engagement for the Public Health and Clinical Data Exchange Objective	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.

Table in Collection of Information	Changes in burden due to proposed CY 2023 policies	Proposed Adjustments in burden continued from CY 2022 PFS final rule policies due to revised methods or updated data
Table 18: Call for Promoting Interoperability Measures	None.	None.
Tables 19: Improvement Activities Submission	None	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year
Table 20: Nomination of Improvement Activities	None.	None.
Table 21: Nomination of MVPs	None	Decrease in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 22: Partial QP Election	None	Increase in number of respondents due to updated projections for the CY 2023 performance period/2025 MIPS payment year.
Table 23: Other Payer Advanced APM Identification: Other Payer Initiated Process	None.	None
Table 24: Other Payer Advanced APM Identification: Eligible Clinician Initiated Process	None.	None
Table 25: Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option	None.	None.
Table 26: Voluntary Participants to Elect to Opt Out of Performance Data Display on Physician Compare	None.	None

Table 32: Annual Requirements and Burden

Regulation Section(s) Under Title 42 of the CFR	No. Respondents	Total No. Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)*
Quality Payment Program	180,365	344,023	Varies	1,469,234	Varies	156,792,565

*With respect to the PRA, the CY 2023 PFS proposed rule does not impose any non-labor costs.

16. Publication and Tabulation Dates

In order to provide expert feedback to clinicians and third-party data submitters in order to help clinicians provide high-value, patient-centered care to Medicare beneficiaries; we provide performance feedback to MIPS eligible clinicians that includes MIPS quality, cost, improvement activities and Promoting Interoperability data; MIPS performance category and final scores; and payment adjustment factors. These reports were made available starting in July 2018 at qpp.cms.gov. We have also provided performance feedback to MIPS eligible clinicians who participate in MIPS APMs in 2018 and future years as technically feasible. This reflects our commitment to providing as timely information as possible to eligible clinicians to help them predict their performance in MIPS.

MIPS information is publicly reported through the Compare Tools website (https://www.medicare.gov/care-compare/) both on public profile pages and via the Downloadable Database as discussed at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/. 2017, 2018, and 2019 Quality Payment Program performance information has been made available for public review.

We plan to provide relevant data to other federal and state agencies, Quality Improvement Networks, and parties assisting consumers, for use in administering or conducting federally funded health benefit programs, payment and claims processes, quality improvement outreach and reviews, and transparency projects.

17. Expiration Date

The expiration date is displayed on all web-based data collection forms.

18. Certification Statement

There are no exceptions to the certification statement.