

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

Background

Authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015), the Quality Payment Program is a value-based payment program, by which the Medicare program rewards clinicians who provide high-value, high-quality care to their patients in a cost-efficient manner. There are two ways for clinicians who provide services under the Medicare program to participate in the Quality Payment Program: MIPS and Advanced APMs. The statutory requirements for the Quality Payment Program are set forth in section 1848(q) and (r) of the Act for MIPS and section 1833(z) of the Act for Advanced APMs.

For the MIPS participation track, MIPS eligible clinicians (defined in § 414.1305) are subject to a MIPS payment adjustment (positive, negative, or neutral) based on their performance in four performance categories: cost, quality, improvement activities, and Promoting Interoperability. CMS applies the MIPS payment adjustment factor to amounts otherwise paid under Part B with respect to covered professional services for the MIPS eligible clinician for the applicable MIPS payment year.

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment). Eligible clinicians who are QPs for the CY 2024 performance year receive a 1.88 percent APM Incentive Payment in the 2026 payment year. Beginning with the CY 2024 performance year (payment year 2026), QPs will also receive a higher PFS payment rate (calculated using the differentially higher “qualifying APM conversion factor”) than non-QPs. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

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 two years prior to the payment year, which we refer to as the QP Determination Submission Deadline (82 FR 53886).

Summary of Changes

For the CY 2025 performance period/2027 MIPS payment year, MIPS eligible clinicians could participate in MIPS as an individual, a group, a virtual group, an APM Entity, or a subgroup as available for each reporting option. There are three MIPS reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

- Traditional MIPS, established in the first year of QPP. Participants select quality measures and improvement activities from the available measures and activities finalized for MIPS each year. Participants complete the Promoting Interoperability measure set.

CMS collects and calculates data for the cost performance category on behalf of participants.

- The APM Performance Pathway (APP) is a streamlined reporting option for clinicians who participate in a MIPS APM. Participants report a predetermined measure set made up of quality measures in addition to the complete Promoting Interoperability measure set. MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
- MIPS Value Pathways (MVPs) are the newest reporting option that offers clinicians a subset of measures and activities relevant to a specialty or medical condition. Participants select, collect, and report on a reduced number of quality measures and improvement activities (as compared to traditional MIPS). Participants report the complete Promoting Interoperability measure set. CMS collects and calculates data for the cost performance category and population health measures on behalf of participants. Beginning with the CY 2023 performance period/2025 MIPS payment year, clinicians can choose to participate as subgroups to report the measures and activities in an MVP.

We finalized in the CY 2022 Physician Fee Schedule (PFS) final rule that a subgroup participating in MIPS Value Pathways (MVPs) reporting will submit its affiliated group's data for the Promoting Interoperability performance category, and in the scenario that a subgroup does not submit its affiliated group's data, the subgroup will receive a zero score for the Promoting Interoperability performance category (86 FR 65413 and 65414). In our December 9, 2024 (89 FR 97710) CY 2025 PFS final rule (CMS-1807-F, RIN 0938-AV33), we finalized to apply this policy for the CY 2025 performance period/ 2027 MIPS payment year and beyond.

As finalized in the CY 2021 PFS final rule (85 FR 84860), for clinicians in APM Entities, the APP will be available for both ACOs and non-ACOs to submit quality data. In our CY 2025 PFS final rule, we finalized to create the APP Plus quality measure set that would allow for alignment of the APP with the Adult Universal Foundation measures. We did not modify the existing APP quality measure set; instead, we finalized our proposal to create the APP Plus quality measure set that will be optional for MIPS eligible clinicians, groups, and APM Entities (not including Medicare Shared Savings Program ACOs) meeting the reporting requirements under the APP starting with the CY 2025 performance period/2027 MIPS payment year. However, Medicare Shared Savings Program ACOs will be required to report the APP Plus quality measure set to meet the reporting requirements of the Medicare Shared Savings Program's quality performance standard. As finalized, each MIPS eligible clinician, group, or APM Entity that elects to report the APP may choose to report either the APP quality measure set or the APP Plus quality measure set. MIPS APM participants may also elect to report via traditional MIPS or MVPs. In our CY 2025 PFS final rule we finalized, with modification, the APP Plus quality measure set, which will include six measures beginning with CY 2025 performance period/2027 MIPS payment year. Five new quality measures within the APP Plus quality measure set will be added incrementally over several performance periods/MIPS payment years.

Due to data limitations and our inability to determine who would use the APP versus the traditional MIPS or MVP submission mechanism for the CY 2025 performance period/2027 MIPS payment year, we assume Shared Savings Program ACO APM Entities will submit data through the APP and MIPS eligible clinicians in non-Shared Savings Program ACO APM

Entities would participate through traditional MIPS or MVPs, thereby submitting as an individual or group rather than as an APM entity.

The implementation of MIPS requires the collection of quality, Promoting Interoperability, and improvement activities performance category data.¹ The mechanism by which a submitter type submits data to CMS (including, as applicable: Direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface) is defined at § 414.1305 as the submission type. The direct submission type allows users to transmit data through a computer-to-computer interaction, such as an API. The log in and upload submission type allows users to upload and submit data in the form and manner specified by CMS with a set of authenticated credentials. The log in and attest submission type allows users to manually attest that certain measures and activities were performed in the form and manner specified by CMS with a set of authenticated credentials. We refer readers to § 414.1325(b) and (c) for available data submission types that individual MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities may utilize to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.

In our CY 2025 PFS final rule, we finalized changes to the inventory in the improvement activities performance category with the CY 2025 performance period/2027 MIPS payment year and subsequent years as follows: adding two new improvement activities; modifying one existing improvement activity; and removing four previously adopted improvement activities. We also finalized, with modification, the removal of four improvement activities and modification of one improvement activity beginning with the CY2026 performance period/2028 MIPS payment year. We also finalized as proposed two scoring and reporting policy changes for the improvement activities performance category beginning in the CY 2025 performance period/2027 MIPS payment year. In our CY 2025 PFS final rule, we finalized our proposal to eliminate the weighting of improvement activities established in the CY 2017 Quality Payment Program final rule (81 FR 28210) and codified at § 414.1380(b)(3) (81 FR 77177 and 77178). Second, we finalized our proposal to further simplify improvement activity reporting requirements by reducing the number of activities to which clinicians are required to attest in order to achieve a score for the improvement activities performance category. As described in our CY 2025 PFS final rule, we finalized our assumption that these policies will not affect our existing burden estimates.

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

CMS has received approval for the collection of information associated with the virtual group election process under OMB control number 0938-1343 (CMS-10652). The updated information collections for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey discussed in the CY 2025 PFS final rule will be submitted to OMB for review under control number 0938-1222 (CMS-10450).

¹ Cost performance category measures do not require the collection of additional data because they are derived from the Medicare claims.

The cost performance category relies on administrative claims data. The Medicare claims submission process to collect data on cost measures from MIPS eligible clinicians is captured under OMB control numbers 0938-1197 (CMS-1500 and CMS-1490S) and 0938-0992.

The changes in this CY 2025 collection of information request are associated with our December 9, 2024 (89 FR 97710) CY 2025 PFS final rule (CMS-1807-F, RIN 0938-AV33) as well as data adjustments due to the availability of updated data and assumptions that are not associated with provisions in the CMS-1807-F final rule. While such adjustments are not detailed in the CY 2025 collection of information pages, they are set out in this collection of information request.

Overall, this iteration proposes to decrease the current estimates by minus 55,241 responses and minus 78,771 hours. See Table 31 of this Supporting Statement for a side-by-side summary of this iteration's rule and non-rule related changes.

We have also revised Appendices A through K and replaced active Appendix L (2023 MVP Registration Form) with a new Appendix L entitled, "2024 MVP Registration Form." The MVP registration collection changed from submitting an Excel file via email in 2023 to an online registration form for 2024.

We are not requesting the addition or removal of any ICRs in the CY 2025 PFS final rule.

A. 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 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 through the CY 2022 performance period/2024 MIPS payment year. The APM incentive payment was extended for two additional years for clinicians who are QPs in the CY 2023 performance period/2025 MIPS payment year and the CY 2024 performance period/2026 MIPS payment year. Beginning with the CY 2024 performance period/2026 MIPS payment year, QPs will receive a higher Medicare Physician Fee Schedule update (qualifying APM conversion factor) than non QPs. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

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 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 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.

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 collections described in this document are 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, many APM Entities would not need to submit improvement activities because they will be reporting through

the APM Performance Pathway (APP). We assume ACO APM Entities would submit data through the APM Performance Pathway and non-ACO APM Entities would participate through traditional MIPS or MVPs, 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 2025 PFS final rule's Regulatory Impact Analysis estimates that approximately 686,645 MIPS eligible clinicians would be subject to MIPS performance requirements.² 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 178,216 clinicians in eligible specialties would be excluded from MIPS data submission requirements because they do not have sufficient charges, services, or beneficiaries under the PFS to exceed all three low volume threshold criteria and do not elect to opt-in as a group or individual. We exclude 405,945 clinicians who are only eligible as a group, but do not elect to participate as a group. Additionally, we exclude 129,806 clinicians who are below the low-volume threshold as both individuals and groups. Further, we exclude an additional 420,287 clinicians who are either QPs, newly enrolled Medicare professionals (to reduce data submission burden to those professionals), or practice non-eligible specialties. Clinicians who are excluded from MIPS because they are a QP, are not an eligible clinician type, and/or are newly enrolled Medicare clinicians may participate in MIPS voluntarily. Clinicians or groups who are not eligible to participate in MIPS because of the low volume threshold and do not opt-in to MIPS participation can also voluntarily submit MIPS data. Medicare professionals voluntarily participating in MIPS would receive feedback on their performance but would not be subject to payment adjustments.

6. Less Frequent Collection

Data on the quality, Promoting Interoperability, and improvement activities performance categories are collected from individual MIPS eligible clinicians, groups, or subgroups annually. If this information were collected less frequently, we would have no mechanism to: (1) determine whether a MIPS eligible clinician, group, or a subgroup 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 to allow us to determine which clinicians are required to report MIPS data.

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 qualified registries and QCDRs will participate in submitting quality measures, improvement activities, or Promoting Interoperability measures, objectives,

² For further detail on MIPS exclusions, see Supporting Statement B and the Regulatory Impact Analysis Section of the CY 2025 PFS final rule.

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 three 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 2025 PFS proposed rule (CMS-1807-P; RIN 0938-AV33) published in the Federal Register on July 31, 2024 (89 FR 61596). We did not receive public comments for our estimated burden in the CY 2025 performance period/2027 MIPS payment year.

The CY 2025 PFS final rule (CMS-1807-F; RIN 0938-AV33) published in the Federal Register on December 9, 2024 (89 FR 97710).

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

We will use eligibility and performance category 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

All information collected will be kept private in accordance with regulations at 45 CFR 155.260, Privacy and Security of Personally Identifiable Information. Pursuant to this regulation, CMS may only use or disclose personally identifiable information to the extent that such information is necessary to carry out their statutory and regulatory mandated functions.

11. Sensitive Questions

There are no sensitive questions included in the information collection requests. 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

We used data from the U.S. Bureau of Labor Statistics' May 2023 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). Table 1 presents the mean hourly wage, the fringe benefits cost (calculated at 100 percent of salary), and the adjusted hourly wage. The adjusted hourly wage is used to calculate the labor costs for the information collections.

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.³

For our purposes, the BLS' May 2023 National Occupational Employment and Wage Estimates does not provide an occupation that we could use for "Physician" wage data. As a result, in order to estimate the cost for "Physicians", we are using a rate of \$291.64/hr, which is the average of the mean wage rates for Anesthesiologists; Family Medicine Physicians; General Internal Medicine Physicians; Obstetricians and Gynecologists; Pediatricians, General; Physicians, All Other; Orthopedic Surgeons, Except Pediatric; Psychiatrists; Pediatric Surgeons; Surgeons, All Other; and Surgeons $[(\$326.42/\text{hr} + \$231.54/\text{hr} + \$236.02/\text{hr} + \$267.94/\text{hr} + \$197.94/\text{hr} + \$239.08/\text{hr} + \$363.70/\text{hr} + \$247.06/\text{hr} + \$432.04/\text{hr} + \$330.76/\text{hr} + \$335.48/\text{hr}) \div 11]$.

We note that the May 2023 BLS data does not include median hourly wage rates for a number of the physician occupation types listed in Table 1; in these cases, the BLS identifies that the

³ 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.

median wage rate is equal to or greater than \$115.00/hr or \$239,200 per year. BLS data for prior years, such as the May 2021 and May 2022 data, provide similar notes for median wage rates for occupations that are above a given threshold (\$100.00/hr or \$208,000 per year for the May 2021 BLS data (https://www.bls.gov/oes/2021/may/oes_nat.htm), and \$115.00/hr or \$239,200 per year for the May 2022 BLS data (https://www.bls.gov/oes/2022/may/oes_nat.htm)). Therefore, for consistency with previous years for estimating physician wage rates, we have continued to use mean hourly wage rates across our wage estimates.

Table 1: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Anesthesiologists	29-1211	163.21	163.21	326.42
Billing and Posting Clerks	43-3021	22.66	22.66	45.32
Computer Systems Analysts	15-1211	53.27	53.27	106.54
Family Medicine Physicians	29-1215	115.77	115.77	231.54
General Internal Medicine Physicians	29-1216	118.01	118.01	236.02
Licensed Practical Nurse (LPN)	29-2061	29.23	29.23	58.46
Medical and Health Services Managers	11-9111	64.64	64.64	129.28
Obstetricians and Gynecologists	29-1218	133.97	133.97	267.94
Orthopedic Surgeons, Except Pediatric	29-1242	181.85	181.85	363.70
Pediatricians, General	29-1221	98.97	98.97	197.94
Pediatric Surgeons	29-1243	216.02	216.02	432.04
Physicians, All Other	29-1229	119.54	119.54	239.08
Psychiatrists	29-1223	123.53	123.53	247.06
Surgeons, All Other	29-1249	165.38	165.38	330.76
Surgeons	29-1240	167.74	167.74	335.48

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. In Table 2, MIPS eligible clinicians and other clinicians voluntarily submitting data to MIPS may submit data 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. The subgroup reporting option is not available for clinicians participating in traditional MIPS. In CY 2022 PFS final rule (86 FR 65413 and 65414), we finalized the, a subgroup reporting measures and activities in an MVP will submit its affiliated group's data for the Promoting Interoperability performance category and in the scenario that a subgroup does not submit its affiliated group's data, the subgroup will receive a zero score for the Promoting Interoperability performance category for the CY 2023 and 2024 MIPS performance periods/2025 and 2026 MIPS payment years. In the CY 2025 PFS final rule, we finalized at § 414.1365(c)(4)(i)(A) to allow a subgroup to submit the affiliated group's data for the MVP Promoting Interoperability performance category for the CY 2025 performance period/2027 MIPS payment year and beyond. As this policy will not create new reporting requirements, there are no burden implications.

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 that the APP is available for clinicians who participate in a MIPS APM for both ACO participants and non-ACO participants to submit quality data (85 FR 84859 through 84866). In the 2025 PFS final rule, we finalized creating the APP Plus quality measure set that would allow for alignment of the APP with the Adult Universal Foundation measures. Under this proposal, Shared Savings Program ACOs would be required to report the APP Plus quality measure beginning with the CY 2025 performance period/2027 MIPS payment year. We did not to modify the existing APP quality measure set of six quality measures; instead, we are finalizing our proposal to create the APP Plus quality measure set that will be optional for MIPS eligible clinicians, groups, and APM Entities (not including Medicare Shared Savings Program ACOs) meeting the reporting requirements under the APP starting with the CY 2025 performance period/2027 MIPS payment year. However, for Medicare Shared Savings Program ACOs, they will be required to report the APP Plus quality measure set to meet the reporting requirements of the Medicare Shared Savings Program's quality performance standard. We are finalizing, with modification, the proposed APP Plus quality measure set, which will include six measures beginning with CY 2025 performance period/2027 MIPS payment year. Five new quality measures within the APP Plus quality measure set will incrementally increase incrementally over several performance periods/MIPS payment years.

Under this proposal, each MIPS eligible clinician, group, or APM Entity that elects to report the APP may choose to report either the APP quality measure set or the APP Plus quality measure set. MIPS APM participants may also elect to report via traditional MIPS or MVPs. We finalized adopting five new quality measures for the APP Plus quality measure set incrementally over several performance periods/MIPS payment years. Due to data limitations and our inability to determine who will use the APP versus the traditional MIPS or MVP submission mechanisms for the CY 2025 performance period/2027 MIPS payment year we assume ACO APM Entities would submit quality data through the APP as required, and MIPS eligible clinicians in non-ACO APM Entities will participate through traditional MIPS or MVPs, submitting as an

individual or group rather than as an APM Entity. Per section 1899(e) of the Act, submissions received from MIPS eligible clinicians in ACOs are not included in burden estimates for the CY 2025 PFS final rule because quality data submissions to fulfill requirements of the Shared Savings Program are not subject to the PRA. Accordingly, this burden is not included in Quality Payment Program burden estimates.

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. Additionally, APM Entities may report the Promoting Interoperability performance category at the APM Entity level beginning with the CY 2023 performance period/2025 MIPS payment year (87 FR 70087 and 70088). Based on the data available, the burden estimates for the CY 2025 PFS final rule assume group TIN-level reporting for eligible clinicians in MIPS APMs.

For the improvement activities performance category, we codified at § 414.1380(b)(3)(i) that individual MIPS eligible clinicians participating in APMs (as defined in section 1833(z)(3)(C) of the Act) for a performance period will earn at least 50 percent for the improvement activities performance category, as established in the 2017 Quality Payment Program final rule (81 FR 30132). We also stated that MIPS eligible clinicians participating in an APM for a performance period may receive an improvement activity score higher than 50 percent (81 FR 30132). To provide clarity for APM participants not scored under the APP, we revised § 414.1380(b)(3)(i) to state that a MIPS eligible clinician participating in an APM receives an improvement activities performance category score of at least 50 percent if the MIPS eligible clinician reports a completed improvement activity or submits data for the quality and Promoting Interoperability performance categories, as finalized in the CY 2024 PFS final rule (88 FR 79365 through 79367). We assume that MIPS eligible clinicians in MIPS APMs will submit the improvement activities performance category via traditional MIPS or MVPs as an individual or group rather than as an APM Entity.

MIPS 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 or Organizations Submitting MIPS Data on Behalf of Clinicians, by Type of Data and Category of Clinician

Type of Data Submitted	Category of Clinician
Quality Performance Category	Individual clinician (MIPS eligible, voluntary, opt-in), group, virtual group, subgroup, or APM Entity. Subgroup reporting is only available for clinicians participating in MVP reporting. Voluntary reporting and virtual group reporting are only available for clinicians participating in traditional MIPS. Opt-in reporting is only available for clinicians participating in traditional MIPS and the APP.

Type of Data Submitted	Category of Clinician
Promoting Interoperability Performance Category	Individual clinician (MIPS eligible, voluntary, opt-in), group, virtual group, subgroup, or APM Entity. Each eligible clinician in an APM Entity could report data for the Promoting Interoperability performance category at the individual level, or as part of their group TIN, or under their APM Entity TIN. The burden estimates for the CY 2025 PFS final rule assume group TIN-level reporting.
Improvement Activities Performance Category	Individual clinician (MIPS eligible, voluntary, opt-in), group, virtual group, subgroup, or APM Entity. For eligible clinicians in an APM Entity, the burden estimates for the CY 2025 PFS final rule assume individual or group TIN-level reporting.
Reweightings Applications for extreme and uncontrollable circumstances, significant hardship, or other exceptions	Clinicians who submit an application may be eligible for a reweighting of the approved performance category to zero percent under specific circumstances as set forth in § 414.1380(c)(2), including, but not limited to, extreme and uncontrollable circumstances and significant hardship or another type of exception. Certain types of MIPS eligible clinicians are automatically eligible for a zero percent weighting for the Promoting Interoperability performance category as described in § 414.1380(c)(2)(i)(C).
MVP and Subgroup Registration	An MVP Participant, as described at § 414.1305, electing to submit data for the measures and activities in an MVP must register. Clinicians who choose to participate as a subgroup for reporting an MVP must also register.
Partial QP Election	Eligible clinicians who attain Partial QP status and choose to participate in MIPS must submit a partial QP election form.
Registration for the CAHPS for MIPS Survey	Groups electing to use a CMS-approved survey vendor to administer the CAHPS for MIPS Survey must register.
Virtual Group Registration	Virtual groups must register via email. Virtual group participation is limited to MIPS eligible clinicians, specifically, solo practitioners who are MIPS eligible and groups consisting of 10 eligible clinicians or fewer that have at least one MIPS eligible clinician.
APM Performance Pathway (APP)	Clinicians in MIPS APMs electing the APP. The burden estimates for the CY 2025 PFS final rule assume that Shared Savings Program ACO APM Entities will submit data through the APP via the APP Plus Measure set beginning in the CY 2025 performance period/2027 MIPS payment year, and non-Shared Savings Program ACO APM Entities will participate through traditional MIPS or MVPs, submitting as an individual or group rather than as an APM Entity.

The policies finalized in the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77008 and 82 FR 53568), the CY 2019, CY 2020, CY 2021, CY 2022, CY 2023, and CY 2024 PFS final rules (83 FR 59452, 84 FR 62568, 85 FR 84472, 86 FR 64996, 87 FR 70131, and 88 FR 78818), and continued in the CY 2025 PFS final rule create some additional data collection requirements not listed in Table 2. These additional data collections consist of:

- Self-nomination of new QCDRs

- Simplified self-nomination process of returning QCDRs
- Self-nomination of new qualified registries
- Simplified self-nomination process of returning qualified registries
- Third party intermediary plan audits
- Open Authorization Credentialing and Token Request Process
- Quality Payment Program Identity Management Application Process
- Reweighting Applications for MIPS Performance Categories
- Call for quality measures
- Nomination of improvement activities
- Nomination of MVPs
- Opt out of performance data display on Compare Tools 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

c. Burden for Third Party Self-Nomination Process and Other Requirements

Under MIPS, the quality, Promoting Interoperability, and improvement activities performance category data may be submitted via relevant third party intermediaries, such as QCDRs and qualified registries. Entities seeking approval to submit data on behalf of clinicians as a QCDR or qualified registry must complete a self-nomination process annually. The processes for self-nomination of entities seeking approval as QCDRs and qualified registries are similar with the exception that QCDRs have the option to nominate QCDR measures for CMS consideration for the reporting of quality performance category data. Therefore, the difference between the QCDR and qualified registry self-nomination is associated with the preparation of QCDR measures for CMS consideration.

As established in the CY 2024 PFS final rule (88 FR 79425), we continue to estimate burden separately for the simplified and full self-nominations of QCDRs and qualified registries, to more accurately capture the distinct number of estimated respondents and burden per self-nomination for the different processes. In the CY 2024 PFS final rule (88 FR 79390 and 79391), we eliminated the category of health information technology (IT) vendors from MIPS third party intermediaries beginning with the CY 2025 performance period/2027 MIPS payment year.

Qualified registries and QCDRs must comply with requirements on the submission of MIPS data to CMS. The burden associated with qualified registry and QCDR data submission requirements will be the time and effort associated with calculating quality measure results from the data submitted to the qualified registry and 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 qualified registry or a QCDR 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 and QCDRs already perform many of these activities for their participants. Therefore, we believe the estimates shown in Tables 3,4,5, and 6 represents the upper bound for qualified registry and QCDR burden, with the potential for less additional MIPS burden if the qualified registry or the QCDR already provides similar data submission services.

The burden associated with qualified registry self-nomination and QCDR self-nomination and measure submission follow:

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

Previously approved qualified registries in good standing (i.e., that are not on remedial action or have been terminated) 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.

Based on the number of applications we received under the simplified process during the CY 2024 self-nomination period, we estimate that qualified registries will submit an application under the simplified qualified registry self-nomination process for the CY 2025 performance period/2027 MIPS payment year. We estimate that it would take 0.5 hours to submit an application for the simplified qualified registry self-nomination process. We assume that the staff involved in the simplified qualified registry self-nomination process will be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr. We estimate the burden per response would be \$53.27 (0.5 hr × \$106.54/hr). In aggregate, as shown in Table 3, we estimate that the annual burden for the simplified qualified registry self-nomination process would be 37 hours (74 applications × 0.5hr) at a cost of \$3,942 (74 applications × \$53.27/application).

Table 3: Estimated Burden for Simplified Qualified Registry Self-Nomination

Burden and Respondent Descriptions	Burden Estimate
# of Simplified Self-Nomination Applications Submitted (a)	74
Annual Hours per Qualified Registry for Simplified Process (b)	0.5
Total Annual Hours for Simplified Self-Nomination (c) = (a) [×] (b)	37
Cost per Application at Labor Cost Computer Systems Analyst of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$53.27
Total Annual Cost (e) = (a) [×] (d)	\$3,942

ii. Burden for Full Qualified Registry Self-Nomination Process 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). The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period.

Based on the number of applications received under the full process for the CY 2024 self-nomination period, we estimate that 14 qualified registries will self-nominate under the full qualified registry self-nomination process for the CY 2025 performance period/2027 MIPS payment year. We estimate that it would take 2 hours to submit an application for the full qualified registry self-nomination process. We assume that the staff involved in the full qualified registry self-nomination process will continue to be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr. We estimate the burden per response would be \$213.08 (2 hr × \$106.54/hr). In aggregate, as shown in Table 4, we estimate that the annual burden for the full qualified registry self-nomination process would be 28 hours (14 applications × 2 hr) at a cost of \$2,983 (14 applications × \$213.08/application).

Table 4: Estimated Burden for Full Qualified Registry Self-Nomination

Burden and Respondent Descriptions	Burden Estimate
# of Qualified Registry Full Self-Nomination Applications Submitted (a)	14
Annual Hours per Qualified Registry for Full Process (b)	2
Total Annual Hours for Full Self-nomination (c) = (a) [×] (b)	28
Cost per Application at Labor Cost Computer Systems Analyst of \$106.54/hr) (d) = (b) [×] \$106.54/hr	\$213.08
Total Annual Cost (e) = (a) [×] (d)	\$2,983

iii. Burden for Simplified QCDR Self-Nomination Process and QCDR Measure Submission

Previously approved QCDRs in good standing (that are not on remedial action or have been terminated) that wish to self-nominate under the simplified process can attest, in whole or in part, that their 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).

Based on the number of applications we received under the simplified process during the CY 2024 self-nomination period, we estimate that 41 QCDRs will self-nominate under the simplified QCDR self-nomination process for the CY 2025 performance period/2027 MIPS payment year. We estimate that it will take 0.5 hours for a QCDR to submit an application under the simplified self-nomination process. Additionally, we estimate that each QCDR will submit 13 measures on average, approximately 2 new measures and 11 existing or borrowed measures, per QCDR. We estimate that it will take 2 hours for a QCDR to submit a new measure and 0.5 hours to submit an existing measure. In aggregate, we estimate that it will take 10 hours [0.5hr for the simplified

self-nomination process + (2 hr per new measure × 2 new measures) + (0.5 hr per existing or borrow measures × 11 measures)] for a QCDR to submit an application under the simplified self-nomination process. On average, the time to nominate each measure is approximately 0.73 hours per measure. We assume that the staff involved in the simplified QCDR self-nomination process will be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr. We estimate the burden per response would be \$1,065.40 (10 hr × \$106.54/hr). In aggregate, as shown in Table 5, we estimate that the annual burden for the simplified QCDR self-nomination process would be 410 hours (41 applications × 10 hr) at a cost of \$43,681 (41 applications × \$1,065.40/application).

Table 5: Estimated Burden for Simplified QCDR Self-Nomination and QCDR Measure Submission

Burden and Respondent Descriptions	Burden Estimate
# of Simplified QCDR Self-Nomination Applications Submitted (a)	41
Annual Hours per QCDR for Simplified Process (b)	10
Total Annual Hours for Simplified Self-Nomination (c) = (a) [×] (b)	410
Cost per Application at Labor Cost Computer Systems Analyst of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$1,065.40
Total Annual Cost (e) = (a) [×] (d)	\$43,681

iv. Burden for Full QCDR Self-Nomination Process and QCDR Measure Submission

New QCDRs 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). The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period.

Based on the number of applications we received under the full QCDR self-nomination process for the CY 2024 self-nomination period, we estimate that 11 QCDRs will self-nominate under the full QCDR self-nomination process for the CY 2025 performance period/2027 MIPS payment year. We estimate that it will take 2.5 hours for a QCDR to submit an application under the full self-nomination process. Additionally, we estimate that each QCDR will submit 13 measures on average, approximately 2 new measures and 11 existing or borrowed measures, per QCDR. We estimate that it will take 2 hours for a QCDR to submit a new measure and 0.5 hours to submit an existing measure. In aggregate, we estimate that it will take 12 hours [2.5 hours for the full self-nomination process + (2 hr per new measure × 2 measures) + (0.5 hr per existing or borrowed measure × 11 measures)] for a QCDR to submit an application under the full self-nomination process. On average, the time to nominate each measure is approximately 0.73 hours per measure. We assume that the staff involved in the full QCDR self-nomination process will be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr. We estimate the burden per response would be \$1,278.48 (12 hr × \$106.54/hr). In aggregate, as shown in Table 6, we estimate that the annual burden for the full QCDR self-nomination process will be 132 hours (11 applications × 12 hr) at a cost of \$14,063 (11 applications × \$1,278.48/application).

Table 6: Estimated Burden for Full QCDR Self-Nomination and QCDR Measure Submission

Burden and Respondent Descriptions	Burden Estimate
# of Full QCDR Self-Nomination Applications Submitted (a)	11
Annual Hours per QCDR for Full Process (b)	12
Total Annual Hours for Full Self-Nomination (c) = (a) [×] (b)	132
Cost per Application at Labor Cost Computer Systems Analyst of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$1,278.48
Total Annual Cost (e) = (a) [×] (d)	\$14,063

v. Third Party Intermediary Plan Audits

d. 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). For the CY 2025 performance period/2027 MIPS payment year, we estimate that the time required for a QCDR or qualified registry to submit a targeted audit ranges between 5 and 10 hours under the simplified and full self-nomination process, respectively. We assume that the staff involved in submitting the targeted audits will be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr.

We estimate that 22 third party intermediaries will submit targeted audits for the CY 2025 performance period/2027 MIPS payment year. We estimate the time required for a QCDR or qualified registry to submit a targeted audit ranges between 5 hours for the simplified self-nomination process and 10 hours for the full self-nomination process, and that the cost for a QCDR or a qualified registry to submit a targeted audit will range from \$532.70 (5 hr × 106.54/hr) to \$1,065.40 (10 hr × 106.54/hr). In aggregate, we estimate the total impact associated with QCDRs and qualified registries completing targeted audits will range from 110 hours (22 responses × 5 hours/audit) at a cost of \$11,719 (22 responses × \$532.70/audit) to 220 hours (22 responses × 10 hours/audit) at a cost of \$23,439 (22 responses × \$1,065.40/audit) under the simplified and full self-nomination process, respectively (See Tables 7 and 8).

e. 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. For the CY 2025 performance period/2027 MIPS payment year, we estimate that it will take 2 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 be computer systems analysts or their equivalent, who have an average labor rate of \$106.54/hr.

We estimate that 11 third party intermediaries will submit participation plans for the CY 2025 performance period/2027 MIPS payment year. We estimate that the cost for a QCDR or a qualified registry to submit a participation plan is \$213.08 (2 hours × 106.54/hr). In aggregate,

we estimate the total impact associated with QCDRs and qualified registries to submit participation plans will be 22 hours (11 participation plans $\times$ 2 hours/plan) at a cost of \$2,344 (11 participation plans $\times$ \$213.08/plan) (See Tables 7 and 8).

f. Corrective Action Plans (CAPs)

In the CY 2017 Quality Payment Program final rule, we established the process for corrective action plans (CAPs) (81 FR 77386 through 77389). We estimate that 6 third party intermediaries will submit CAPs for the CY 2025 performance period/2027 MIPS payment year. Additionally, we estimate that it will take 3 hours for a QCDR or qualified registry to submit a CAP. We assume that the staff involved in submitting the CAPs will be computer systems analysts or their equivalent, who have an average labor rate of 106.54/hr. We estimate that the cost for a QCDR or a qualified registry to submit a CAP is \$319.62 (3 hours $\times$ \$106.54/hr). In aggregate, we estimate the total impact associated with QCDRs and qualified registries to CAPs would be 18 hours (6 CAPs $\times$ 3 hours/response) at a cost of \$1,918 (6 CAPs $\times$ \$319.62/response) (See Tables 7 and 8).

g. Transition Plans

In the CY 2020 PFS final rule (84 FR 63052 through 63053), we established a policy at § 414.1400(a)(3)(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.

We estimate that we will receive 3 transition plans from QCDRs and qualified registries for the CY 2025 performance period/2027 MIPS payment year. We estimate that it will take 1 hour for a computer system analyst or their equivalent at a labor rate of \$106.54/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 3 hours (3 transition plans $\times$ 1 hour/plan) at a cost of \$320 (3 transition plans $\times$ \$106.54/plan).

In aggregate, as shown in Table 7, we assume that 42 third party intermediaries will submit plan audits (22 targeted audits, 11 participation plans, 6 CAPs, and 3 transition plans).

Table 7: Estimated Number of Respondents to Submit Plan Audits

Burden and Respondent Descriptions	# of Respondents
# of Targeted Audits (a)	22
# of Participation Plans (b)	11
# of Corrective Action Plans (CAPs) (c)	6
# of Transition Plans (d)	3
Total Respondents (e) = (a) + (b) + (c) + (d)	42

As shown in Table 8, for the CY 2025 performance period/2027 MIPS payment year, in aggregate, the estimated annual burden to submit plan audits under the simplified and full self-nomination process will range from 297 hours to 472 hours at a cost ranging from \$31,642 (297 hr × 106.54/hr) and \$50,286 (472 hr × 106.54/hr), respectively.

Table 8: Estimated Burden for Third Party Intermediary Plan Audits

Burden and Respondent Descriptions	Simplified Process	Full Process
# of Hours per Completion of Targeted Audit (a)	5	10
Total Annual Hours for Completion of 22 Targeted Audits (b)	110	220
# of Hours per Submission of Participation Plan (c)	2	2
Total Annual Hours for Submission of 11 Participation Plans (d)	22	22
# of Hours per Submission of CAP (e)	3	3
Total Annual Hours for Submission of 6 CAPs (f)	18	18
# of Hours per Submission of Transition Plan (g)	1	1
Total Annual Hours for Submission of 3 Transition Plans (h)	3	3
Total Annual Hours for Submission of Plan Audits (i) = (b) + (d) + (f) + (h)	153	263
Cost per Targeted Audit (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (j) = (a) [×] \$106.54/hr	\$532.70	\$1,065.40
Cost per Participation Plan (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (k) = (c) [×] \$106.54/hr	\$213.08	\$213.08
Cost per CAP (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (l) = (e) [×] \$106.54/hr	\$319.62	\$319.62
Cost per Transition Plan at Computer Systems Analyst's Labor Rate of \$106.54/hr (m) = (g) [×] \$106.54/hr	\$106.54	\$106.54
Total Cost of Targeted Audits (n) = j [×] 22	\$11,719	\$23,439
Total Cost of Participation Plans (o) = (k) [×] 11	\$,344	\$2,344
Total Cost of CAPs (p) = (l) [×] 6	\$1,918	\$1,918
Total Cost of Transition Plans (q) = (m) [×] 3	\$320	\$320
Total Annual Cost (r) = (n) + (o) + (p) + (q) (simplified) and (r) = (n) + (o) + (p) + (q)(full)	\$16,301	\$28,021

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

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 with a more comprehensive and less administratively burdensome experience using the direct submission type.

As shown in Table 9, we estimate that we will receive 15 requests to complete this process for the CY 2025 performance period/2027 MIPS payment year. We estimate that it would take 2 hours at \$106.54/hr for a computer systems analyst (or their equivalent) to complete the process, resulting in an estimated cost of \$213.08 (2 hours × \$106.54/hr) per response. In aggregate, we estimate an annual burden of 30 hours (15 vendors × 2 hr) at a cost of \$3,196 (15 requests × \$213.08/request).

Table 9: 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 at Computer Systems Analyst's Labor Rate of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$213.08
Total Annual Cost (e) = (a) [×] (d)	\$3,196

ii. Burden Estimate for the Quality Performance Category

Under our current policies, two groups of clinicians submit data for the quality performance category under MIPS: those who submit data as MIPS eligible clinicians, and those who 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 final snapshot date for the CY 2022 QP performance period and the QP thresholds applied to the regulatory impact analysis. 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 2025 performance period/2027 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 electronic health record (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, QCDR, and eCQM collection types, we also assume that each clinician or group will submit, on average, six quality measures. Additionally, we separately capture the burden for clinicians who choose to submit via these collection types for the quality performance category of MVPs. Additionally, as finalized in the CY 2022 PFS final rule (86 FR 65394 through 65397), group tax identification numbers (TINs) could also choose to participate as subgroups for MVP reporting beginning with the CY 2023 performance period/2025 MIPS payment year. 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 four quality measures, including one outcome measure (or, if an outcome measure is not available, one high priority measure), included in the MVP.

iii. 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.

As shown in Table 10, we estimate that 6,237 unique TINs will submit their information to obtain new user accounts in the HARP system for the CY 2025 performance period/2027 MIPS payment year, based up updated data from March 2022 to February 2023. We estimate that it would take 1 hour at \$106.54/hr for a computer systems analyst (or their equivalent) to obtain an account for the HARP system, resulting in an estimated cost of \$106.54 per application. In aggregate we estimate an annual burden of 6,237 hours (6,237 applications × 1 hr/registration) at a cost of \$664,490 (6,237 applications × \$106.54/application).

Table 10: 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)	6,237
Total Hours Per Application (b)	1
Total Annual Hours for Completing the Identity Management Application Process (c) = (a) [×] (b)	6,237

Burden and Respondent Descriptions	Burden Estimate
Cost per Application at Computer Systems Analyst's Labor Rate of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$106.54
Total Annual Cost for Completing the Identity Management Application Process (e) = (a) [×] (d)	\$664,490

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

As noted in Table 11, based on updated data available from the CY 2022 performance period/2024 MIPS payment year and updated MVP reporting assumptions, for the CY 2025 performance period/2027 MIPS payment year, we assume that 12,197 individual clinicians will collect and submit quality data via the Medicare Part B claims collection type.

As shown in Table 11, 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 \$15.98 (0.15 hr × \$106.54/hr) to 7.2 hours at a cost of \$767.09 (7.2 hr × \$106.54/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 \$129.28/hr for a medical and health services manager, 1 hour at \$291.64/hr for a physician, 1 hour at \$58.46/hr for an LPN, 1 hour at \$106.54/hr for a computer systems analyst, and 1 hour at \$45.32/hr for a billing and posting clerk.

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 11, for the CY 2025 performance period/2027 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 87,209 hours (7.15 hr × 12,197 clinicians) to 173,197 hours (14.2 hr × 12,197 clinicians). The estimated annual cost (per clinician) ranges from \$905.78 [(0.15 hr × \$106.54/hr) + (3 hr × \$129.28/hr) + (1 hr × \$106.54/hr) + (1 hr × \$58.46/hr) + (1 hr × \$45.32/hr) + (1 hr × \$291.64/hr)] to a maximum of \$1,656.89 [(7.2 hr × \$106.54/hr) + (3 hr × \$129.28/hr) + (1 hr × \$106.54/hr) + (1 hr × \$58.46/hr) + (1 hr × \$45.32/hr) + (1 hr × \$291.64/hr)]. The total annual cost for the CY 2025 performance period/2027 MIPS payment year ranges from a minimum of \$11,047,799 (12,197 clinicians × \$905.78) to a maximum of \$20,209,087 (12,197 clinicians × \$1,656.89).

Table 11: 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)	12,197	12,197	12,197

Burden and Respondent Descriptions	Minimum Burden Estimate	Median Burden Estimate	Maximum Burden Estimate
Hours Per Computer Systems Analyst 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 Physician 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)	87,209	98,186	173,197
Cost to Submit Quality Data (at Computer Systems Analyst's Labor Rate of \$106.54/hr at varying times) (j)	\$15.98	\$111.87	\$767.09
Cost to Review Measure Specifications (at Medical and Health Services Manager's Labor Rate of \$129.28/hr at 3 hr) (k)	\$387.84	\$387.84	\$387.84
Cost to Review Measure Specifications (at Computer Systems Analyst's Labor Rate of \$106.54/hr at 1 hr) (l)	\$106.54	\$106.54	\$106.54
Cost to Review Measure Specifications (at LPN's Labor Rate of \$58.46/hr at 1 hr) (m)	\$58.46	\$58.46	\$58.46
Cost to Review Measure Specifications (at Billing Clerk's Labor Rate of \$45.32/hr at 1 hr) (n)	\$45.32	\$45.32	\$45.32
Cost to Review Measure Specifications (at Physician's Labor Rate of \$291.64/hr at 1 hr) (o)	\$291.64	\$291.64	\$291.64
Total Annual Cost Per Clinician (p) = (j)+(k)+(l)+(m)+(n)+(o)	\$905.78	\$1,001.67	\$1,656.89

Burden and Respondent Descriptions	Minimum Burden Estimate	Median Burden Estimate	Maximum Burden Estimate
Total Annual Cost (q) = (a) [×] (p)	\$11,047,799	\$12,217,369	\$20,209,087

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

Based on updated data available from the CY 2022 performance period/2024 MIPS payment year and updated MVP reporting assumptions, for the CY 2025 performance period/2027 MIPS payment year, we estimate that 17,008 clinicians (10,850 individual clinicians and 6,158 groups and virtual groups) will submit quality data for the MIPS CQM and QCDR collection types. 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 collection type, 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 hours. This consists of 3 hours at \$106.54/hr for a computer systems analyst (or their equivalent) to submit quality data along with 2 hours at \$129.28/hr for a medical and health services manager, 1 hour at \$106.54/hr for a computer systems analyst, 1 hour at \$58.46/hr for a LPN, 1 hour at \$45.32/hr for a billing clerk, and 1 hour at \$291.64/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 \$106.54/hr for a computer systems analyst at a cost of \$8.84 (0.083 hr × \$106.54/hr). Overall, we estimate 9.083 hr/response (3 hr + 2 hr + 1 hr + 1 hr + 1 hr + 1 hr + 0.083 hr) at a cost of \$1,088.98/response [(3 hr × \$106.54/hr) + (2 hr × \$129.28/hr) + (1 hr × \$291.64/hr) + (1 hr × \$106.54/hr) + (1 hr × \$58.46/hr) + (1 hr × \$45.32/hr) + (0.083 hr × \$106.54/hr)].

As shown in Table 12, for the CY 2025 performance period/2027 MIPS payment year, in aggregate, we estimate a burden of 154,484 hours [9.083 hr/response × 17,008 responses (10,850 clinicians submitting as individuals + 6,158 groups submitting via QCDR or MIPS CQM on behalf of individual clinicians)] at a cost of \$18,521,372 (17,008 responses × \$1,088.98/response).

Table 12: 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)	10,850
# of Groups Submitting via QCDR or MIPS CQM on Behalf of Individual Clinicians (b)	6,158
Total # of Respondents (c) = (a) + (b)	17,008
# of Hours Per Respondent to Report Quality Data (d)	3
# of Hours per Medical and Health Services Manager to Review Measure Specifications (e)	2
# of Hours for Computer Systems Analyst to Review Measure Specifications (f)	1
# of Hours for LPN to Review Measure Specifications (g)	1
# of Hours for Billing Clerk to Review Measure Specifications (h)	1
# of Hours for Physician to Review Measure Specifications (i)	1
# 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)	154,484
Cost Per Respondent to Submit Quality Data (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (m)=(d) × \$106.54/hr	\$319.62
Cost to Review Measure Specifications (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) (n) =(e) × \$129.28/hr	\$258.56
Cost per Computer System's Analyst Review of Measure Specifications (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (1) =(e) ×\$106.54/hr	\$106.54
Cost per LPN to Review Measure Specifications (at LPN's Labor Rate of \$58.46/hr) (p) =(g) × \$58.46/hr	\$58.46
Cost per Billing Clerk to Review Measure Specifications (at Clerk's Labor Rate of \$45.32/hr) (q) =(h) × \$45.32/hr	\$45.32
Cost for Physician to Review Measure Specifications (at Physician's Labor Rate of \$291.64/hr) (r)	\$291.64
Cost for Respondent to Authorize Qualified Registry/QCDR to Report on Respondent's Behalf (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (s) =(j) × \$106.54/hr	\$8.84
Total Annual Cost Per Respondent (t) = (m) + (n) + (o) + (p) + (q) + (r) + (s)	\$1,088.98
Total Annual Cost (u) = (c) [×] (t)	\$18,521,372

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

As noted in Table 13 below, based on updated data available from the CY 2022 performance period/2024 MIPS payment year and updated MVP reporting assumptions, we estimate that 27,179 clinicians (21,240 individual clinicians and 5,939 groups and virtual groups) will submit

quality data using the eCQM collection type for the CY 2025 performance period/2027 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 CMS will be accepting MIPS data extracted from eQCMs, select the appropriate quality measures, extract the necessary clinical data from their CEHRT, and submit the necessary data to a QCDR/qualified registry 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 third party intermediary 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 \$106.54/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 \$129.28/hr for a medical and health services manager, 1 hour at \$291.64/hr for a physician, 1 hour at \$106.54/hr for a computer systems analyst, 1 hour at \$58.46/hr for an LPN, and 1 hour at \$45.32/hr for a billing clerk. As shown in Table 13, we estimate a cost of \$973.60/response $[(2 \text{ hr} \times \$106.54/\text{hr}) + (2 \text{ hr} \times \$129.28/\text{hr}) + (1 \text{ hr} \times \$291.64/\text{hr}) + (1 \text{ hr} \times \$106.54/\text{hr}) + (1 \text{ hr} \times \$58.46/\text{hr}) + (1 \text{ hr} \times \$45.32/\text{hr})]$.

As shown in Table 13, for the CY 2025 performance period/2027 MIPS payment year, we estimate a burden of 217,432 hours $[8 \text{ hr} \times 27,179 \text{ (5,939 groups and 21,240 clinicians submitting as individuals)}]$ at a cost of \$26,461,474 $(27,179 \text{ responses} \times \$973.60/\text{response})$.

Table 13: 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)	21,240
# of Groups Submitting via EHR on Behalf of Individual Clinicians (b)	5,939
Total # of Respondents (c)=(a)+(b)	27,179
# of Hours Per Respondent to Submit MIPS Quality Data File (d)	2
# of Hours Per Medical and Health Services Manager to Review Measure Specifications (e)	2
# of Hours Per Computer Systems Analyst to Review Measure Specifications (f)	1
# of Hours Per LPN to Review Measure Specifications (g)	1

Burden and Respondent Descriptions	Burden Estimate
# of Hours Per Billing Clerk to Review Measure Specifications (h)	1
# of Hours Per Physician to Review Measure Specifications (i)	1
Annual Hours Per Respondent (j) = (d) + (e) + (f) + (g) + (h) + (i)	8
Total Annual Hours (k) = (c) [×] (j)	217,432
Cost Per Respondent to Submit Quality Data (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (l) = \$106.54/hr × (d)	\$213.08
Cost to Review Measure Specifications (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) (m) = \$129.28/hr × (e)	\$258.56
Cost to Review Measure Specifications (at Computer System's Analyst's Labor Rate of \$106.54/hr) (n) = \$106.54/hr × (f)	\$106.54
Cost to Review Measure Specifications (at LPN's Labor Rate of \$58.46/hr) (o) = \$58.46/hr × (g)	\$58.46
Cost to Review Measure Specifications (at Clerk's Labor Rate of \$45.32/hr) (p) = \$45.32/hr × (h)	\$45.32
Cost to Review Measure Specifications (at Physician's Labor Rate of \$291.64/hr) (q) = \$291.64/hr × (i)	\$291.64
Total Cost Per Respondent (r)=(l)+(m)+(n)+(o)+(p)+(q)	\$973.60
Total Annual Cost (s) = (c) [×] (r)	\$26,461,474

h. ICRs Regarding Burden for MVP Reporting

In the CY 2022 PFS final rule, we finalized the implementation of voluntary MVP and subgroup reporting for eligible clinicians beginning with the CY 2023 performance period/2025 MIPS payment year. Clinicians participating in MIPS have the option to voluntarily submit data via MVPs starting with the CY 2023 performance period/2025 MIPS payment year. Additionally, clinicians participating in MIPS and reporting through MVP(s) can also choose to form subgroups beginning with the CY 2023 performance period/2025 MIPS payment year. All MVPs include a foundational layer (the same across all MVPs) which includes the complete Promoting Interoperability performance category measure set and administrative claims population health measures, in addition to MVP-specific measures and activities in the quality, cost, and improvement activities performance categories. Clinicians choosing to participate in MIPS and report MVPs will 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 and improvement activities performance categories sections below. The following ICRs reflect the burden associated with data collection related to MVPs and subgroup reporting in the CY 2025 performance period/2027 MIPS payment year.

For the ICRs related to MVP Participants, our burden estimates are based on the MIPS submission data from the CY 2022 performance period/2024 MIPS payment year. In the MVP Inventory of the CY 2025 PFS final rule, we finalized the addition of six new MVPs to the MVP Inventory. Additionally, we finalized the consolidation of the previously finalized Optimal Care for Patients with Episodic Neurological Conditions and Supportive Care for Neurodegenerative

Conditions MVPs. As finalized, MVP Participants will have a total of 21 MVPs available for the CY 2025 performance period/2027 MIPS payment year.

Advanced Primary Care Management (APCM) payment finalized in the CY2025 PFS final rule incorporates several specific, existing care management and communication technology-based services into a bundle and includes performance measurement requirements that, for MIPS eligible clinicians, could be met by reporting the Value in Primary Care MVP beginning in the CY 2025 performance period/2027 MIPS payment year. Billing practitioners who are not MIPS eligible clinicians (as defined at §414.1305) will not have to report the MVP in order to furnish and bill for APCM services. Billing practitioners who are not MIPS eligible clinicians (as defined at §414.1305) will not have to report the MVP in order to furnish and bill for APCM services. We estimate MVP reporting as a percentage of previous traditional MIPS quality submissions. In line with this approach, we are unable to determine how many additional clinicians or practices will report the Value in Primary Care MVP above our current MVP submission estimates due to the finalized APCM requirements. Similarly, we cannot assess what participation levels clinicians or practices who may use these APCM codes have reported MIPS in the past (for example, eligibility requirements and special statuses, participation at the individual, group, virtual group, or APM Entity level, or reporting via traditional MIPS, the APP, or MVPs), or if they will be MIPS eligible clinicians in future years. With updated submission data available for the CY 2022 performance period/2024 MIPS payment year and quality measure modifications within the MVP Inventory for the CY 2024 performance period/2026 MIPS payment year (88 FR 79978 through 80047), we conducted an analysis on the average quality measure submission rate for the 16 MVPs approved for the CY 2024 performance period/2026 MIPS payment year. The total of these average quality measure submissions for each approved MVP was equivalent to six percent of the total quality measure submissions in the CY 2022 performance period/2024 MIPS payment year. For each MVP finalized for introduction in the CY 2025 PFS final rule, we similarly calculated the average quality measure submission rate across the measures available in each MVP for the CY 2022 performance period/2024 MIPS payment year. Using updated data available from the CY 2022 performance period/2024 MIPS payment year, we calculated that the total of these average quality measure submissions for each MVP finalized for introduction in the CY 2025 PFS final rule was equivalent to about four percent of total quality measure submissions. We assume there will not be any changes to MVP submissions due to the finalized policy to consolidate the measures in the Optimal Care for Patients with Episodic Neurological Conditions MVP and Supportive Care for Neurodegenerative Conditions MVP into the Quality Care for Patients with Neurological Conditions MVP. That is, we assume clinicians who would have submitted the Optimal Care for Patients with Episodic Neurological Conditions MVP or the Supportive Care for Neurodegenerative Conditions MVP would instead submit the Quality Care for Patients with Neurological Conditions MVP. Therefore, we estimate the finalized changes to the MVP Inventory in this final rule would result in an additional four percent of MIPS clinicians moving from traditional MIPS to MVP reporting.

Taking together the aforementioned analyses where we assessed the MVP Participation rate for the 16 previously established MVPs at six percent using updated quality measure submission data from the CY 2022 performance period/2024 MIPS payment year, and the assessment that four percent of MIPS clinicians may move to the six new MVPs finalized in the CY 2025 PFS final rule due to quality measure submission trends for the CY 2022 performance period/2024

MIPS payment year, we estimate that a total of 10 percent of the clinicians will participate in MVP reporting in the CY 2025 performance period/2027 MIPS payment year. This is a decrease of 4 percentage points from the currently approved estimate of 14 percent in the CY 2024 PFS final rule (88 FR 79443). This decrease reflects the updated analysis of MVP submissions for established MVPs (from 14 percent to 4 percent) to account for the latest available MIPS submission data, and the additional 6 percent of MIPS clinicians we believe may report the six new MVPs introduced in the CY 2025 PFS final rule due to updated quality measure submission data.

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

In the CY 2022 PFS final rule (86 FR 65417), we finalized at § 414.1365(b)(2)(i) that MVP Participants are required to select one population health measure at the time of MVP registration. Since the MVP population health measures are administrative claims-based, they do not require data submission from clinicians and do not contribute to reporting burden. In the CY 2025 PFS final rule, we finalized our proposal to update the registration process and scoring policies for population health measures. These changes include revising § 414.1365(d)(3)(i)(A) to state that we would use the highest score of all available population health measures beginning in the CY 2025 performance period/2027 MIPS payment year. This policy will remove the requirement for MVP Participants to select a population health measure during MVP registration, which is currently completed via a drop-down selection. We assume the associated reduction in burden per application will be minimal. Therefore, we did not adjust the burden per MVP registration from the currently approved registration time of 15 minutes (0.25 hr). The MVP registration collection changed from submitting an Excel file via email in 2023 to an online registration form for 2024.

In Table 14 below, we estimate that the registration process for clinicians choosing to submit MIPS data for the measures and the activities in an MVP will 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 \$106.54/hour.

Based on submission data from the CY 2022 performance period/2024 MIPS payment year, and accounting for the previously finalized changes to the existing MVPs and the finalized addition of 6 new MVPs in the CY 2025 PFS final rule, we estimate that 10 percent of the clinicians that currently participate in MIPS will submit data for the measures and activities in an MVP. For the CY 2025 performance period/2027 MIPS payment year, we assume that a total of 6,285 submissions will 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 estimate that the total number of individual clinicians, groups, subgroups and APM Entities to complete the MVP registration process is 6,285. As shown in Table 14, we estimate that it will take 1,571 hours (6,285 registrations × 0.25 hr/registration) for individual clinicians, groups, subgroups, and APM Entities to complete the MVP registration process at a cost of \$167,432 (6,285 registrations × \$26.645/registration) for the CY 2025 performance period/2027 MIPS payment year.

Table 14: 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)	6,285
Estimated Time Per Registration (hr) (b)	0.25
Estimated Total Annual Time for MVP Registration (c) = (a) [×] (b)	1,571
Computer Systems Analyst's Labor Rate (d)	\$106.54/hr
Estimated Cost Per Registration (e) = (d) [×] (b)	\$26.64
Estimated Total Annual Cost for MVP Registration (f) = (a) [×] (e)	\$167,432

ii. Burden for Subgroup Registration

In the CY 2022 PFS final rule, we 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 14, clinicians who choose to form subgroups for reporting the MVPs will 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 2025 performance period/2027 MIPS payment year, we 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 15 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 \$106.54/hr. In aggregate, we estimate that it will take 10 hours (20 subgroups × 0.5 hr/subgroup) to complete the subgroup registration process at a cost of \$1,065 (20 subgroups × \$53.27/registration).

As subgroup participation option is only available to report MVPs, the burden associated with subgroup reporting of the quality performance category 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 15: Total Estimated Burden for Subgroup Registration

Burden and Respondent Descriptions	Burden Estimate
# of Subgroups Registering (a)	20
Total Annual Hours Per Subgroup (b)	0.5
Total Annual Hours for Subgroup Reporting (c) = (a) [×] (b)	10
Cost Per Subgroup (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (d) = (b) [×] \$106.54/hr	\$53.27

Burden and Respondent Descriptions	Burden Estimate
Total Annual Cost for Subgroup Registration (e) = (a) [×] (d)	\$1,065

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 four quality measures, including one outcome measure (or, if an outcome measure is not available, one high priority measure), included in the MVP. The decrease in the number of required measures in the quality performance category from six to four 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 final rule. Therefore, we 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 2025 performance period/2027 MIPS payment year, we estimate that 10 percent of the clinicians who participated in MIPS for the CY 2022 performance period/2024 MIPS payment year, and 20 subgroups will submit data for the quality performance category of MVPs. As shown in Table 16, we estimate that approximately 3,020 clinicians and 10 subgroups will submit data using eQMs collection type at a cost of \$644.93/response (see line q for eQMs); 1,890 clinicians and 10 subgroups will submit data using MIPS CQM and QCDR collection type at a cost of \$716.31/response (see line q for CQM and QCDRs); and 1,355 clinicians and 0 subgroups will submit data for the MVP quality performance category using the Medicare Part B claims collection type at a cost of \$1,101.24/response (see line q for claims).

As shown in Table 16, for the CY 2025 performance period/2027 MIPS payment year, we estimate a burden of 16,059 hours [5.3 hr × 3,030 (3,020 +10) responses] at a cost of \$1,954,138 (3,030 responses × \$644.93/response) for the eCQM collection type, 11,343 hours [5.97 hr × 1,900 (1,890 +10 responses)] at a cost of \$1,360,989 (1,900 responses × \$716.31/responses) for the MIPS CQM and QCDR collection type, and 12,791 hours (9.44 hr × 1,355 clinician responses) at a cost of \$1,492,180 (1,355 responses × \$1,101.24/response) for the Medicare Part B claims collection type.

Table 16: Estimated Burden for MVP 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)	3,020	1,890	1,355
# of Subgroup Reporters (b)	10	10	0
Total MVP Participants (c) = (a) + (b)	3,030	1,900	1,355

Burden and Respondent Descriptions	eCQM Collection Type	CQM and QCDR Collection Type	Claims Collection Type
Hours Per Computer Systems Analyst 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)	16,059	11,343	12,791
Cost to Submit Quality Data (at Computer Systems Analyst's Labor Rate of \$106.54/hr at Varying Times) (l)	\$141.70	\$213.08	\$511.39
Cost to Review Measure Specifications (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) at Varying Times (m)	\$171.94	\$171.94	\$258.56
Cost to Review Measure Specifications (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (n)	\$70.32	\$70.32	\$70.32
Cost to Review Measure Specifications (at LPN's Labor Rate of \$58.46/hr) (o)	\$38.58	\$38.58	\$38.58
Cost to Review Measure Specifications (at Billing Clerk's Labor Rate of \$45.32/hr) (p)	\$29.91	\$29.91	\$29.91
Cost to Review Measure Specifications (at Physician's Labor Rate of \$291.64/hr) (q)	\$192.48	\$192.48	\$192.48
Total Annual Cost Per Submission (r) = (l) + (m) + (n) + (o) + (p) + (q)	\$644.93	\$716.31	\$1,101.24

Burden and Respondent Descriptions	eQCM Collection Type	CQM and QCDR Collection Type	Claims Collection Type
Total Annual Cost (s) = (c) [×] (r)	\$1,954,138	\$1,360,989	\$1,492,180

i. *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 17, we estimate that we will receive 16 quality measure submissions for the CY 2025 performance period/2027 MIPS payment year based on the number of measure submissions for the CY 2023 Call for Quality Measures. We estimate that it would take approximately 5.5 hours per quality measure submission. This estimate includes 2.4 hours for the practice administrator/medical and health services manager at \$129.28/hr and 1.1 hours at \$291.64/hr for a clinician to identify, propose, and link the quality measure, and approximately 2 hours at \$291.64/hr for a clinician to complete the Peer Review Journal Article Form.

As shown in Table 17, in aggregate we estimate an annual burden of 88 hours (16 submissions × 5.5 hr/submission) at a cost of \$19,430 {16 measure submissions × \$1,214.35 [(2.4 hr × \$129.28/hr) + (3.1 hr × \$291.64/hr)]}.

Table 17: Burden Estimates for Call for Quality Measures

Burden and Respondent Descriptions	Burden Estimate
# of New Quality Measures Submitted for Consideration (a)	16
# of Hours per Practice Administrator to Identify, Propose and Link Measure (b)	2.4
# of Hours per Clinician to Identify and Link Measure (c)	1.1
# of Hours per Clinician to Complete Peer Review Article Form (d)	2
Annual Hours Per Response (e) = (b) + (c) + (d)	5.5
Total Annual Hours (f)=(a) [×] (e)	88
Cost to Identify and Submit Measure (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) [×] 2.4 hr = (g)	\$310.27
Cost to Identify Quality Measure and Complete Peer Review Article Form (at Clinician's Labor Rate of \$291.64/hr) [×] 3.1 hr = (h)	\$904.08
Total Annual Cost Per Submitted Measure (i) = (g) + (h)	\$1,214.35
Total Annual Cost (j)=(a) [×] (i)	\$19,430

j. Burden Estimate for the Promoting Interoperability Performance Category

For the CY 2025 performance period/2027 MIPS payment year, MIPS eligible clinicians and groups, subgroups, and APM Entities 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 both quality and Promoting Interoperability 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 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 MIPS Performance Categories

As established in the CY 2017 and CY 2018 Quality Payment Program final rules, MIPS eligible clinicians may submit an application requesting reweighting to zero percent for the Promoting Interoperability, quality, cost, and/or improvement activities performance categories under specific circumstances as set forth in § 414.1380(c)(2), including, but not limited to, extreme and uncontrollable circumstances, significant hardship, or other exceptions (81 FR 77240 through 77243, 82 FR 53680 through 53686, and 82 FR 53783 through 53785).

Respondents (MIPS eligible individual clinicians, groups, or APM Entities) who apply for reweighting of the quality, cost, and/or improvement activities performance categories have the option of applying for reweighting of 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 18 summarizes the burden for clinicians to apply for reweighting for one or more of the MIPS performance categories to zero percent due to an extreme or uncontrollable circumstance, significant hardship, or other exception as provided in § 414.1380(c)(2)(i). We updated our burden estimates relevant to this ICR on the number of reweighting applications received for the CY 2023 performance period/2025 MIPS payment year by January 2, 2024, that did not cite the COVID-19 public health emergency (PHE) as the basis for reweighting. The federal PHE for COVID-19 under section 319 of the Public Health Service Act ended on May 11, 2023.⁴ As a result of the end of the PHE, MIPS eligible clinicians will no longer be able to submit a reweighting application citing hardships from the PHE for COVID-19; therefore, we are excluding reweighting applications citing the COVID-19 PHE in our estimate for CY 2025 performance period/2027 MIPS payment year reweighting applications. Based on these updated assumptions and data, we assume that we will receive approximately 3,297 applications to request reweighting for any or all of the four MIPS performance categories for the CY 2025

⁴ <https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html>.

performance period/2027 MIPS payment year. Of the 3,297, we estimate that 2,490 MIPS eligible clinicians or groups will submit a request that includes reweighting the Promoting Interoperability performance category to zero percent due to a significant hardship or other exception as provided in § 414.1380(c)(2)(i)(C), and we estimate that 802 MIPS eligible clinicians or groups will submit a request to reweight one or more of the MIPS performance categories as provided in § 414.1380(c)(2)(i). Additionally, we estimate five APM Entities will submit an extreme and uncontrollable circumstances exception application to reweight one or more MIPS performance category for the CY 2025 performance period/2027 MIPS payment year. This adjustment, due to both updated data and the end of the COVID PHE, results in a decrease of 25,930 respondents compared to our currently approved estimate of 29,227 respondents (88 FR 79449 and 79450). We note the currently approved estimate included reweighting applications citing the COVID-19 PHE.

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 also requires the completion of a short online form and identification of the type of extreme and uncontrollable circumstance experienced.

As shown in Table 18, we estimate that it will take 0.25 hours at \$106.54/hr for a computer system analyst to complete and submit the application. As shown in Table 18, in aggregate, we estimate an annual burden of 824 hours (3,297 applications × 0.25 hr/application) at an annual cost of \$87,832 (3,297 applications × \$26.64/application).

Table 18: Estimated Burden for Reweighting Applications for MIPS Performance Categories

Burden and Respondent Descriptions	Burden Estimate
# of Eligible Clinicians or Groups Applying Due to Significant Hardship and Other Exceptions or Extreme and Uncontrollable Circumstances (a)	3,292
# APM Entities Requesting Extreme and Uncontrollable Circumstances Exception (b)	5
Total Applications Submitted (c)	3,297
Annual Hours Per Applicant per Application Submission (d)	0.25
Total Annual Hours (e) = (c) [×] (d)	824
Cost to Submit a Reweighting Application at Computer Systems Analyst’s Labor Rate of \$106.54/hr (f) = (d) [×] \$106.54/hr	\$26.64
Total Annual Cost (g) = (c) [×] (f)	\$87,832

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, individual, or a group.

In the CMS Interoperability and Prior Authorization final rule (89 FR 8758), we finalized the addition of the “Electronic Prior Authorization” measure, under the Health Information Exchange (HIE) objective for the MIPS Promoting Interoperability performance category beginning with the CY 2027 performance period/2029 MIPS payment year (89 FR 8909 through 8927). The burden estimate for MIPS clinicians to report the “Electronic Prior Authorization measure” was provided in the CMS Interoperability and Prior Authorization final rule (89 FR 8953 through 8956). In the CMS Interoperability and Prior Authorization final rule, we identified that this measure will be included in a collection of information request related to the CMS Interoperability and Prior Authorization final rule (89 FR 8946).

As shown in Table 19, based on data from the CY 2022 performance period/2024 MIPS payment year, we estimate that a total of 18,609 respondents consisting of 14,500 individual MIPS eligible clinicians, 4,089 groups and virtual groups, and 20 subgroups will submit Promoting Interoperability data for the CY 2025 performance period/2027 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, and clinical social workers. 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 estimate that it will take 2.70 hours of 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) for clinicians to submit data for the Promoting Interoperability performance category. As shown in Table 19, 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 \$106.54/hr. In aggregate, the total burden estimate for submitting data on the specified Promoting Interoperability objectives and measures is estimated to be 50,244 hours (18,609 respondents × 2.70 hours) and \$5,353,065 (18,609 respondents × \$287.66/respondent).

Table 19: Estimated Burden for Promoting Interoperability Performance Category Data Submission

Burden and Respondent Description	Burden Estimate
Number of Individual Clinicians to Submit Promoting Interoperability (a)	14,500
Number of Groups to Submit Promoting Interoperability (b)	4,089

Burden and Respondent Description	Burden Estimate
Number of Subgroups to Submit Promoting Interoperability (c)	20
Total Respondents (d) = (a) + (b) + (c)	18,609
Annual Hours Per Respondent (e)	2.70
Total Annual Hours (f) = (d) [×] (e)	50,244
Cost per Respondent to Submit Promoting Interoperability Data at Computer System Analyst's Labor Rate of \$106.54/hr (g) = (e) [×] \$106.54/hr	\$287.66
Total Annual Cost (h) = (d) [×] (e)	\$5,353,065

iii. Burden Estimate for the Submission of Improvement Activities Data

As established in the CY 2017 Quality Payment Program final rule, for the improvement activities performance category, we codified at § 414.1380(b)(3)(i) that individual MIPS eligible clinicians participating in APMs (as defined in section 1833(z)(3)(C) of the Act) for a performance period will earn at least 50 percent for the improvement activities performance category (81 FR 30132). We also stated that MIPS eligible clinicians participating in an APM for a performance period may receive an improvement activity score higher than 50 percent (81 FR 30132). To provide clarity for APM participants not scored under the APP, we revised § 414.1380(b)(3)(i) to state that a MIPS eligible clinician participating in an APM receives an improvement activities performance category score of at least 50 percent. To receive this credit, MIPS eligible clinicians in APMs must attest to having completed an improvement activity or submit data for the quality and Promoting Interoperability performance categories in order to receive such credit (88 FR 79365 through 79367). As noted in Table 2, we assume MIPS APM participants who are MIPS eligible participate in MIPS at the individual or group reporting level.

As represented in Table 20, based on CY 2022 performance period/2024 MIPS payment year, we estimate that a total of 38,433 respondents consisting of 29,017 individual clinicians and 9,396 groups, and 20 subgroups will submit improvement activities during the CY 2025 performance period/2027 MIPS payment year.

We estimate that it would take 5 minutes (0.083 hours) for a computer system analyst at a labor rate of \$106.54/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 20, we estimate an annual burden of 3,190 hours (38,433 responses × 0.083 hr/response) at a cost of \$339,748 (38,433 respondents × \$8.84/response) for the CY 2025 performance period/2027 MIPS payment year.

Table 20: Estimated Burden for Improvement Activities Data 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 2025 Performance Period (a)	38,433
Total Annual Hours Per Respondent (b)	0.083

Burden and Respondent Descriptions	Burden Estimate
Total Annual Hours (c) = (a) [×] (b)	3,190
Cost per Respondent to Submit Improvement Activities Data at Computer System Analyst's Labor Rate of \$106.54/hr (d) = (b) [×] \$106.54/hr	\$8.84
Total Annual Cost (e) = (a) [×] (d)	\$339,748

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 2025 performance period/2027 MIPS payment year, we estimate that we will receive 15 nominations of new or modified activities which will be evaluated for the Improvement Activities Under Consideration list for possible inclusion in the CY 2025 Improvement Activities Inventory.

As shown in Table 21, we estimate that it would take 2.8 hours at \$129.28/hr for a medical and health services manager or equivalent and 1.6 hours at \$291.64/hr for a physician to nominate an improvement activity. In aggregate, we estimate an annual information collection burden of 66 hours (15 nominations × 4.4 hr/nomination) at a cost of \$12,429 (15 × [(2.8 hr × \$129.28/hr) + (1.6 hr × \$291.64/hr)]) for the CY 2025 performance period/2027 MIPS payment year.

Table 21: Burden Estimates for Nomination of Improvement Activities

Burden and Respondent Descriptions	Burden Estimate
# of Nominations of New IAs (a)	15
# of Hours Per Medical and Health Services Manager (b)	2.8
# of Hours Per Physician (c)	1.6
Annual Hours Per Respondent (d)= (b) + (c)	4.4
Total Annual Hours (e) = (a) [×] (d)	66
Cost to Nominate an IA (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) (f) = (b) × \$129.28/hr	\$361.98
Cost to Nominate an IA (at Physician's Labor Rate of \$291.64/hr) (g) = (c) × \$291.64/hr	\$466.62
Total Annual Cost Per Respondent (h) = (f) + (g)	\$828.60
Total Annual Cost (i) = (a) [×] (h)	\$12,429

l. Nomination of MVPs

We have previously established MVP development criteria for interested parties submitting an MVP candidate for inclusion in the MVP Inventory (85 FR 84849 through 84856 and 87 FR 70035 through 70037). As new 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 2025 performance period/2027 MIPS payment year, we estimate that we will receive 10 MVP nominations, and we estimate that 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 \$129.28/hr for a medical and health services manager or equivalent and 4.8 hours at \$291.64/hr for a physician to nominate an MVP. As shown in Table 22, we estimate an annual burden of 120 hours (10 nominations × 12 hr/nomination) at a cost of \$23,307 (10 × [(7.2 hr × \$129.28/hr) + (4.8 hr × \$291.64/hr)]).

Table 22: Estimated Burden for Nomination of MVPs

Burden and Respondent Descriptions	Burden Estimate
# of Nominations of New MVPs (a)	10
# 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)	120
Cost to Nominate an MVP (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) (f) = (b) [×] \$129.28/hr	\$930.82
Cost to Nominate an MVP (at Physician's Labor Rate of \$291.64/hr) (g) = (c) [×] \$291.64/hr	\$1399.87
Total Annual Cost Per Respondent (h) = (f) + (g)	\$2,330.69
Total Annual Cost (i) = (a) [×] (h)	\$23,307

m. 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 individual eligible clinician level, the burden of Partial QP election will be incurred by the individual 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 23, based on the number of QP elections submitted for the CY 2023 performance period/2025 MIPS payment year, we estimate that a total of 18 APM respondents (representing 333 distinct national provider identifiers (NPIs) and 363 distinct TIN/NPIs) will make the election to participate as a Partial QP in MIPS. We estimate it will take the APM Entity representative 15 minutes (0.25 hr) at a rate of \$106.54/hr, resulting in a cost of \$26.64, to make this election. We do not estimate any Partial QP elections at the eligible individual clinician level, as no individual eligible clinicians elected to report as partial QPs for the CY 2023 performance period/2025 MIPS payment year. In aggregate, we estimate an annual burden of 5

hours (18 Partial QP elections × 0.25 hr/election) and \$480 (18 Partial QP elections × \$26.64/election).

Table 23: Estimated Burden for Partial QP Election

Burden and Respondent Descriptions	Burden Estimate
Total # of Respondents Making Partial QP Election (Representing 333 Distinct NPIs and 363 Distinct TIN/NPIs) (a)	18
Total Hours Per Respondent to Elect to Participate as Partial QP (b)	0.25
Total Annual Hours (c) = (a) [×] (b)	5
Cost per Respondent at Labor Rate for Computer Systems Analyst at \$106.54/hr (d) = (b) [×] \$106.54/hr	\$26.64
Total Annual Cost (e) = (a) [×] (d)	\$480

n. 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.

As shown in Table 24, based on the historical number of requests, we estimate that for the 2025 QP performance period, 10 payer-initiated requests for Other Payer Advanced APM determinations will be submitted (2 Medicaid payers, 6 Medicare Advantage Organizations, and 2 remaining other payers). We estimate it would take 10 hours at \$106.54/hr for a computer system analyst, resulting in a cost of \$1,065.40 per submission. In aggregate, we estimate an annual burden of 100 hours (10 submissions × 10 hr/submission) and \$10,654 (10 submissions × \$1,065.40/submission) for the CY 2025 performance period/2027 MIPS payment year.

Table 24: Estimated Burden for Other Payer Advanced APM Identification Determinations: Payer-Initiated Process

Burden and Respondent Descriptions	Burden Estimate
Total # of Other Payer Payment Arrangements (2Medicaid, 6 Medicare Advantage Organizations, 2 Remaining Other Payers) (a)	10
Total Annual Hours Per Other Payer Payment Arrangement (b)	10
Total Annual Hours (c) = (a) [×] (b)	100
Cost per Respondent at Labor Rate for Computer Systems Analyst at \$106.54/hr (d) = (b) [×] \$106.54/hr	\$1,065.40
Total Annual Cost (e) = (a) [×] (d)	\$10,654

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.

As shown in Table 25, we estimate 10 other payer arrangements will be submitted by APM Entities and eligible Other Payer Advanced APM determinations in the CY 2025 performance period/2027 MIPS payment year. We estimate it would take 10 hours at \$106.54/hr for a computer system analyst, resulting in a cost of \$1,065.40 per submission. In aggregate, we estimate an annual burden of 100 hours (10 submissions × 10 hr/submission) at a cost of \$10,654 (10 submissions × \$1,065.40/submission) for the CY 2025 performance period/2027 MIPS payment year.

Table 25: Estimated Burden for Other Payer Advanced APM Identification Determinations: Eligible Clinician-Initiated Process

Burden and Respondent Descriptions	Burden Estimate
Total # of Other Payer Payment Arrangements from APM Entities and Eligible Clinicians	10
Total Annual Hours Per Other Payer Payment Arrangement (b)	10
Total Annual Hours (c) = (a) [×] (b)	100
Cost per Respondent at Labor Rate for Computer Systems Analyst at \$106.54/hr (d) = (b) [×] \$106.54/hr	\$1,065.40
Total Annual Cost (e) = (a) [×] (d)	\$10,654

iii. 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 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 shown in Table 26, we assume that 10 APM Entities, 100 TINs, and 10 eligible clinicians will submit data for QP determinations under the All-Payer Combination Option in CY 2025 performance period/2027 MIPS payment year. We estimate it will take the APM Entity representative, TIN representative, or eligible clinician 5 hours at \$129.28/hr for a medical and health services manager to complete this submission, resulting in a cost of \$646.40 per submission. In aggregate, we estimate an annual burden of 600 hours (120 submissions × 5 hr) at a cost of \$77,568 (120 submissions × \$646.40/submission).

Table 26: Estimated Burden for the Submission of Data for All-Payer QP Determinations

Burden and Respondent Descriptions	Burden Estimate
Total # of APM Entities Submitting Data for All-Payer QP Determinations (a)	10
Total # of TINs Submitting Data for All-Payer QP Determinations (b)	100
Total # of Eligible Clinicians Submitting Data for All-Payer QP Determinations (c)	10
Total # of Respondents (d) = (a) + (b) + (c)	120
Hours Per respondent QP Determinations (e)	5
Total Annual Hours (f) = (d) [×] (e)	600
Cost per Respondent at Medical and Health Services Manager Labor Rate of \$129.28/hr (g) = (e) [×] \$129.28/hr	\$646.40
Total Annual Cost (h) = (d) [×] (g)	\$77,568

o. Burden Estimate for Voluntary Participants Election to Opt-Out of Performance Data Display 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 of the low-volume criteria, but not all three, 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 2025 performance period/2027 MIPS payment year.

For the CY 2025 performance period/2027 MIPS payment year, we continue to estimate that 38 clinicians and groups will voluntarily opt-out of public reporting on Compare Tools.

As shown in Table 27, we estimate that it would take 0.25 hours at \$106.54/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 × 0.25 hr/request) at a cost of \$1,012 (38 requests × \$26.64/request).

Table 27: Estimated Burden for Voluntary Participants Election to Opt-Out of Performance Data Display on Compare Tools

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
Cost Per Request at Labor Rate for a Computer Systems Analyst (d) = (b) [×] \$106.54/hr	\$26.64
Total Annual Cost (e) = (a) [×] (d)	\$1,012

p. Burden Estimate Summary

Table 28 below provide summaries of all burden estimates for each of the information collections included in this PRA for the CY 2025 performance period/2027 MIPS payment year. With respect to the PRA, the CY 2025 PFS final rule does not impose any non-labor costs.

Table 28: CY 2025 Performance Period/2027 MIPS Payment Year Burden Summary

Regulation Section(s) Under Title 42 of the CFR	Table Number	Number of Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost (\$/hr)	Total Cost (\$)
§414.1400 (Simplified Qualified Registry Self- Nomination)	3	74	74	0.5	37	106.54	3,942
§414.1400 (Full Qualified Registry Self- Nomination)	4	14	14	2	28	106.54	2,983
§414.1400 (Simplified QCDR Self-Nomination)	5	41	41	10	410	106.54	43,681
§414.1400 (Full QCDR Self-Nomination)	6	11	11	12	132	106.54	14,063
§414.1400 (Third Party Intermediary Plan Audits)	8	42	42	Varies (see Table 8)	263	106.54	28,020
Open Authorization Credentialing and Token Request Process	9	15	15	2	30	106.54	3,196
§414.1325 and 414.1335 (QPP Identity Management Application Process)	10	6,237	6,237	1	6,237	106.54	664,490
§414.1325 and 414.1335 [(Quality Performance Category) Clinicians Using the Claims Collection Type]	11	12,197	12,197	14.2	173,197	Varies (see Table 11)	20,209,087
§414.1325 and 414.1335 [(Quality Performance Category) Clinicians Using the MIPS CQM and QCDR Collection Type]	12	17,008	17,008	9.083	154,484	Varies (see Table 12)	18,521,372
§414.1325 and 414.1335 [(Quality Performance Category) Clinicians Using the eCQM Collection Type]	13	27,179	27,179	8.0	217,432	Varies (see Table 13)	26,461,474

Regulation Section(s) Under Title 42 of the CFR	Table Number	Number of Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost (\$/hr)	Total Cost (\$)
§ 414.1365 MVP Registration	14	6,285	6,285	0.25	1,571	106.54	167,432
§ 414.1365 Subgroup Registration	15	20	20	0.5	10	106.54	1,065
§ 414.1365 MVP Quality Performance Category Submission	16	6,285	6,285	Varies	40,193	Varies (see Table 16)	4,807,307
[(Quality Performance Category) Call for Quality Measures]	17	16	16	5.5	88	Varies (see Table 17)	19,430
§414.1375 and 414.1380[(Promoting Interoperability Performance Category) Reweighting Applications for MIPS Performance Categories]	18	3,297	3,297	0.25	824	106.54	87,832
§414.1375 [(Promoting Interoperability Performance Category) Data Submission]	19	18,609	18,609	2.70	50,244	106.54	5,353,065
§414.1360 [(Improvement Activities Performance Category) Data Submission]	20	38,433	38,433	0.083	3,190	106.54	339,748
§414.1360 [(Improvement Activities Performance Category) Nomination of Improvement Activities]	21	15	15	4.4	66	Varies (see Table 22)	12,429
Nomination of MVPs	22	10	10	12	120	Varies (see Table 23)	23,307
§414.1430 [Partial Qualifying APM Participant (QP) Election]	23	18	18	0.25	5	106.54	480

Regulation Section(s) Under Title 42 of the CFR	Table Number	Number of Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Labor Cost (\$/hr)	Total Cost (\$)
§414.1440 [Other Payer Advanced APM Identification Determinations: Payer-Initiated Process]	24	10	10	10	100	106.54	10,654
§414.1445 [Other Payer Advanced APM Identification Determinations: Eligible Clinician-Initiated Process]	25	10	10	10	100	106.54	10,654
§414.1440 [Submission of Data for All-Payer QP Determinations]	26	120	120	5	600	129.28	77,568
§414.1395 [(Physician Compare) Voluntary Participants Election to Opt-out of Performance Data Display on Compare Tools]	27	38	38	0.25	10	106.54	1,012
Total	n/a	135,984	135,984	Varies	649,371	Varies	76,864,292

q. Information Collection Instruments/Instructions

We have included a list of the Appendices that we submitted in the CY 2025 final rule MIPS PRA package. We have revised Appendices A through K based on internal review feedback. We have replaced the previous Appendix L, 2023 MVP Registration Form, with a new Appendix L titled 2024 MVP Registration Form.

Appendix A (See Tables 3, 4, 5, 6, 7, and 8): 2025 MIPS QCDR and Registry Self-nomination User Guide (Revised)

Appendix B (See Table 24): 2025 Submission Form for Other Payer Requests for Other Payer Advanced Alternative Payment Model Determinations (Payer Initiated Submission Form) (Revised)

Appendix C (See Table 25): 2025 Submission Form for Eligible Clinician and APM Entity Requests for Other Payer Advanced Alternative Payment Model Determinations (Eligible Clinician Initiated Submission Form) (Revised)

Appendix D (See Table 26): 2025 Submission Form for Requests for Qualifying Alternative Payment Model Participant (QP) Determinations under the All-Payer Combination Option (Revised)

Appendix E (See Table 17): Measures under Consideration 2024 Data Template for Candidate Measures (Revised)

Appendix F (See Table 17): 2024 Peer Reviewed Journal Article Requirement Template (Revised)

Appendix G (See Table 21): Improvement Activities Performance Category, 2025 Call for Activities Submission Form (Revised)

Appendix H (See Table 18): 2024 MIPS Promoting Interoperability Hardship Exception Application Guide (Revised)

Appendix I (See Table 16): 2024 MIPS Extreme and Uncontrollable Circumstances Exception Application Guide (Revised)

Appendix J (See Table 22): 2025 MVP Candidates: Instructions and Template (Revised)

Appendix K (See Table 23): 2024 Partial QP Election Form (for submission in CY 2025) (Revised)

Appendix L (See Tables 14 and 15): 2024 MVP Registration Form (The MVP registration collection changed from submitting an Excel file via email in 2023 to an online registration form for 2024.)

13. Capital Costs

There are no anticipated capital costs associated with these information collections.

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 started 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 \$64.06/hr (\$64.06 plus 100% fringe benefit of \$64.06 = \$128.12/hr) for a GS-13 Step 5 to nominate an improvement activity for a total cost of \$384.36 (3 hr × \$128.12/hr) per activity.

15. Program and Burden Changes

The following changes are associated with our December 9, 2024 (89 FR 97710) CY 2025 PFS final rule (CMS-1807-F; RIN 0938-AV33) and adjustments to the currently approved burden as a result of updated data sources and assumptions. Table 29 below, illustrates both types of changes. The same for Table 31 (below) except that Table 31 also provides a side-by-side summary of this iteration's rule and non-rule related changes.

Overall, this iteration proposes to decrease the current estimates by minus 55,241 responses (from 191,225 to 135,984 responses or 2,506 – 57,747 responses) and minus 78,771 hours (from 728,142 to 649,371 hr or -71,201 – 7,570 hr).

We have also revised Appendices A through K and replaced active Appendix L (2023 MVP Registration Form) with a new Appendix L entitled, “2024 MVP Registration Form.” The MVP registration collection changed from submitting an Excel file via email in 2023 to an online registration form for 2024.

Table 29: Change in Burden for CY 2025 Performance Period/2027 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	135,984	+2,506	0	133,478 (191,225 - 57,747)	191,225
Total Time (hr)	649,371	-7,570	0	656,941 (728,142 - 71,201)	728,142
Total Cost (\$)	76,864,292	-913,176	0	77,777,468 (85,908,261 - 8,130,793)	85,908,261

* CY 2024 Performance Period/2026 MIPS Payment Year Burden Summary

As shown above in Table 29, the increase of 2,506 responses, decrease of 7,570 hours, and decrease \$913,176 is due to new statutes (Column B). The changes are associated with (1) the addition of six new MVPs to the existing MVP Inventory resulting in an increase in the number of respondents registering for MVP reporting, (2) an increase in the number of respondents submitting for the quality performance category of MVPs, and (3) a decrease in the number of respondents submitting for the Medicare Part B Claims, and (4) a decrease in MIPS CQM, 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 details the changes in burden for each information collection. Table 31: identifies each of the series 30 tables, identifies the changes, and sets forth the reason for each change.

Table 30A: Burden Reconciliation for Simplified 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	84	1	84	0.5	42	106.54	4,475
Requested (See Table 3)	74	1	74	0.5	37	106.54	3,942
Adjustment	-10	No change	-10	n/a	-5	No change	-533

Table 30B: Burden Reconciliation for Full 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	27	1	27	2	54	106.54	5,753
Requested (See Table 4)	14	1	14	2	28	106.54	2,983
Adjustment	-13	No change	-13	No change	-26	No change	-2,770

Table 30C: Burden Reconciliation for Simplified 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	44	1	44	9.5	418	106.54	44,534
Requested (See Table 5)	41	1	41	10	410	106.54	43,681
Adjustment	-3	No change	-3	+0.5	-8	No change	-853

Table 30D: Burden Reconciliation for Full 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	12	1	12	11.5	138	106.54	14,703
Requested (See Table 6)	11	1	11	12	132	106.54	14,063
Adjustment	-1	No change	-1	+0.5	-6	No change	-640

Table 30E: 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	126	1	126	Varies	499	106.54	53,164
Requested (See Tables 7 and 8)	42	1	42	Varies	263	106.54	28,021
Adjustment	-84	No change	-84	Varies	-236	No change	-25,143

Table 30F: 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	6,500	1	6,500	1	6,500	106.54	692,510
Requested (See Table 10)	6,237	1	6,237	1	6,237	106.54	664,490
Adjustment	-263	No change	-263	No change	-263	No change	-28,020

Table 30G: 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	13,413	1	13,413	14.2	190,465	Varies	22,223,866
Requested (See Table 11)	12,197	1	12,197	14.2	173,197	Varies	20,209,087
Adjustment	-1,216	No change	-1,216	No change	-17,268	No change	-2,014,779

Table 30H: 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	16,632	1	16,632	9.083	151,068	Varies	18,111,915
Requested (See Table 12)	17,008	1	17,008	9.083	154,484	Varies	18,521,372
Adjustment	+376	No change	+376	No change	+3,416	No change	+409,457

Table 30I: 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	28,714	1	28,714	8	229,712	Varies	27,955,950
Requested (See Table 13)	27,179	1	27,179	8	217,432	Varies	26,461,474
Adjustment	-1,535	No change	-1,535	No change	-12,280	No change	-1,494,476

Table 30J: 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	9,585	1	9,585	0.25	2,396	106.54	255,344

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 (\$)
Requested (See Table 14)	6,285	1	6,285	0.25	1,571	106.54	167,432
Adjustment	-3,300	No change	-3,300	No change	-825	No change	-87,912

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	9,585	1	9,585	Varies	61,662	Varies	7,372,174
Requested (See Table 16)	6,285	1	6,285	Varies	40,193	Varies	4,807,307
Adjustment	-3,300	No change	-3,300	No change	-21,469	No change	-2,564,867

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	31	1	31	5.5	171	Varies	37,645
Requested (See Table 17)	16	1	16	5.5	88	Varies	19,430
Adjustment	-15	No change	-15	No change	-83	No change	-18,215

Table 30M: Burden Reconciliation for Reweighting Applications for MIPS 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	29,227	1	29,227	0.25	7,307	106.54	778,607
Requested (See Table 18)	3,297	1	3,297	0.25	7,307824	106.54103.40	87,832
Adjustment	-25,930	No change	-25,930	No change	-6,843	No change	-690,775

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	25,990	11	25,990	2.702.70	70,173	106.54	7,476,283
Requested (See Table 19)	18,609	1	18,609	2.70	50,244	106.54	5,353,065
Adjustment	-7,381	No change	-7,381	No change	-19,929	No change	-2,123,218

Table 30O: 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	50,289	1	50,289	0.083	4,174	106.54	444,555
Requested (See Table 20)	38,433	1	38,433	0.083	3,190	106.54	339,748
Adjustment	-11,856	No change	-11,856	No change	-984	No change	-104,807

Table 30P: 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	287	1	287	0.25	72	106.54	7,646
Requested (See Table 24)	18	1	18	0.25	5	106.54	480
Adjustment	-269	No change	-269	No change	-67	No change	-7,166

Table 30Q: 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	106.54	15,981
Requested (See Table 25)	10	1	10	10	100	106.54	10,654
Adjustment	-5	No change	-5	No change	-50	No change	-5,327

Table 30R: 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	106.54	15,981
Requested (See Table 26)	10	1	10	10	100	106.54	10,654
Adjustment	-5	No change	-5	No change	-50	No change	-5,327

Table 30S: 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	129.28	356,166

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 (\$)
Requested (See Table 27)	120	1	120	5	600	129.28	77,568
Adjustment	-431	No change	-431	No change	-2,155	No change	-278,598

Table 31 provides the reasons for changes in the estimated burden for finalized policies and information collections for the CY 2025 performance period/2027 MIPS payment year set forth in the CY 2025 PFS final rule. We have divided the reasons for the change in burden into those related to newly finalized policies and those related to updated data and methods for the CY 2025 performance period/2027 MIPS payment year burden set forth in the CY 2024 PFS final rule.

Table 31: Reasons for Change in Burden Compared to the Currently Approved CY 2024 Information Collection Burden

Table in Information Collection	Changes in Burden Due to CY 2025 Final Rule Policies	Adjustments in Burden Continued from CY 2024 PFS Final Rule Policies Due to Revised Methods or Updated Data
Table 30A: Simplified Qualified Registry Self-Nomination and Other Requirements	None	Decrease of 10 respondents and 5 hours due to updated data.
Table 30B: Full Qualified Registry Self-Nomination and Other Requirements	None	Decrease of 13 respondents and 26 hours due to updated data.
Table 30C: Simplified QCDR Self-Nomination and Other Requirements	None	Decrease of 3 respondents and decrease of 8 hours due to updated data.
Table 30D: Full QCDR Self-Nomination and Other Requirements	None	Decrease of 1 respondent and decrease of 6 hours due to updated data.
Table 30E: Third Party Intermediary Plan Audits	None	Decrease of 84 respondents and 236 hours due to updated data.
Table 30F: Quality Payment Program Identity Management Application Process	None	Decrease of 263 respondents and 263 hours due to updated data.
Table 30G: Quality Performance Category Claims Collection Type	Decrease in number of 542 respondents and 7,697 hours due to the estimated increase in the number of respondents submitting for the MVP quality performance category via the claims collection type due to 6 new MVPs.	Decrease of 674 respondents and 9,571 hours due to updated data.

Table in Information Collection	Changes in Burden Due to CY 2025 Final Rule Policies	Adjustments in Burden Continued from CY 2024 PFS Final Rule Policies Due to Revised Methods or Updated Data
Table 30H: Quality Performance Category QCDR/MIPS CQM Collection Type	Decrease in number of 756 respondents and 6,866 hours due to the estimated increase in the number of respondents submitting for the MVP quality performance category via the QCDR and MIPS CQM collection type due to 6 new MVPs.	Increase of 1,132 respondents and 10,282 hours due to updated data.
Table 30I: Quality Performance Category eCQM Collection Type	Decrease of 1,208 respondents and 9,664 hours due to the estimated increase in the number of respondents submitting for the MVP quality performance category via the eCQM collection type due to 6 new MVPs.	Decrease of 327 respondents and 2,616 hours due to updated data.
Table 30J: MVP Registration	Increase of 2,506 respondents and 626 hours due to 6 new MVPs.	Decrease of 5,806 respondents and 1,451 hours due to updated data.
Table 30K: MVP Quality Performance Category Submission	Increase of 2,506 respondents and 16,031 hours due to 6 new MVPs.	Decrease of 5,806 respondents and 37,500 hours due to updated data.
Table 30L: Call for Quality Measures	None	Decrease of 15 respondents and 83 hours due to updated data.
Table 30M: Reweighting Applications for MIPS Performance Categories	None	Decrease of 25,930 respondents and 6,483 hours due to updated data.
Tables 30N: Promoting Interoperability Performance Category Data Submission	None	Decrease of 7,381 respondents and 19,929 hours due to updated data.
Table 30O: Improvement Activities Submission	None	Decrease of 984 respondents and 104,807 hours due to updated data.
Table 30P: Partial QP Election	None	Decrease of 67 respondents and 7,166 hours due to updated data.
Table 30Q: Other Payer Advanced APM Identification: Other Payer Initiated Process	None	Decrease of 50 respondents and 5,327 hours due to updated data.
Table 30R: Other Payer Advanced APM Identification: Eligible Clinician Initiated Process	None	Decrease of 50 respondents and 5,327 hours due to updated data.
Table 30S: Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option	None	Decrease of 2,155 respondents and 278,598 hours due to updated data.

Table 32 below provides a snapshot of the estimated burden described above in Table 28. Additionally, we have included the estimated total number of unique respondents that will submit data for the quality, Promoting Interoperability, and improvement activity performance categories in the CY 2025 performance period/2027 MIPS payment year. We assume the 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. With respect to the PRA, the estimated burden in the CY 2025 PFS final rule does not impose any non-labor costs.

Table 32: Quality Payment Program Annual Requirements and Burden Regulation Section(s) Under Title 42 of the CFR

Also see Table 29 column A.

Burden Category	Burden Estimate
Total # of Responses	135,984
Time per Response (Hours)	Varies
Total Annual Time (Hours)	649,371
Labor Cost (\$/hr)	Varies
Total Cost (\$)	76,864,292

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 <https://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/>. On these websites, 2017, 2018, 2019, 2020, 2021, and 2022 Quality Payment Program performance information has been made available for public review. Additionally, QPP participation and performance data are released annually at <https://qpp.cms.gov/resources/performance-data>. Quality Payment Program resources for the 2018, 2019, 2020, 2021, and 2022 performance periods are 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 and OMB control number will appear on the first page of all web-based data collection forms.