Supporting Statement – Part B
Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS)
(CMS-10621, OMB control number: 0938-1314)

Background

The Merit-based Incentive Payment System (MIPS) is one of two paths for clinicians available through the Quality Payment Program (QPP) authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program replaced three precursor Medicare reporting programs with a flexible system that allows clinicians to choose from two paths that link quality to payments: MIPS and Advanced Alternative Payment Models (APMs). The MIPS path measures MIPS eligible clinicians and groups 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 APM path, clinicians participating in certain types of APMs (Advanced APMs) may become Qualifying APM participants (QPs) and be excluded from MIPS.

The primary purpose of this collection is to generate data on a MIPS eligible clinician, group, or subgroup so that CMS can assess MIPS eligible clinician performance in the four performance categories, calculate the final score, and apply performance-based payment adjustments. We will also use this information to provide regular performance feedback to MIPS eligible clinicians and eligible entities. This information will also be made available to beneficiaries, as well as to the general public, on the care compare tool hosted by the U.S. Department of Health and Services. In addition, the data collected under this PRA will be used for research, evaluation, and measure assessment and refinement activities.

Specifically, CMS uses the data to produce annual statistical reports that provide a comprehensive representation of the overall experience of MIPS eligible clinicians. Further, CMS has processes to monitor and assess measures to ensure their soundness and appropriateness for continued use in MIPS. As required by MACRA, the ongoing measure assessment and monitoring process will be used to refine, add, and drop measures as appropriate, as shown in the proposed changes to the measure sets discussed in the CY 2025 Physician Fee Schedule (PFS) proposed rule. Supporting Statement Part B characterizes the respondents of this collection and any sampling used in data collection so that, when grouped/aggregated data are presented, the inferences that can be drawn from those data are clear.

There are 24 information collections in the CY 2025 PFS proposed rule requirements and burden estimates. The discussion in this Supporting Statement Part B focuses on the 6 information collections for which we plan to conduct statistical reporting and analyses: quality performance category data submitted via Medicare Part B claims, electronic clinical quality measure (eCQM), and MIPS clinical quality measure (CQM) and qualified clinical data registry (QCDR) collection types, the quality performance category submissions for MIPS Value Pathways (MVPs), and data submitted for the Promoting Interoperability and improvement activities performance categories.

B1. Respondent Universe and Sampling Methods

Quality Performance Category Data Submission

Potential respondent universe and response rates

We anticipate that two groups of clinicians will submit quality data under MIPS: those who submit as MIPS eligible clinicians and those who submit data voluntarily. We estimate the potential respondent universe and response rates for MIPS eligible clinicians and clinicians excluded from MIPS using data from the CY 2022 performance period/2024 MIPS payment year and other CMS sources. To determine which QPs should be excluded from MIPS, we used Advanced APM payment and patient percentages from the APM Participant List for the third snapshot date for the 2022 QP Performance Period. From this data, we calculated the QP determinations as described in the Qualifying APM Participant definition at § 414.1305 for the CY 2025 performance period/2027 MIPS payment year. Due to data limitations, we could not identify specific clinicians who may become QPs in the CY 2025 performance period/2027 MIPS payment year; hence, our model may underestimate or overestimate the fraction of clinicians and allowed charges for covered professional services that will remain subject to MIPS after the exclusions.

We assume that 100 percent of ACO APM Entities will submit quality data to CMS as required under their models. While we do not believe there is additional reporting for ACO APM Entities, consistent with assumptions used in the CY 2024 PFS final rule (88 FR 79434), we include all quality data voluntarily submitted by MIPS APM participants made at the individual or TIN-level in our respondent estimates. We assume non-ACO APM Entities will participate through traditional MIPS or MVPs and submit as an individual or group rather than as an entity. To estimate who will be a MIPS APM participant that can report using the APM performance pathway (APP) in the CY 2025 performance period/2027 MIPS payment year, we used the final snapshot data from the 2022 QP performance period. We elected to use this data source because the overlap with the data submissions for the CY 2022 performance period/2024 MIPS payment year enabled the exclusion of Partial QPs that elected to not participate in MIPS and required fewer assumptions as to who is a QP or not. Based on this information, if we determine that a MIPS eligible clinician will not be scored as a MIPS APM, then their reporting assumption is based on their reporting as a group or individual for the CY 2022 performance period/2024 MIPS payment year.

As discussed in Supporting Statement A, we explain that we assume 686,645 MIPS eligible clinicians will be subject to MIPS performance requirements. Included in this number, we estimate that 6,516 clinicians who exceeded at least one but not all low-volume threshold criteria, elected to opt-in and submitted data in the CY 2022 performance period/2024 MIPS payment year would elect to opt-in to MIPS in the CY 2025 performance period/2027 MIPS payment year. Also included in this number are an estimated 40,813 clinicians, who are MIPS eligible as an individual, because they exceeded all the low-volume threshold in all 3 criteria, but we predict would not report in the CY 2025 performance period/2027 payment year. While this is the estimated number of MIPS eligible clinicians, the number of respondents that actually submit data varies significantly due to differences in individual, group, virtual group, and APM Entity reporting and by the requirements and policies for each performance category.

CMS annual statistical reports about MIPS will be able to provide estimates of the numbers and percentages of MIPS eligible clinicians submitting quality performance category data that can be generalized to the entire population of MIPS eligible clinicians, and to relevant subpopulations (such as eligible clinicians participating in MIPS APMs).

Sampling for quality data submission

For the CY 2025 performance period/2027 MIPS payment year, we finalized the data completeness criteria threshold of at least 75 percent for MIPS eligible clinicians and groups submitting data for the quality performance category (87 FR 70049 through 70052). In the CY 2024 PFS final rule, we maintained the data completeness criteria threshold of at least 75 percent for the CY 2026 performance period/2028 MIPS payment year (88 FR 79334 through 79337). In the CY 2025 PFS proposed rule, we proposed to maintain the data completeness criteria threshold of at least 75 percent for the CY 2027 and CY 2028 performance periods/2029 and 2030 MIPS payment years. Tables 1 and 2 summarize the finalized data completeness criteria for the CY 2025 performance period/2027 MIPS payment year.

Table 1: Summary of Data Completeness Requirements and Performance Period by Collection Type for the CY 2025 Performance Period/2027 MIPS payment year

Collection Type	Performance Period	Data Completeness
Medicare Part B Claims measures	Jan 1- Dec 31	For the CY 2025 performance period/ 2027 MIPS payment year, 75 percent sample of individual MIPS eligible clinician's, group or subgroup's Medicare Part B patients for the performance period.
Administrative claims measures	Jan 1- Dec 31	100 percent sample of individual MIPS eligible clinician's Medicare Part B patients for the performance period.
QCDR measures, MIPS CQMs, and eCQMs	Jan 1- Dec 31	For the CY 2025 performance period/2027 MIPS payment year, 75 percent sample of individual MIPS eligible clinician's, group, or subgroup's patients across all payers for the performance period.
CAHPS for MIPS survey measure	Jan 1- Dec 31	Sampling requirements for the group and subgroup's Medicare Part B patients.

Table 2: Summary of Quality Data Submission Criteria for the CY 2025 Performance Period/2027 MIPS Payment Year for Individual Clinicians and Groups

Clinician Type	Submission Criteria	Measure Collection Types (or Measure Sets) Available for Submission (Excludes Administrative Claims)
Individual Clinicians in Traditional MIPS	Report at least 6 measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if fewer than 6 measures apply then report on each measure that is applicable. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Individual MIPS eligible clinicians select their measures from the following collection types: Medicare Part B claims measures (individual clinicians in small practices only), MIPS CQMs, QCDR measures, eCQMs, or reports on one of the specialty measure sets if applicable.
Groups in Traditional MIPS	Report at least 6 measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if fewer than 6 measures apply then report on each measure that is applicable. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Groups select their measures from the following collection types: Medicare Part B claims measures (small practices only), MIPS CQMs, QCDR measures, eCQMs, or the CAHPS for MIPS survey - or reports on one of the specialty measure sets if applicable.
MVP Participant	An MVP Participant must select and report 4 quality measures, including one outcome measure (or, if an outcome measure is not available, one high priority measure, included in the MVP). For small practices reporting an MVP with fewer than 4 Medicare Part B claims measures, they are only required to report the available Medicare Part B claims measures available in the MVP. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	MVP Participants (individual MIPS eligible clinician, single specialty group, multispecialty group, subgroup, or APM Entity that is assessed on an MVP) report on the applicable measures and activities in MVPs included in the MVP Inventory.

Data Submission for Promoting Interoperability and Improvement Activities Performance Categories

For the CY 2025 performance period/2027 MIPS payment year, eligible clinicians, groups, subgroups and APM Entities can submit Promoting Interoperability and improvement activities data through direct, log in and upload, or log in and attest submission types.

Based on updated MIPS submission data from the CY 2022 performance period/2024 MIPS payment year we estimate that a total of 18,609 respondents (14,500 individual MIPS eligible clinicians, 4,089 groups, and 20 subgroups) would submit Promoting Interoperability data for the CY 2025 performance period/2027 MIPS payment year. These estimates reflect that certain MIPS eligible clinicians will qualify for automatic reweighting of the Promoting Interoperability performance category to zero percent, including MIPS eligible clinicians who are hospital-based, ambulatory surgical center-based, small practices, and non-patient facing clinicians.

As discussed in Supporting Statement A, 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. 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 and 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. In the CY 2023 PFS final rule (87 FR 70087 and 70088), we finalized 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.

As discussed in Supporting Statement A, we estimate that total of 38,433 respondents (29,017 individually eligible clinicians, 9,396 groups and virtual groups, and 20 subgroups) will submit data for the improvement activities performance category during the CY 2025 performance period/2027 MIPS payment year, based on updated MIPS submission data from the CY 2022 performance period/2024 MIPS payment year.

B2. Procedures for Collection of Information

There are 24 information collections in the 2025 proposed rule QPP/MIPS PRA package. We do not anticipate using sampling or statistical estimation in all the information collections.

B3. Methods to Maximize Response Rates and Deal with Nonresponse

Quality Performance Category Data Submission

We expect additional experience with submissions under MIPS to clarify optimal data completeness thresholds and submission criteria for use in future performance periods. We will continually evaluate our policies and notify the public through future notice and comment rulemaking if we make substantive changes. As we evaluate our policies, we plan to continue a dialogue with interested parties to discuss opportunities for program efficiency and flexibility.

We believe that by continuing to provide virtual group participation as an option we will experience continued improvement in response rates due to the ability to better pool resources from participating as part of a virtual group, allowing for reporting on 6 quality measures in traditional MIPS.

Promoting Interoperability Performance Category Data Submission

The revised scoring methodology finalized in the CY 2019 PFS final rule (83 FR 59791) has provided a simpler, more flexible, less burdensome structure, allowing MIPS eligible clinicians

to put their focus back on patients. This scoring methodology encourages MIPS eligible clinicians to push themselves on measures that are most applicable to how they deliver care to patients, instead of focusing on measures that may not be as applicable to them. We believe the increased flexibility to MIPS eligible clinicians that enables them to focus more on patient care and health data exchange through interoperability will continue to help to maximize response rates for the Promoting Interoperability performance category.

In the CY 2020 PFS final rule, we required QCDRs and qualified registries to be able to submit data for each of the quality, improvement activities, and Promoting Interoperability performance categories with the stipulation that based on the amendment to § 414.1400(a)(2)(iii) a third party could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(1) through (7) or § 414.1380(c)(2)(i)(C)(9)). As a result, MIPS reporting for clinicians who utilized qualified registries or QCDR that have not previously offered the ability to report performance categories other than quality will be able to report MIPS data in a more streamlined and less burdensome manner.

Improvement Activities Performance Category Data Submission

User experiences from the CY 2019 performance period/2021 MIPS payment year reflect that the majority of users submit improvement activities data as part of the login and upload or direct submission types which allow data for multiple performance categories (i.e., quality and Promoting Interoperability) to be submitted at once. This results in less additional required time to submit improvement activities data which consists of manually attesting that certain activities were performed. In addition, the same improvement activity may be reported across multiple performance periods so many MIPS eligible clinicians may submit the same information for the CY 2025 performance period/2027 MIPS payment year as they did for previous MIPS performance periods/MIPS payment years. There is also a financial incentive to submit improvement activities data, as clinicians would not receive credit in their MIPS final score otherwise. We believe a less burdensome user experience combined with the financial incentives for submitting improvement activities data will continue to improve response rates in the CY 2025 performance period/2027 MIPS payment year.

In the CY 2025 PFS proposed rule, we proposed two scoring and reporting policy changes for the improvement activities performance category effective for the CY 2025 performance period/2027 MIPS payment year and subsequent years. First, we proposed to eliminate the weighting of improvement activities. In the CY 2017 Quality Payment Program final rule, we established a differentially weighted model for the improvement activities performance category with two categories, medium and high, to provide flexible scoring (81 FR 28210). In that rule (81 FR 77177 and 77178), we codified at 42 CFR 414.1380(b)(3) that clinicians (except for non-patient facing MIPS eligible clinicians, small practices, and practices located in rural areas and geographic health professional shortage areas (HPSAs)) receive 10 points for each medium-weighted improvement activity and 20 points for each high-weighted improvement activity. Non-patient facing MIPS eligible clinicians, small practices, and practices located in rural areas and geographic HPSAs receive 20 points for each medium-weighted improvement activity and 40 points for each high-weighted improvement activity.

Second, we proposed to further simplify improvement activity reporting requirements by reducing the number of activities to which clinicians are required to attest to achieve a score in the improvement activities performance category, beginning in the CY 2025 performance period/2027 MIPS payment year. Currently, MIPS eligible clinicians are required to report two high-weighted activities, four medium-weighted activities, or one high-weighted and two medium-weighted activities while MVP participants are currently required to report one high-weighted activity or two medium-weighted activities. We proposed that MIPS eligible clinicians who participate in traditional MIPS would be required to report two activities and MVP participants would be required to report one activity to achieve 40 points, or full credit. In addition, we proposed that MIPS eligible clinicians who are categorized as small practice, rural, in a provider-shortage area, or non-patient facing would now be required to report one activity (for either traditional MIPS or MVPs). We believe a less burdensome user experience combined with the financial incentives for submitting improvement activities data will continue to improve response rates year over year.

B4. Test Procedures for Methods to be Undertaken

We are refining our procedures, methods, and testing over time to be more efficient. We do not have any additional testing to describe in this section, including no additional tests that call for answers to identical questions from 10 or more respondents.

As stated above, we expect that additional experience with MIPS will clarify optimal reporting thresholds and submission criteria for use in future performance periods across the quality, Promoting Interoperability, and improvement activities performance categories. We will continually evaluate our policies based on our analysis of MIPS and other data.

B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

We do not anticipate any additional statistical reporting on data other than that presented here for the quality or Promoting Interoperability and improvement activities performance categories.

Quality, Promoting Interoperability, and Improvement Activities Performance Category Data

We anticipate that a contractor will analyze information collected from individual MIPS eligible clinicians and groups submitting data to the quality, Promoting Interoperability and improvement activities performance categories.