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Comparison of 2022 and 2023 MIPS Requirements

Policy	2022	2023
Performance Threshold (PT)	Performance Threshold is set at **75 points**. Additional performance threshold set at **89 points** for exceptional performance.	Performance Threshold is set at **75 points**. No exceptional performance threshold
Payment Adjustments	**+/- 9% plus additional bonus for exceptional performance** Positive payment adjustments will be multiplied by a scaling factor to ensure budget neutrality- maximum positive adjustment will be below 9%	**+/- 9%** **No** bonus for exceptional performance Positive payment adjustments will be multiplied by a scaling factor to ensure budget neutrality- maximum positive adjustment will be below 9%
Category Weights for Non-Patient Facing Pathologists	For large practices of 16+ clinicians • Quality: **85%** • Improvement Activities: **15%** • Promoting Interoperability: 0% • Cost: 0% unless the CMS can calculate it for your practice. • For small practices of ≤15 clinicians: • Quality: **50%** • Improvement Activities: **50%** • Promoting Interoperability: 0% • Cost: 0% unless the CMS can calculate it for your practice.	Same as 2022
Data Completeness Minimum	Report at least 70% of all denominator-eligible cases	Same as 2022 For **2024** and **2025**, data completeness will increase to **75%**

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Quality Measure Scoring	• Report on a minimum of 6 measures with one being a high priority measure
	• 20 case minimum for each measure
	
	• Measures with a benchmark will receive 3-10 points
	   ◦ Topped out measures will receive 3-7 points
	• Measures that don't meet the case minimum will receive 3 points
	• Measures that don't meet data completeness will receive 0 points for large practices and 3 points for small practices
		• Report on a minimum of 6 measures with one being a high priority measure
		• 20 case minimum for each measure
		
		• Measures with a benchmark will receive **1-10 points**
		   ◦ Topped out measures will receive **1-7 points**
		• Measures without a benchmark will receive 0 points for large practices and 3 points for small practices
		• Measures that don't meet the case minimum will receive 0 points for large practices and 3 points for small practices
		• Measures that don't meet data completeness will receive 0 points for large practices and 3 points for small practices

Improvement Activities	Report at least 1 high-weighted (40 points) or 2 medium-weighed (20 points) activities, undertaken for a minimum of 90 consecutive days At least 50% of the clinicians in a group must attest to the same Improvement activity • Clinicians do not need to complete the activity at the same time • Clinicians do not need to do the same project but must attest to the same IA Retain documentation of each activity for 10 years	Same as 2022 IA_PSPA_20, covering leadership engagement in implementing practice improvement changes, has been removed Practices who previously reported IA_PSPA_20 should report IA_PSPA_19, which now includes language covering leadership engagement activities

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Policy	2022	2023
Facility-Based Scoring	**Individual:** MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period. Clinicians must have at least a single service billed with the POS code used for the inpatient hospital (21) or emergency room (23). **Group:** A facility-based group is one in which 75% or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals. Facility-based measurement is automatically applied to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who have a higher combined Quality and Cost score. There are no data submission requirements for the Quality and Cost performance categories for individual clinicians and groups in facility-based measurement. An individual or group must submit data in the **Improvement Activities** performance category to maximize MIPS score under facility-based measurement.	Same as 2021.

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Measure	2022	2023
CAP 22	Previously included gastric and urinary bladder carcinoma biopsies in Denominator	**NEW: Denominator Exclusion** Cases whose turnaround time is captured by other measures: biopsies for gastritis and urinary bladder carcinoma (ICD-10 K29.30, K29.31, K29.40, K29.41, K29.50, K29.51, K29.60, K29.61, K29.70, K29.71, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.8, C67.9)
CAP 39	Previously CAP 36 (no longer in use)	**NEW: High-Risk Human Papillomavirus Status to Inform Patient Prognosis in Oropharyngeal Squamous Cell Carcinoma**
QPP 440	Denominator Note: Only biopsy results should be reported for this measure. Do not include specimens sent for wide local excision or re-excision	**NEW: Denominator Exception** Pathology report for tissue specimens produced from wide local excisions or re-excisions (M1166)
QPP 491	Previously CAP 33 (no longer in use)	**NEW: Converted to MIPS CQM QPP 491** Now publicly available for any pathologist to use. **NO** changes to measure specifications.

CAP 35 & CAP 37	**No longer in use.**

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