Quality Payment PROGRAM

Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) Final Rule: Quality Payment Program (QPP) Fact Sheet

Table of Contents

QPP Policy Overview

In the CY 2025 Medicare Physician Fee Schedule (PFS) Final Rule, we've kept our focus on the future of MIPS by continuing the development and maintenance of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs). Additionally, we finalized the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set, offering clinicians who participate in a MIPS APM a more robust opportunity for MIPS quality measurement. We also updated the MIPS measure/activity inventories and scoring methodologies to provide all clinicians with the opportunity to successfully participate in MIPS. Finally, we finalized proposals intended to maintain stability within the MIPS program through the established performance threshold and data completeness criteria.

Policy Highlights

(Note this isn't a comprehensive list of all QPP finalized policies finalized in the CY 2025 Medicare PFS Final Rule.)

Maintaining Stability

- We're maintaining our current performance threshold policies, which will leave the **performance threshold set at 75 points** for the CY 2025 performance period/2027 MIPS payment year.
- We're also maintaining the 75% data completeness criteria threshold through the 2028 performance period/2030 MIPS payment year.

MVP Development and Maintenance

- We finalized **6 new MVPs** that will be available beginning with the 2025 performance period related to **ophthalmology**, **dermatology**, **gastroenterology**, **pulmonology**, **urology**, and **surgical care**.
- We finalized **limited modifications to the previously finalized MVPs, including the consolidation of 2 neurology-focused MVPs into a single neurological MVP**.

For more information on the MVPs finalized in this rule, review the 2025 Finalized MVPs Guide (PDF).

APP Plus Quality Measure Set

- We finalized, with modification, an **additional quality measure set under the APP called the APP Plus quality measure set.**
    - The APP Plus quality measure set will be an optional quality measure set for MIPS APM participants, except for Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs).
    - The existing APP quality measure set will also continue to be available as an optional quality measure set for MIPS APM participants, except for Shared Savings Program ACOs.

- We finalized that, for Shared Savings Program performance year 2025 and subsequent performance years, Shared Savings Program ACOs will be required to report the APP Plus quality measure set.
    - The existing APP quality measure set will no longer be available to Shared Savings Program ACOs for reporting beginning in performance year 2025.

- The APP Plus quality measure set will be comprised of 11 measures, consisting of the 6 measures in the existing APP quality measure set, 5 of which are Adult Universal Foundation measures, and 5 additional measures from the Adult Universal Foundation measure set. These measures will be incrementally incorporated over time, more gradually than originally proposed. Refer to this section of the policy comparison table for a list of these measures.

- We finalized, with modification, the collection types available for Shared Savings Program ACOs reporting the APP Plus quality measure set:

    - The eCQM and Medicare CQM collection types will be available for the CY 2025 performance period and subsequent performance periods. **Note:** Shared Savings Program ACOs that report eCQMs are eligible to receive the newly finalized complex organization adjustment.

    - The MIPS CQM collection type will be available for 2 additional years (i.e., the CY 2025 and 2026 performance periods/2027 and 2028 MIPS payment years) compared to the original proposal. MIPS CQMs won't be available to Shared Savings Program ACOs reporting the APP Plus quality measure set beginning in the CY 2027 performance period/2029 MIPS payment year.

    - We finalized that beginning with the CY 2025 performance period/2027 MIPS payment year, measures newly incorporated into the APP Plus quality measure set and reported using the Medicare CQM collection type (available only to Shared Savings Program ACOs) will be scored using flat benchmarks for the measures' first 2 performance periods in MIPS.

For more information on the Shared Savings Program's requirement that ACOs report the APP Plus quality measure set, and other policies finalized for the Shared Savings Program, review the Medicare Shared Savings Program Finalized Policies Fact Sheet.

Measure/Activity Inventories and Scoring Methodologies

- We finalized, with modification, the addition of 7 new quality measures.
- We finalized, with modification, the removal of 10 quality measures.
- We finalized substantive changes to 66 quality measures.
- We finalized 6 new episode-based cost measures.
- We finalized revisions to 2 existing episode-based cost measures.
- We're **revising our cost measure scoring methodology** to assess clinician cost of care more appropriately.

- We're **removing the 7-point cap for scoring certain topped out quality measures** (defined through annual rulemaking) in specialty sets with limited measures. (Review the measures finalized to receive defined topped out measure benchmarks in this FAQ.)
- We're changing our policy governing our treatment of multiple data submissions received for the Promoting Interoperability performance category.
- We're **removing improvement activity weighting** and streamlining the reporting requirements for the performance category.
- We finalized **minimum criteria for a qualifying data submission (i.e., eligible for scoring)** in the quality, improvement activities, and Promoting Interoperability performance categories.

QPP Policy Comparison Table:
Current Policies vs. Finalized Policies

- MIPS Overview
- Advanced APMs Overview

Appendices

- Appendix A: Previously Finalized Policies for the 2025 Performance Period
- Appendix B: Quality Measures Previously Finalized for the 2025 Performance Period and Future Years
- Appendix C: Quality Measures Previously Finalized for Removal in the 2025 Performance Period and Future Years
- Appendix D: New Quality Measures Finalized for the 2025 Performance Period and Future Years
- Appendix E: Quality Measures Finalized for Removal in the 2025 Performance Period and Future Years
- Appendix F: New Improvement Activities Finalized for the 2025 Performance Period and Future Years
- Appendix G: Improvement Activities Finalized for Modification in the 2025 Performance Period and Future Years
- Appendix H: Improvement Activities Finalized for Removal in the 2025 Performance Period and Future Years
- Appendix I: Improvement Activities Finalized for Removal in the 2026 Performance Period and Future Years

The 2025 Finalized MVPs Guide (PDF) documents information about new MVPs and changes to previously finalized MVPs.

The Medicare Shared Savings Program Finalized Policies Fact Sheet documents information about proposals specific to Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs).

MIPS Overview

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

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

Refer to the 2025 Finalized MVPs Guide (PDF) for information about the new and modified MVPs finalized for the 2025 performance period.

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Performance Category			
Quality Measures	**Quality Measure Inventory** There are 198 quality measures available for the 2024 performance period, excluding Qualified Clinical Data Registry (QCDR) measures which are approved outside the rulemaking process and aren't included in this total.	**Quality Measure Inventory** We finalized a **total of 195 quality measures** for the 2025 performance period. Note that QCDR measures are approved outside the rulemaking process and aren't included in this total. These policies reflect: • **Addition of 7 quality measures**. We didn't finalize the addition of the Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer and Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer measures. (See Appendix D). • **Removal of 10 quality measures** from the MIPS quality measure inventory. (See Appendix E). We didn't finalize the removal of Q144:	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		Oncology: Medical and Radiation – Plan of Care for Pain. • Substantive changes to 66 existing quality measures. Please refer to Appendix B for new measures previously finalized for reporting beginning in the 2025 performance period and Appendix C for measures previously finalized for removal in the 2025 performance period and future years.	
Quality Measures	**Data Completeness** The data completeness threshold for electronic clinical quality measures (eCQMs), MIPS clinical quality measures (CQMs), Medicare CQMs, Medicare Part B claims measures, and QCDR measures is 75% through the 2026 performance period.	**Data Completeness** We finalized our proposal to maintain the data completeness threshold of 75% for the 2027 and 2028 performance periods for all available collection types.	• **Traditional MIPS** • **MVPs** • **APP**
Quality Measures	**Removal Criteria** We previously finalized the following criteria to determine the removal of a quality measure: 1. If the Secretary determines that the quality measure is no longer meaningful, such as measures that are topped out.	**Removal Criteria** We finalized our proposal to codify the quality measure removal criteria in § 414.1330, as outlined below: (c)(1) CMS uses the following criteria to determine the removal of a quality measure:	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	2. If a measure steward is no longer able to maintain the quality measure. 3. If the quality measure reached extremely topped out status. 4. If the quality measure is duplicative. 5. If the quality measure is not updated to reflect current clinical guidelines, which are not reflective of a clinician's scope of practice. 6. If the quality measure is a process measure. a. Prior to removal, consideration will be given to, but will not be limited to the following: i. Whether the removal of the process measure impacts the number of measures available for a specific specialty. ii. Whether the quality measure addresses a priority area. iii. Whether the quality measure promotes positive outcomes in patients. iv. Considerations and evaluation of the measure's performance data.	(i) If the Secretary determines that the quality measure is no longer meaningful, such as measures that are topped out. (ii) If a measure steward is no longer able to maintain the quality measure. (iii) If the quality measure reached extremely topped out status. (iv) If the quality measure does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. (v) If the quality measure is duplicative. (vi) If the quality measure is not updated to reflect current clinical guidelines, which are not reflective of a clinician's scope of practice. (vii) If the quality measure is a process measure. (viii) If the quality measure addresses a measurement gap. (ix) If the quality measure is a patient-reported outcome.	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	v. Whether the quality measure is designated as high priority or not. vi. Whether the quality measure has reached extremely topped out status. 7. If the quality measure does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. a. Other factors for consideration, but not limited to: i. The robustness of the quality measure; ii. Whether the quality measure addresses a measurement gap; iii. Whether the quality measure is a patient-reported outcome; and iv. Consideration of the quality measure in developing MVPs. 8. If the quality measure is not available for MIPS quality reporting by or on behalf of all MIPS eligible clinicians. **Note:** A quality measure can be considered for removal if it meets any of the criteria listed above.	(x) If the quality measure is not available for MIPS quality reporting by or on behalf of all MIPS eligible clinicians. (xi) The robustness of the quality measure. (xii) Consideration of the quality measure in developing MIPS Value Pathways (MVPs). (2) A quality measure that otherwise meets the criteria for removal in paragraph (c)(1) of this section may nonetheless be retained based on the following considerations: (i) Whether the removal of the process measure impacts the number of measures available for a specific specialty. (ii) Whether the quality measure addresses a priority area. (iii) Whether the quality measure promotes positive outcomes in patients. (iv) Whether the quality measure is designated as high priority or not. (v) Whether the quality measure has reached extremely topped out status. (vi) Evaluation of the quality measure's performance data.	

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2025 FINALIZED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr>
<td>Quality Measure Scoring</td>
<td>Topped Out Measure Benchmarks
There is a single benchmark methodology that applies to all topped out measures.</td>
<td>Defined Topped Out Measure Benchmarks
• We finalized our proposal to apply an alternative benchmarking methodology to a subset of topped out measures that belong to specialty sets with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.
• We’ll propose the measures to which this policy will apply during each year in rulemaking.
• Review this FAQ for the measures receiving the defined topped out benchmarks below for the 2025 performance period.
Specifically, we’ll apply the following benchmarks:
<table>
<tr><th>Performance Rate</th><th>Available Points</th></tr>
<tr><td>84-85.9%</td><td>1-1.9</td></tr>
<tr><td>86-87.9%</td><td>2- 2.9</td></tr>
<tr><td>88-89.9%</td><td>3-3.9</td></tr>
<tr><td>90-91.9%</td><td>4-4.9</td></tr>
<tr><td>92-93.9%</td><td>5-5.9</td></tr>
<tr><td>94-95.9%</td><td>6-6.9</td></tr>
<tr><td>96-97.9%</td><td>7-7.9</td></tr>
<tr><td>98-98.9%</td><td>8-8.9</td></tr>
</table>
</td>
<td>• Traditional MIPS
• MVPs
• APP</td>
</tr>
</table>

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		<table><tr><td>99-99.99%</td><td>**9-9.9***</td></tr><tr><td>100%</td><td>**10**</td></tr></table> * We proposed, but aren't finalizing, to omit the possibility of earning 9 – 9.9 points to hold the scoring of these measures to a high standard in achieving maximum points.	
Quality Measure Scoring	**Complex Organization Adjustment** No existing policy.	**Complex Organization Adjustment** We finalized a **complex organization adjustment** to account **for** the organizational complexities facing **APM Entities (including Shared Savings Program ACOs) and virtual groups** when reporting eCQMs. Under this policy: • We'll **add one measure achievement point for each submitted eCQM** for an APM Entity or virtual group that meets data completeness and case minimum requirements. The adjustment may not exceed 10% of the total available measure achievement points in the quality performance category.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measure Scoring	**Flat Benchmarks for Medicare CQMs** No existing policy.	**Flat Benchmarks for Medicare CQMs** We finalized that, beginning with the CY 2025 performance period/2027 MIPS payment year, Medicare CQMs (available only to Shared Savings Program ACOs) will be scored using flat benchmarks for the measures' first 2 performance periods in MIPS. Refer to this FAQ for more specific information.	• **APP**
Quality Data Submission	**Minimum Criteria** We consider any submission received in the QPP submission environment during the designated MIPS submission period as a data submission and assign a score for the submission.	**Minimum Criteria** We finalized that a submission for the quality performance category must include numerator and denominator information for at least one quality measure from the list of MIPS quality measures to be considered a data submission and scored. Data submissions without any scorable data (e.g., practice ID, date, activity ID, measure ID, or CMS Electronic Health Record (EHR) Certification ID (CEHRT ID)) wouldn't satisfy the submission criteria. This policy is intended to mitigate the negative scoring impact on clinicians due to unintentional submissions without data that can be scored, which would override an approved reweighting application or a prior data submission and result in a zero score.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Data Submission	**Data Submission Criteria for the APP Plus Quality Measure Set** No existing policy.	**Data Submission Criteria for the APP Plus Quality Measure Set** We finalized that the APP Plus quality measure set will be optional for MIPS eligible clinicians, groups, and APM Entities, but will be required for Shared Savings Program ACOs. To meet the reporting requirements of the APP Plus quality measure set, all measures in the APP Plus quality measure set for a year must be reported.	• **APP**
Quality Data Submission	**Multiple Submissions** We haven't included language about our process for handling multiple submissions in previous years' rules.	**Multiple Submissions** For multiple quality submissions for an individual clinician, group, subgroup, or virtual group **from different organizations** (for example by a qualified registry and the practice administrator) for the same reporting option, we finalized our proposal to codify our existing process to score each submission received and assign the highest of the scores. In practice, this means we: • **Calculate and score all measures received.** • **Pick the highest scoring measures to contribute to the quality score (as required by the reporting option submitted).**	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		NOTE: We won't combine data submitted by different organizations for different reporting options. Refer to this FAQ for more information. For multiple data submissions received for an individual clinician, group, subgroup, or virtual group **from the same organization** (for example, by 2 practice administrators) for the same reporting option, we finalized our proposal to codify our existing process: • **Score the most recent submission.** • **The new submission will override a previous submission (of the same submission type) from the same organization.** **NOTE:** This policy won't apply to quality data submitted by the same organization through different submission methods, or by the same organization for different reporting or participation options. Refer to this FAQ for examples.	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Performance Category Scoring	**Population Health Measures** **(MVPs: Foundational Layer)** MVP participants can only be scored on the population health measure selected during registration.	**Population Health Measures** **(MVPs: Foundational Layer)** We finalized our proposal to calculate all available population health measures for an MVP participant and apply the highest scoring population health measure to their quality performance category score. • MVP participants will no longer be required to select a population health measure as part of their MVP registration.	• **MVPs**
Alternative Payment Model (APM) Performance Pathway (APP) Measure Set	**Alternative Payment Model (APM) Performance Pathway (APP) Quality Measure Set** MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM may fulfill MIPS reporting by reporting the APP quality measure set. Shared Savings Program ACOs are required to report the APP quality measure set. Beginning with the CY 2025 performance period, MIPS APM participants that report the APP quality measure set must submit: • Diabetes: Hemoglobin A1c (HbA1c) Poor Control (Quality ID #001)	**APP Plus Quality Measure Set:** We finalized our proposal to establish the APP Plus quality measure set as a second distinct measure set under the APP. The APP Plus quality measure set will be an optional measure set for MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM, but will be **required for Shared Savings Program ACOs**. The existing APP quality measure set will remain available and optional for MIPS APM participants **except** for Shared Savings Program ACOs. The **new APP Plus quality measure set**: • Beginning with the **CY 2025 performance period/2027 MIPS payment year**, will initially **consist** of the **5 measures** in the existing APP	• **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	• Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID #134) • Controlling High Blood Pressure (Quality ID #236) These 3 measures can be reported as eCQMs, MIPS CQMs, Medicare CQMs (Shared Savings Program ACOs only), or any combination of these 3 collection types. Additionally, APP reporters must administer: • Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (Quality ID #321) APP reporters are also automatically evaluated on the following administrative claims-based measures: • Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID #479) • Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Quality ID #484)	quality measure set that are also Adult Universal Foundation measures, plus Quality #112: Breast Cancer Screening, for a **total of 6 measures.** • Over subsequent performance periods, will **incrementally incorporate** 5 additional measures (including the **4 remaining measures** from the Adult Universal Foundation not already included in the existing APP quality measure set) **more gradually than proposed** such that Quality #113: Colorectal Cancer Screening will be added beginning with the CY 2026 performance period/2028 MIPS payment year (in addition to incorporating Quality #484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions); Quality #305:itiation and Engagement of Alcohol and Other Drug Dependence Treatment will be added beginning with the CY 2027 performance period/2029 MIPS payment year; and Quality #487: Screening for Social Drivers of Health and Quality #493: Adult Immunization Status, both of which presently do not have an eCQM, will be added beginning with the CY 2028 performance period/2030 MIPS payment year or the CY performance period/payment year that is one year after the eCQM specification becomes available for	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	(As previously finalized, the CY 2024 performance period is the final year for Shared Saving Program ACOs to report the 10 CMS Web Interface measures under the APP.)	each measure, respectively, whichever is later, for a **total of 11 measures.** • Shared Savings Program ACOs will be required to report the APP Plus quality measure set and to submit their measures through the eCQM, MIPS CQM, or Medicare CQMs (Shared Savings Program ACOs only) or any combination of the 3 collection types in the CY 2025 and 2026 performance periods; ACOs won't have the option to report the MIPS CQM collection type beginning with the CY 2027 performance period. We finalized with modification the following timeline for incorporating the 11 quality measures into the APP Plus quality measure set (10 of which are part of the Adult Universal Foundation) so that APM Entities, groups and clinicians can make investments in infrastructure, skill development, and knowledge to report the measures successfully and to allow time for eCQM and Medicare CQM specifications to be developed, when not available:	

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2025 FINALIZED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Measure Name/ID</th><th>Performance Period</th></tr>
<tr><td>Diabetes: Glycemic Status Assessment Greater Than 9% (Quality #001, previously named Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%))[1]</td><td>2025</td></tr>
<tr><td>Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality #134)</td><td>2025</td></tr>
<tr><td>Controlling High Blood Pressure (Quality #236)</td><td>2025</td></tr>
<tr><td>CAHPS for MIPS Survey (Quality #321)</td><td>2025</td></tr>
<tr><td>Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible MIPS Clinician Groups (Quality #479)</td><td>2025</td></tr>
</table>
</td><td></td></tr>
</table>

[1] In the CY 2025 Medicare Physician Fee Schedule Final Rule, we used the former measure name (Diabetes Hemoglobin A1c (HbA1c) Poor Control) to identify Quality ID 001 within the APP and APP Plus quality measure sets. We plan to issue a technical correction to update the measure name for APP reporting to align with the name change finalized in this rule.

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		Breast Cancer Screening (Quality #112) — 2025 **Colorectal Cancer Screening** (Quality #113) — 2026 **Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure** (Quality #484, not included in the Adult Universal Foundation) — 2026 **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** (Quality #305) — 2027 **Screening for Social Drivers of Health** (Quality #487) — 2028 or the performance period that is one year after the eCQM specification becomes available, whichever is later **Adult Immunization Status** (Quality #493) — 2028 or the performance period that is one year after eCQM	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		specification becomes available, whichever is later	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Cost Performance Category			

Cost Measures	**Inventory**
	There are a total of 29 cost measures available in the 2024 performance period.
		Inventory
		We finalized our proposal to **add 6 episode-based cost measures** beginning with the 2025 performance period for implementation at the group (TIN) and clinician (TIN/NPI) level with a 20-episode case minimum.
		• 1 acute inpatient medical condition measure:
		  ○ **Respiratory Infection Hospitalization**
		• 5 chronic condition measures:
		  ○ **Chronic Kidney Disease**
		  ○ **End-Stage Renal Disease**
		  ○ **Kidney Transplant Management**
		  ○ **Prostate Cancer**
		  ○ **Rheumatoid Arthritis**
			• **Traditional MIPS**
			• **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		We finalized **substantive updates** to 2 existing episode-based cost measures so that their specifications reflect re-evaluated versions: • **Cataract Removal with Intraocular Lens (IOL) Implantation** (currently named Routine Cataract with Intraocular Lens [IOL] Implantation) • **Inpatient Percutaneous Coronary Intervention (PCI)** (currently named ST-Elevation Myocardial Infarction [STEMI] Percutaneous Coronary Intervention [PCI]). You can review the Measure Information Forms on the CMS website for details about each final cost measure (new or modified).	
Cost Measures	**Removal Criteria** No finalized criteria for removing cost measures from MIPS.	**Removal Criteria** We finalized the following criteria to serve as guidance when considering whether to remove a cost measure: 1. It isn't feasible to implement the measure specifications. 2. The measure steward is no longer able to maintain the cost measure. 3. The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		4. The measure specifications don't reflect current clinical practice or guidelines. 5. A more applicable measure is available. including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic. We also finalized that we may retain a cost measure that meets one or more of these criteria if we determine the benefit of retaining the measure outweighs the benefit of removing it.	
Cost Measure Scoring	**Exclusion from Scoring** If data used to calculate a cost measure score are impacted by significant changes during the performance period, such that calculating the cost measure score would lead to misleading or inaccurate results, we exclude the affected cost measure from the MIPS eligible clinician's or group's cost performance category score. We define "significant changes" as changes external to the care provided, and that CMS determines may lead to misleading or inaccurate results.	**Exclusion from Scoring** We finalized our proposal to add a new cost measure exclusion policy beginning with the CY 2024 performance period / 2026 MIPS payment year. Under the new cost measure exclusion policy, "errors" in addition to "significant changes" will be included as a reason to exclude a cost measure to further align our measure exclusion policies among the performance categories. Additionally, under the new cost measure exclusion policy we will exclude a cost measure if the significant changes or errors affect the performance period (not only if they occur during the performance period) to allow us to exclude cost measures when such changes and errors occur	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		outside of the performance period, but otherwise affect the performance period.	
Cost Measure Scoring	**Benchmarks** We assign cost measure points based on the benchmark decile range and the corresponding percentile that a MIPS eligible clinician's cost performance falls into. 1-10 achievement points are assigned across 10 percentile ranges.	**Benchmarks** We finalized our proposal **to revise the cost scoring benchmarking methodology starting in 2024 performance period/2026 MIPS payment year**. (These changes will take effect when 2024 final scores are released in June 2025.) The finalized cost scoring methodology will use a new distribution for cost scoring in which the median cost for a measure will be set at a score derived from the performance threshold established for that MIPS payment year. For example, for the CY 2024 performance period/2026 MIPS payment year, the median cost for a measure will be given a MIPS score of 7.5, the performance threshold equivalent. The cut-offs for benchmark point ranges will be calculated based on standard deviations from the median cost. The finalized benchmark methodology will more appropriately incentivize or penalize clinicians with below or above national average spending.	• **Traditional MIPS** • **MVPs**

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2025 FINALIZED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td></td><td>
<table>
<tr><th>Points</th><th>Percentile</th></tr>
<tr><td>1 - 1.9</td><td>99th +
(highest costs)</td></tr>
<tr><td>2 - 2.9</td><td>90th – 81st</td></tr>
<tr><td>3 = 3.9</td><td>80th – 71st</td></tr>
<tr><td>4 - 4.9</td><td>70th – 61st</td></tr>
<tr><td>5 - 5.9</td><td>60th – 51st</td></tr>
<tr><td>6 - 6.9</td><td>50th – 41st</td></tr>
<tr><td>7 - 7.9</td><td>40th – 31st</td></tr>
<tr><td>8 - 8.9</td><td>30th – 21st</td></tr>
<tr><td>9 - 9.9</td><td>20th – 11th</td></tr>
<tr><td>10</td><td>10th – 1st
(lowest costs)</td></tr>
</table>
</td><td>
<table>
<tr><th>Points</th><th>Cut Offs (adjust cost scoring methodology)</th></tr>
<tr><td>1 - 1.9</td><td>Median cost ($) + (2.75 x standard deviation ($))</td></tr>
<tr><td>2 - 2.9</td><td>Median cost ($) + (2.5 x standard deviation ($))</td></tr>
<tr><td>3 - 3.9</td><td>Median cost ($) + (2.25 x standard deviation ($))</td></tr>
<tr><td>4 - 4.9</td><td>Median cost ($) + (2 x standard deviation ($))</td></tr>
<tr><td>5 - 5.9</td><td>Median cost ($) + (1.5 x standard deviation ($))</td></tr>
<tr><td>6 - 6.9</td><td>Median cost ($) + (1 standard deviation ($))</td></tr>
<tr><td>7 - 7.9</td><td>Median cost ($) + (0.5 x standard deviation ($))</td></tr>
<tr><td>8 - 8.9</td><td>Median cost ($) - (0.5 x standard deviation ($))</td></tr>
<tr><td>9 - 9.9</td><td>Median cost ($) – (1 x standard deviation ($))</td></tr>
<tr><td>10</td><td>Median cost ($) - (1.5 x standard deviation ($))</td></tr>
</table>
</td><td></td></tr>
</table>

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)

Example using current methodology:

Points	Range of Costs Per Episode
1 - 1.9	$1330.65 - $1126.35
2 - 2.9	$1126.34 - $1062.93
3 - 3.9	$1062.92 - $1025.75
4 - 4.9	$1025.74 - $997.78
5 - 5.9	$997.77 - $969.73
6 - 6.9	$969.72 - $940.03
7 - 7.9	$940.02 - $904.83
8 - 8.9	$904.82 - $860.44
9 - 9.9	$860.43 - $779.69
10	$779.68

Let's look at **an example** of how the finalized benchmark methodology will affect scoring:

- Dr. Clark's average cost per episode for a cost measure is **$1,104**, and the national median for this measure is $969.72.
- Under the **current methodology**, **she'd receive between 2 – 2.9 points**.
- Under the **finalized methodology**, **she'll receive between 6 and 6.9 points**.

Points	Range of Costs Per Episode
1 - 1.9	$1,341.93 - $1,308.1
2 - 2.9	$1,308.09 - $1,274.26
3 - 3.9	$1,274.25 - $1,240.43
4 - 4.9	$1,240.42 - $1,172.75
5 - 5.9	$1,172.74 - $1,105.08
6 - 6.9	$1,105.07 - $1,037.4
7 - 7.9	$1,037.39 - $902.05
8 - 8.9	$902.04 - $834.38
9 - 9.9	$834.37 - $766.7
10	$766.69

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Improvement Activities Performance Category			
Improvement Activities	**Inventory** There are a total of 106 improvement activities available for the 2024 performance period.	**Inventory** We finalized the following changes to the improvement activities inventory for a total of 104 improvement activities available for the 2025 performance period: • Addition of 2 new activities (Appendix F) • Modification of 1 existing activity (Appendix G) • Removal of 4 activities (Appendix H) We have also finalized the removal of 4 activities beginning with the 2026 performance period (Appendix I)	• **Traditional MIPS** • **MVPs**
Improvement Activities	**Removal Criteria** We previously finalized the following seven removal factors to identify activities for potential removal or modification from the Inventory: 1. Activity is duplicative of another activity. 2. There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.	**Removal Criteria** We finalized our proposal to codify these improvement activity removal factors in § 414.1355.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	3. Activity does not align with current clinical guidelines or practice. 4. Activity does not align with at least one meaningful measure area. 5. Activity does not align with the quality, cost, or Promoting Interoperability performance categories. 6. There have been no attestations of the activity for 3 consecutive years. 7. Activity is obsolete. We note that these factors are criteria that are used as guidance in determining removal of an activity, but its use is at CMS discretion.		
Improvement Activities Reporting Requirements	**Activity Weighting** Activities are classified as either medium-weighted or high-weighted. High-weighted activities are worth 2xs as many points as medium-weighted activities.	**Activity Weighting** We finalized our proposal to remove activity weightings to simplify scoring and complement our ongoing efforts to refine and improve the Inventory.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Improvement Activities Reporting Requirements	**Number of Required Activities** Most clinicians must attest to 2 to 4 improvement activities to receive the maximum improvement activities score of 40 points for the 2024 performance year. The number of improvement activities attested to is dependent on special status, APM participation and activity weight.	**Number of Required Activities** We finalized our proposal to simplify requirements by reducing the number of activities clinicians are required to attest to completing. **MVP Reporting** • Clinicians, groups, and subgroups (regardless of special status) must attest to 1 activity. **Traditional MIPS Reporting** • Clinicians, groups, and virtual groups with the small practice, rural, non-patient facing, or health professional shortage area special status must attest to 1 activity. • All other clinicians, groups, and virtual groups must attest to 2 activities.	• **Traditional MIPS** • **MVPs**
Improvement Activities Data Submission	**Minimum Criteria** We consider any submission received in the QPP submission environment during the designated MIPS submission period as a data submission and assign a score for the submission.	**Minimum Criteria** We finalized that a submission for the improvement activities performance category must include a “yes” response for at least one improvement activity to be considered a data submission and scored. • A submission with only a date and practice ID won’t be considered a data submission and will be assigned a null score.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		This policy is intended to mitigate the negative scoring impact on clinicians due to unintentional submissions without data that can be scored, which would override an approved reweighting application or a prior data submission and result in a zero score.	
Improvement Activities Data Submission	**Multiple Submissions** We haven't included language about our process for handling multiple submissions in previous years' rules.	**Multiple Submissions** For multiple improvement activity submissions for an individual clinician, group, subgroup, or virtual group **from different organizations** (for example by a qualified registry and the practice administrator) for the same reporting option, we finalized our proposal to codify our existing process to score each submission received and assign the highest of the scores. In practice, this means we: • Score all activities (not to exceed the maximum points available in the performance category). For multiple data submissions received for an individual clinician, group, subgroup, or virtual group **from the same organization** (for example, by 2 practice administrators) for the same reporting option, we finalized our proposal to codify our existing process: • Score the most recent submission.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		• The new submission will override a previous submission (of the same submission type) from the same organization. **NOTE:** This policy won't apply to different submission types by the same organization. For example, a group reporting traditional MIPS can submit one improvement activity via attestation (manual entry), and a second through a file upload. The activity submitted via file upload won't override the activity submitted via attestation, as these are distinct submission types.	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Performance Category			
Reweighting for Promoting Interoperability	We finalized the **continuation** of automatic reweighting for the following clinician type for the CY 2024 performance period/2026 MIPS payment year: • **Clinical social workers**	**No changes will be made to these policies.** Please note that we didn't propose to continue automatic reweighting for clinical social workers in the CY 2025 performance period/2027 MIPS payment year. (This isn't a change as we previously finalized automatic reweighting for clinical social	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	(There was no policy proposed or finalized to continue performance category reweighting beyond the CY 2024 performance period.) Automatic reweighting applies to MIPS eligible clinicians, groups, and virtual groups with the following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practice	workers specifically for the CY 2024 performance period/2026 MIPS payment year.) Beginning with the 2025 performance period, automatic reweighting will only apply to MIPS eligible clinicians, groups, and virtual groups with the following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practice	
Promoting Interoperability Data Submission	**Minimum Criteria** We consider any submission received in the QPP submission environment during the designated MIPS submission period as a data submission and assign a score for the submission. We assign a score of zero for incomplete submissions in the Promoting Interoperability performance category and cancel reweighting.	**Minimum Criteria** Beginning with the CY 2024 performance period/2026 MIPS payment year (data submission period in CY 2025), we finalized that a data submission for the Promoting Interoperability performance category must include all of the following elements to be considered a qualifying data submission and scored: • Performance data, including any claim of an applicable exclusion, for the required measures in each objective, as specified by CMS;	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		• Required attestation statements, as specified by CMS; • CMS EHR Certification ID (CEHRT ID) from the Certified Health IT Product List (CHPL); and • The start date and end date for the applicable performance period as set forth in § 414.1320. A submission with only a date and practice ID won't be considered a data submission and will be assigned a null score; it won't override reweighting of the Promoting Interoperability performance category. This policy is intended to mitigate the negative scoring impact on clinicians due to unintentional submissions without data that can be scored, which would override an approved reweighting application or a prior data submission and result in a zero score.	
Promoting Interoperability Data Submission	**Multiple Data Submissions** We currently assign a score of zero when we receive multiple submissions with conflicting data for the Promoting Interoperability performance category.	**Multiple Data Submissions** Beginning with the CY 2024 performance period/2026 MIPS payment year (data submission in CY 2025), we finalized that, for multiple data submissions received, CMS will calculate a score for each data submission received and assign the highest of the scores.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Subgroups Reporting the Promoting Interoperability Performance Category	**Subgroup Reporting** For the 2023 and 2024 performance periods, an MVP Participant that is a subgroup is required to submit its affiliated group's data for the Promoting Interoperability performance category.	**Subgroup Reporting** We finalized our proposal to continue our policy that a subgroup is required to submit its affiliated group's data for the Promoting Interoperability performance category.	• **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Final Scoring			
Performance Category Reweighting	**Reweighting** Clinicians have requested reweighting for each of the performance categories in scenarios where no data was submitted by their third party intermediary due to reasons outside of the clinician's control. We don't currently have a reweighting policy to address such scenarios.	**Reweighting** We finalized our proposal to allow clinicians to **request reweighting** for quality, improvement activities, and/or Promoting Interoperability performance category (or categories) where **data are inaccessible and unable to be submitted due to reasons outside of the control of the clinician** because the clinician delegated submission of the data to their third party intermediary (evidenced by a written agreement) and the third party intermediary didn't submit the data on the clinician's behalf in accordance with applicable deadlines.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		In determining whether to apply reweighting to the affected performance category (or categories), CMS will consider the following: • Whether the clinician knew or had reason to know of the issue with its third party intermediary's submission of their data. • Whether the clinician took reasonable efforts to correct the issue. • Whether the issue between the clinician and their third party intermediary caused no data to be submitted. We finalized: • These requests will be **submitted through the QPP Service Center** and must be received on or before November 1 prior to the relevant MIPS payment year. • These requests can be submitted **beginning with the CY 2024 performance period**/2026 MIPS payment year (data submission period in calendar year 2025).	
Performance Threshold	**Performance Threshold** We use the mean as the methodology for determining the performance threshold. For the CY 2024 performance period/2026	**Performance Threshold** We finalized our proposal to continue using the mean as the methodology for determining the performance threshold for the CY 2025	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	MIPS payment year, the performance threshold was set at 75 points.	performance period/2027 MIPS payment year through CY 2027 performance period/2029 MIPS payment year. We also finalized to continue using the mean final score from the CY 2017 performance period/2019 MIPS payment year. On this basis, we're **setting the performance threshold at 75 points** for the CY 2025 performance period/2027 MIPS payment year.	

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Third Party Intermediaries			
Certified Survey Vendors	**CAHPS for MIPS Survey Vendor Cost** No existing policy for survey vendors to submit pricing estimates to CMS.	**CAHPS for MIPS Survey Vendor Cost** We finalized that survey vendors must submit the best estimate of the cost of their services to CMS. These **costs will be published** to increase transparency on the cost of participation in the program and improve consistency across requirements.	• **Traditional MIPS** • **MVPs** • **APP**

Advanced APMs Overview

POLICY AREA	EXISTING POLICY	CY 2025 FINALIZED POLICY
Qualifying APM Participant (QP) Determinations	**Calculating Payment Amount and Patient Count Threshold Scores: Attribution-Eligible Beneficiary Definition** For purposes of QP determinations, attribution-eligible beneficiaries are identified by applying the following six criteria: 1) Not enrolled in Medicare Advantage or a Medicare cost plan; 2) Does not have Medicare as a secondary payer; 3) Is enrolled in both Medicare Parts A and B; 4) Is at least 18 years of age; 5) Is a United States resident; and 6) Minimum of one claim for evaluation and management services or, for certain Advanced APMs, the attribution basis we determine based on the Advanced APM's attribution methodology.	**Calculating Payment Amount and Patient Count Threshold Scores: Attribution-Eligible Beneficiaries** We proposed but didn't finalize our proposal to amend the 6th criterion of our definition to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs.

Frequently Asked Questions (FAQs)

Are there any proposals that weren't finalized?

Yes, there are a small number of proposals that we didn't finalize.

- We didn't finalize the removal of Q144: Oncology: Medical and Radiation – Plan of Care for Pain.
- We didn't finalize the addition of 2 new measures:
  - Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer
  - Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer
- We didn't finalize our proposal to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs.

Are there any policies previously finalized for the 2025 performance period?

Yes.

- Please refer to Appendix A for a list of policies previously finalized to be effective beginning in the 2025 performance period.
- Please refer to Appendix B for the measure previously finalized for the 2025 performance period.
- Please refer to Appendix C for the measure previously finalized for removal for the 2025 performance period.

What MIPS Value Pathways (MVPs) are available for reporting in 2025?

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Advancing Cancer Care
- Advancing Care for Heart Disease
- Advancing Rheumatology Patient Care
- Complete Ophthalmologic Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Dermatological Care
- Focusing on Women's Health
- Gastroenterology Care
- Improving Care for Lower Extremity Joint Repair
- Optimal Care for Kidney Health
- Optimal Care for Patients with Urologic Conditions
- Patient Safety and Support of Positive Experiences with Anesthesia
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
- Pulmonology Care
- Quality Care for Patients with Neurological Conditions

- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support for Musculoskeletal Care
- Surgical Care
- Value in Primary Care

Where can I learn more about the MVP reporting option?

Please visit the MIPS Value Pathways (MVPs) webpage for general information; the 2025 MVPs Implementation Guide will be available in early 2025. You can also learn more about which MIPS reporting option (traditional MIPS, MVPs, APM Performance Pathway (APP)) may be best for you by reviewing the MIPS Reporting Options Comparison Resource.

Which quality measures will be subject to the new topped out measure benchmarks for the 2025 performance period?

As finalized, the following measures would be scored according to the new topped out measure benchmarks.

Quality ID	Measure Title	Collection Type
143	Oncology: Medical and Radiation - Pain Intensity Quantified	eCQM, MIPS CQM
249	Barret's Esophagus	Medicare Part B Claims Measure, MIPS CQM
250	Radical Prostatectomy Pathology Reporting	Medicare Part B Claims Measure, MIPS CQM
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medical Studies	MIPS CQM
364	Optimized Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	MIPS CQM
395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Medicare Part B Claims Measure, MIPS CQM
396	Lung Cancer Reporting (Resection Specimens)	MIPS CQM
397	Melanoma Reporting	Medicare Part B Claims Measure, MIPS CQM
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	MIPS CQM
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	MIPS CQM
424	Perioperative Temperature Management	MIPS CQM
430	Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy	MIPS CQM
436	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	MIPS CQM
440	Skin Cancer: Biopsy Reporting Time Pathologist to Clinician	MIPS CQM
463	Prevention of Post-Operative Vomiting (POV) Combination Therapy (Pediatrics)	MIPS CQM
477	Multimodal Pain Management	MIPS CQM

Are Medicare CQMs eligible for flat benchmarks in the CY 2025 performance period?

Beginning in the CY 2025 performance period/2027 MIPS payment year, Medicare CQMs (only available to Shared Savings Program ACOs) will be scored using flat benchmarks for their first 2 performance periods in MIPS.

Performance Year	Quality ID for Medicare CQMs eligible for flat benchmarks
2025	• 001, 134, 236, 112
2026	• 112, 113
2027	• 113, 305
2028*	• 305, 487*, 493*

*Quality ID #487: Screening for Social Drivers of Health and Quality ID #493: Adult Immunization Status will be eligible for flat benchmarks for 2 years beginning in the CY 2028 performance period or the performance period that is 1 year after the eCQM specification becomes available for each measure, respectively, whichever is later.

Why are you changing the policy for multiple quality submissions?

We're not. We've finalized a policy that aligns with our existing processing rules when we receive multiple quality submissions from the same organization or different organizations.

Multiple quality submissions from the same organization.

- **Please review the QPP Submissions Application Program Interface (API) documentation for detailed information about API submissions.**

We'll keep the most recent data submitted when the data is **submitted the same way** (e.g., via file upload) AND **by the same organization** (e.g., the practice) AND **for the same**:

- ✓ **Performance category** (e.g., quality)
- ✓ **Collection type**
- ✓ **Participation option** (e.g., group)
- ✓ **Reporting option** (e.g., traditional MIPS)

This approach allows practices to correct and resubmit previously submitted data.

Let's look at 3 examples.

<table>
<tr><td>Example 1</td><td>John and Kathy are practice staff at Mountain Medical and support the group’s MIPS reporting. Mountain Medical is reporting traditional MIPS as a group.
<table>
<tr><th>John uploaded a file with 3 measures (047, 130, and 134) on Tuesday</th><th>Kathy uploaded a file with 3 measures (134, 155, and 181) on Thursday</th></tr>
<tr><td>✓ Quality performance category</td><td>✓ Quality performance category</td></tr>
<tr><td>✓ MIPS CQM collection type</td><td>✓ MIPS CQM collection type</td></tr>
<tr><td>✓ Group reporting</td><td>✓ Group reporting</td></tr>
<tr><td>✓ Traditional MIPS</td><td>✓ Traditional MIPS</td></tr>
</table></td></tr>
<tr><td>Outcome</td><td>The group will be scored on the 3 MIPS CQMs that Kathy submitted on Thursday.</td></tr>
<tr><td>Why?</td><td>Kathy submitted the most recent data by their organization, through the same submission method, for the same performance category, collection type, participation option, and reporting option.</td></tr>
<tr><td>Example 2</td><td>Dr. Andrews is a solo practitioner reporting traditional MIPS.
She reported 3 quality measures through Medicare Part B claims throughout the performance period.
She uploaded a file with 3 eCQMs (a report she extracted from her EHR) during the submission period.
<table>
<tr><th>Dr. Andrews reported 3 measures during the performance period:</th><th>Dr. Andrews submitted 3 measures during the submission period:</th></tr>
<tr><td>✓ Quality performance category</td><td>✓ Quality performance category</td></tr>
<tr><td>× Medicare Part B claims</td><td>× eCQM collection type</td></tr>
<tr><td>✓ Individual reporting</td><td>✓ Individual reporting</td></tr>
<tr><td>✓ Traditional MIPS</td><td>✓ Traditional MIPS</td></tr>
</table></td></tr>
<tr><td>Outcome</td><td>Dr. Andrews will be scored on all 6 measures.</td></tr>
<tr><td>Why?</td><td>The 3 measures submitted by file upload won’t overwrite the 3 measures submitted through Medicare Part B claims because they were submitted through different methods and for different collection types.</td></tr>
</table>

<table>
<tr><td>Example 3</td><td>Steven and Elise are assistant practice managers at Keaton’s Oncology Center, which is reporting both traditional MIPS and the Advancing Cancer Care MVP at the group level. Steven oversees their traditional MIPS reporting and Elise oversees their MVP reporting.
<table>
<tr><th>Steven uploaded a file with 6 measures on Thursday:</th><th>Elise uploaded a file with 4 measures on Friday:</th></tr>
<tr><td>✓ Quality performance category</td><td>✓ Quality performance category</td></tr>
<tr><td>✓ MIPS CQM collection type</td><td>✓ MIPS CQM collection type</td></tr>
<tr><td>✓ Group reporting</td><td>✓ Group reporting</td></tr>
<tr><td>× Traditional MIPS</td><td>× Advancing Cancer Care MVP</td></tr>
</table></td></tr>
<tr><td>Outcome</td><td>The group will receive a quality score in traditional MIPS (based on the 6 measures Steven submitted) <u>and</u> a quality score for the Advancing Cancer Care MVP (based on the 4 measures submitted by Elise).

(When a group reports both traditional MIPS and an MVP, the group will ultimately receive the higher MIPS final score, either from traditional MIPS reporting (based on traditional MIPS submissions for all categories) or MVP reporting (based on MVP submissions for all categories).)</td></tr>
<tr><td>Why?</td><td>Elise’s data didn’t overwrite Steven’s data because they submitted data for different reporting options.</td></tr>
</table>

Multiple quality submissions from different organizations.
When different organizations submit quality data for the same reporting option for the clinician, group, subgroup, virtual group, or APM Entity, we’ll:

- Score all the quality measures that were submitted.
- Pick the highest scoring measures, in accordance with the reporting requirements for that reporting option.

This approach allows a practice (or virtual group or AM Entity) to work with one or more third party intermediaries to meet their quality reporting requirements.

Let’s look at 2 examples.

Example 1	Don Hopkins Family Medical Center is participating as a group. They’re working with 2 third party intermediaries to submit their quality measures for traditional MIPS. • QCDR A submits 4 measures on behalf of the group for traditional MIPS. • QCDR B submits 3 different measures on behalf of the group for traditional MIPS.

Outcome	**The group's traditional MIPS quality score will include the 6 highest-scoring measures (including an outcome measure) of the 7 submitted (by both QCDRs).**
Why?	All 7 measures were considered for scoring because they were submitted by 2 different organizations.
Example 2	The Seaver Clinic is reporting both traditional MIPS and an MVP as a group. They're submitting their own eCQMs and working with a QCDR to submit several QCDR measures. • The Seaver Clinic uploads one file with 3 eCQMs for their MVP on Monday and uploads a file with 4 eCQMs for traditional MIPS on Tuesday. • The QCDR submits 1 QCDR measure for the group's MVP reporting and 2 QCDR measures for the group's traditional MIPS reporting.
Outcome	**The group will receive a quality score in traditional MIPS (based on 6 measures: 4 eCQMs + 2 QCDR measures) and a quality score for their MVP (based on 4 measures: 3 eCQMs + 1 QCDR measure).** (When a group reports both traditional MIPS and an MVP, the group will ultimately receive the higher MIPS final score, either from traditional MIPS reporting (based on traditional MIPS submissions for all categories) or MVP reporting (based on MVP submissions for all categories).)
Why?	Both the Seaver Clinic and the QCDR submitted data for 2 different reporting options.

When will measure specifications/supporting documentation and activity descriptions be available for finalized measures/activities?
Measure specifications and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the QPP Resource Library before the performance period begins on January 1, 2025.

(When searching in the QPP Resource Library, scroll past the General and Regulatory Resource sections until you reach the "Full Resource Library." Filter by the 2025 Performance Year and choose "Measure Specifications and Benchmarks" as the Resource type.)

When will historical quality benchmarks be available for the 2025 performance period?
We anticipate that the 2025 Quality Benchmarks will be available on the Benchmarks page of the QPP website in late January 2025.

Where can I find a list of topped out quality measures for the 2025 performance period?
We identify topped out quality measures, including those capped at 7 points, through the benchmarking process. We anticipate that the 2025 Quality Benchmarks will be available in late January 2025.

What's the maximum negative payment adjustment for the CY 2025 performance period/2027 MIPS payment year?

As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year (2020 performance year) and beyond is **-9%**. The **actual** payment adjustment (positive, neutral, or negative) you'll receive for the 2027 MIPS payment year will be based on your MIPS final score from the 2025 performance period and may be subject to a scaling factor to ensure budget neutrality, as required by MACRA.

How many points do I need to avoid a negative payment adjustment for the CY 2025 performance period/2027 MIPS payment year?

The performance threshold is the number against which your final score is compared to determine your payment adjustment. **The performance threshold for the CY 2025 performance period /2027 MIPS payment year remains 75 points.** See the table below for more information about the relationship between 2025 final scores and 2027 payment adjustments.

Your 2025 Final Score	Payment Impact for MIPS Eligible Clinicians for the 2027 MIPS Payment Year
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (between -9% and 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

Contact Us

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

Version History

Date	Change Description
11/01/2024	Original Posting.

Appendix A: Previously Finalized Policies for the 2025 Performance Period

The table below identifies policies finalized in the CY 2024 Medicare PFS Final Rule that apply to the 2025 performance period.

Policy Area	Previously Finalized Policy Applicable To The 2025 Performance Period
Quality Performance Category	
New Measures	Please refer to Appendix B for details about quality measures previously finalized to be available beginning with the 2025 performance period.
Measures Finalized for Removal	Please refer to Appendix C for details about quality measures previously finalized for removal beginning with the 2025 performance period.
Promoting Interoperability Performance Category	
Certified EHR Technology (CEHRT) Requirements	We updated the CEHRT definition to align with the Office of the National Coordinator for Health IT (ONC)'s regulations. All certification criteria will be maintained and updated at 45 CFR 170.315. We've aligned our definitions of CEHRT for QPP and the Medicare Promoting Interoperability Program with the definitions and requirements ONC currently has in place and may adopt in the future.
Third Party Intermediaries	
Health Information Technology (IT) Vendors	We finalized the **elimination of the health IT vendor category of third party intermediaries**, beginning with the 2025 performance period, to remove gaps in third party intermediary requirements and improve data integrity. To submit data on behalf of clinicians, a health IT vendor will need to meet the requirements of and self-nominate to become a qualified registry or QCDR. They can continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.

Appendix B: Quality Measure Previously Finalized for the 2025 Performance Period and Future Years

Measure Title	Description	Collection Type	Measure Type	Rationale for Inclusion
Q494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)	This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible. This measure is not telehealth eligible. This eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM. Additional details are included in the Guidance field.	eCQM Specifications	Intermediate Outcome	This eCQM was previously finalized in the CY 2025 PFS Final Rule **with a 1-year delay to CY 2025** because it adds an important outcome measure in the diagnostic radiology set and addresses patient safety within the scope of diagnostic radiology. This measure will fill a gap area in care for patients undergoing diagnostic CT imaging to assess actual radiation dosing, complementing the current MIPS measures that address radiation dosing utilization and documentation of dose lowering techniques or appropriateness of follow-up imaging. This measure will operationalize accessibility of data into electronic clinical data systems for increased efficiency.

Appendix C: Quality Measure Previously Finalized for Removal for the 2025 Performance Period and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
436	Medicare Part B Claims Measure Specifications, MIPS CQM Specifications / Process	No	**Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques:** Percentage of final reports for patients aged 18 years and older undergoing computed tomography (CT) with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control. • Adjustment of the mA and/or kV according to patient size. • Use of iterative reconstruction technique.	American College of Radiology/ American Medical Association/ National Committee for Quality Assurance	Duplicative to new measure Q494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level) that was previously finalized in the CY 2024 PFS final rule with a 1-year delay to 2025.

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

Quality #: Measure Title, And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q506: Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy Society for Immunotherapy of Cancer (SITC)	Percentage of patients, aged 18 years and older, with a diagnosis of metastatic non-small cell lung cancer (NSCLC) or squamous cell carcinoma of head and neck (HNSCC) on first-line immune checkpoint inhibitor (ICI) therapy, who had a positive PD-L1 biomarker expression test result prior to giving ICI therapy.	MIPS CQM Specifications	Process High Priority	This measure addresses timely biomarker testing for patients with a diagnosis of metastatic non-small cell lung cancer or squamous cell carcinoma that impacts treatment decisions. The measure aligns with a CMS priority of improving patient outcomes. Appropriate intervention and timeliness of PD-L1 biomarker expression testing prior to initiation of first-line treatment for the metastatic non-small cell lung cancer or squamous cell carcinoma of head and neck can lead to improvements in mortality and morbidity.
Q507: Appropriate Germline Testing for Ovarian Cancer Patients American Society of Clinical Oncology	Percentage of patients aged 18 and older diagnosed with epithelial ovarian, fallopian tube, or primary peritoneal cancer who undergo germline testing within 6 months of diagnosis.	MIPS CQM Specifications	Process	This measure addresses patients diagnosed with epithelial ovarian, fallopian tube, or primary peritoneal cancer who undergo germline testing within 6 months of their diagnosis. It addresses a CMS priority of promoting more personalized diagnostic, predictive, prognostic, and therapeutic strategies for the patient. This measure could be considered for inclusion within the Advancing Cancer Care MVP. This measure fills a current quality measure inventory gap within the oncologic clinical topic and adds a specialty specific measure to the MIPS Oncology/Hematology specialty set.
Q508: Adult COVID-19 Vaccination Status	Percentage of patients aged 18 years and older seen for a visit during the performance period	MIPS CQM Specifications	Process	This measure represents an important clinical topic owing to the recently ended Public Health Emergency (PHE). Based upon clinical guidelines and systemic

Quality #: Measure Title, And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Centers for Medicare & Medicaid Services	that are up-to-date on their COVID-19 vaccinations as defined by Centers for Disease Control and Prevention (CDC) recommendations on current vaccination.			reviews, there is general agreement about the safety and efficacy of the COVID-19 vaccine, preventing costly and potentially harmful hospitalizations.
Q509: Melanoma: Tracking and Evaluation of Recurrence American Academy of Dermatology	Percentage of patients who had an excisional surgery for melanoma or melanoma in situ with initial American Joint Committee on Cancer (AJCC) staging of 0, I, or II, in the past 5 years in which the operating clinician examines and/or diagnoses the patient for recurrence of melanoma.	MIPS CQM Specifications	Process High Priority	This measure evaluates the frequency of recurrence of melanoma along with the type of recurrence after an excisional procedure and aims to drive communication about the recurrence status of melanoma patients. The measure addresses a CMS high priority outcome measure for care coordination as a lack of communication has been recognized between the excising clinician and clinician continuing care. This measure allows for the development of a system in which melanomas can be accurately tracked to increase the understanding of the effectiveness of care.
Q510: First Year Standardized Waitlist Ratio (FYSWR) Centers for Medicare & Medicaid Services	The number of newly initiated patients on dialysis in a practitioner group who are under the age of 75 and were either listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis. The practitioner group is inclusive of physicians and	MIPS CQM Specifications	Process	This measure addresses a CMS high priority clinical topic addressing patients with ESRD. This measure looks at patients that are in their first year of dialysis to assess whether within that year, following initiation of dialysis, they were placed on the kidney or kidney-pancreas transplant waitlist, or that the patient received a living donor transplant. The measure is fully developed, and data submitted by the measure developer indicates a performance gap for a process that can be directly linked to patient outcomes. This measure is separate from the other transplant waitlist measure below as it is

Quality #: Measure Title, And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
	advanced practice providers. The measure is the ratio-observed number of waitlist events in a practitioner group to its expected number of waitlist events. The measure uses the expected waitlist events calculated from a Cox model, which is adjusted for age, patient comorbidities, and other risk factors at the time of dialysis.			constricted to the first year after initiation of dialysis and is capturing the timely addition of these patients to that waitlist, a crucial step in driving positive outcomes in the patient population.
Q511: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) Centers for Medicare & Medicaid Services	The measure tracks dialysis patients who are under the age of 75 in a practitioner group and on the kidney or kidney-pancreas transplant waitlist (all patients or patients in active status). This measure is a risk-adjusted percentage of waitlist events among dialysis patients.	MIPS CQM Specifications	Process	This measure addresses a CMS priority clinical topic addressing patients with ESRD. This measure captures the adjusted count of patient months on the kidney and kidney-pancreas transplant waitlist for all dialysis patients in a dialysis practitioner or group practice by reviewing patient status on the last day of each month during the reporting year and those on the transplant waitlist in active status as of the last day of the month during the reporting year. This fully developed process measure is directly linked to driving positive outcomes and measure data indicates a performance gap.

Appendix E: Quality Measures Finalized for Removal for the 2025 Performance Period and Future Years

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
104	MIPS CQM Specifications/ Process	No	**Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate.	American Urological Association Education and Research	Limited patient population and adoption of the quality measure does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement.
137	MIPS CQM Specifications/ Structure	Yes	**Melanoma: Continuity of Care – Recall System:** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment.	American Academy of Dermatology	Measure is duplicative to the new Melanoma: Tracking and Evaluation of Recurrence measure being finalized for 2025. The new measure is a process measure that provides a more meaningful impact to quality improvement.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
254	MIPS CQM Specifications/ Process	No	**Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain:** Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location.	American College of Emergency Physicians	End of topped out lifecycle with limited opportunity to improve clinical outcomes.
260	MIPS CQM Specifications/	Yes	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing Carotid Endarterectomy (CEA) who are discharged to home no later than post-operative day #2.	Society for Vascular Surgeons	Measure is duplicative to current MIPS measure Q344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) due to substantive changes finalized for measure Q344 in this final rule.
409	MIPS CQM Specifications/ Outcome	Yes	**Clinical Outcome Post Endovascular Stroke Treatment:** Percentage of patients with a Modified Rankin Score (mRS) score of 0 to 2 at 90 days following endovascular stroke intervention.	Society of Interventional Radiology	Measure no longer being maintained by measure steward.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
433	MIPS CQM Specifications/ Outcome	Yes	**Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing surgical repair of pelvic organ prolapse that is complicated by a bowel injury at the time of index surgery that is recognized intraoperatively or within 30 days after surgery.	American Urogynecologic Society	Measure is duplicative to current MIPS measure Q432: Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair due to substantive changes finalized for measure Q432 in this final rule. Substantive changes to measure Q432 include updates to the measure title and description.
439	MIPS CQMs Specifications/ Efficiency	Yes	**Age Appropriate Screening Colonoscopy:** The percentage of screening colonoscopies performed in patients greater than or equal to 86 years of age from January 1 to December 31.	American Gastroenterological Association	Extremely topped out with limited opportunity to improve clinical outcomes.
452	MIPS CQMs Specifications/ Process	Yes	**Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies:** Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and RAS (KRAS or NRAS) gene mutation spared treatment with anti-EGFR monoclonal antibodies.	American Society of Clinical Oncology	Measure is duplicative to current MIPS measure Q451: RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy. Although they are similar measures, measure Q451 is more clearly worded than measure

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
					Q452 and measure Q452 is a component of the quality action within measure Q451.
472	eCQM Specifications/Process	Yes	**Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture:** Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.	Centers for Medicare & Medicaid Services	Extremely topped out with limited opportunity to improve clinical outcomes.

Appendix F: New Improvement Activities Finalized for the 2025 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description

IA_PM_24	Population Management	**Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake**
		Establish a process or procedure to increase rates of lung cancer screening through one or more of the following interventions:
		• Implementation of protocols that support enhanced documentation methods to identify eligible patients for lung cancer screening.
		  ○ Example: A practice could embed electronic health record (EHR) prompts to flag insufficient patient smoking history (e.g., total pack-years) and increase practice awareness around patient eligibility for screening
		  ○ Example: A practice could implement documentation processes or procedures (e.g., retrospective chart review, lung cancer screening eligibility questionnaire) to improve patient lung cancer screening eligibility data in the medical record
		• Development of a patient outreach and activation plan consisting of educational materials and resources for patients at high-risk of lung cancer for improved patient engagement and decision-making.
		  ○ Example: Providers or clinic staff could provide culturally and linguistically appropriate patient-directed educational or care navigation materials related to lung cancer screening, eligibility criteria for low-dose computed tomography (LDCT), and the purpose and benefits of screening
		  ○ Example: Providers or clinic staff could provide tools to prepare patients for shared decision-making (SDM) clinical encounters and promote patient-provider communication on lung cancer screening decision-making
		• Establishment of a navigation program to improve uptake and adherence of lung cancer screening and increase rates of LDCT referral completion.
		  ○ Example: A practice could designate and train existing clinic staff or hire an additional staff member to counsel patients on the importance of lung cancer screening and refer them to existing resources (e.g., transportation assistance, translator, financial services, appointment scheduling) to support ability to obtain LDCT
		  ○ Example: A practice could create a process to follow up with referred patients via telephone reminders or virtual notifications (e.g., email, patient charts)

IA_PM_25	Population Management	**Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk** Implement standardized, evidence-based cardiovascular disease risk assessment and care management for a defined population in the clinician's practice.

Activity ID	Subcategory	Activity Title and Description
		The clinician or clinician group will apply standardized risk assessment and care management to a broad, clinician-defined patient population in the practice. The population can be defined by 1) patient age and/or atherosclerotic cardiovascular disease (ASCVD) risk factors; or 2) the constraints of the risk assessment tool (for example, the American College of Cardiology (ACC)/American Heart Association (AHA) ASCVD Risk Calculator is validated for patients over age 40). The results of screening and the plan for treatment and follow up will be documented using a standardized method in the patient's medical record. Care management plan and follow up intervals will be influenced by the degree of patient risk. Cardiovascular care management should be defined by risk assessment and lead to the development of individualized care plans with specific goals. Shared decision making should be part of the development of every patient care plan.

Appendix G: Improvement Activities Finalized for Modification for the 2025 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
IA_PM_26 (formerly IA_ERP_6)	Population Health (formerly Emergency Response and Preparedness)	**Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B** Demonstrate that the MIPS eligible clinician's practice has achieved and/or maintained a vaccination rate of 60 percent of clinical practice staff for COVID-19, and 80 percent for influenza. Demonstrate vaccination, immunity, or non-responder status to hepatitis B for 95 percent of clinical practice staff. Vaccination recommendations are from Centers for Disease Control and Prevention; staff with contraindications to the vaccinations, as determined by the CDC, are excluded from the requirements.

Appendix H: Improvement Activities Finalized for Removal for the 2025 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
IA_EPA_1	Expanded Practice Access	**Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record** Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management.
IA_ERP_4	Emergency Response and Preparedness	**Implementation of a Personal Protective Equipment (PPE) Plan** Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients. In accordance with guidance from the Centers for Disease Control and Prevention (CDC) the PPE plan should address: • Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use. • Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages. • Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. The PPE plan should address all of the following types of PPE: • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators)
IA_ERP_5	Emergency Response and Preparedness	**Implementation of a Laboratory Preparedness Plan** Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the

Activity ID	Subcategory	Activity Title and Description
		laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities. For laboratories without a preparedness plan, MIPS eligible clinicians would meet with stakeholders, record minutes, and document a preparedness plan, as needed. The laboratory must then implement the steps identified in the plan and maintain them. For laboratories with existing preparedness plans, MIPS eligible clinicians should review, revise, or update the plan as necessary to meet the needs of the current PHE, implement new procedures, and maintain the plan. Maintenance of the plan in this activity could include additional hazard assessments, drills, training, and/or developing checklists to facilitate execution of the plan. Participation in debriefings to evaluate the effectiveness of plans are additional examples of engagement in this activity.
IA_PSPA_27	Patient Safety and Practice Assessment	**Invasive Procedure or Surgery Anticoagulation Medication Management** For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.

Appendix I: Improvement Activities Finalized for Removal for the 2026 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
IA_PM_12	Population Management	**Population Empanelment** Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care
IA_CC_1	Care Coordination	**Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop** Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
IA_CC_2	Care Coordination	**Implementation of Improvements that Contribute to More Timely Communication of Test Results** Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.
IA_BMH_8	Behavioral and Mental Health	**Electronic Health Record Enhancements for BH Data Capture** Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).