Quality Payment PROGRAM

Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) Notice of Proposed Rulemaking: Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table

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QPP Policy Overview: Proposals and Requests for Information

In this Notice of Proposed Rulemaking (NPRM), we've proposed policies that keep 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've proposed to establish 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're also proposing updates to the MIPS measure/activity inventories and scoring methodologies to provide all clinicians the opportunity to successfully participate in MIPS. Finally, we're proposing a small number of policies intended to maintain stability within the MIPS program through the established performance threshold and data completeness criteria.

In addition to these proposals, we're including Requests for Information (RFIs) related to increasing adoption of MVP reporting and subgroup participation, the Public Health and Clinician Data Exchange Objective within the Promoting Interoperability performance category, guiding principles for the development of patient-reported outcome quality measures, and changes to the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey.

Proposal Highlights

MVP Development and Maintenance

- We're proposing **6 new MVPs** that would be available beginning with the 2025 performance period related to **ophthalmology**, **dermatology**, **gastroenterology**, **pulmonology**, **urology**, and **surgical care**.

- We're also proposing **limited modifications to the currently finalized MVPs, including the consolidation of 2 neurology-focused MVPs into a single neurological MVP**.

For more information on MVP proposals, review the 2025 Proposed and Modified MVPs Guide (PDF).

APP Plus Quality Measure Set

- We're proposing an **additional quality measure set under the APP** which would include the 6 measures currently in the APP quality measure set and incrementally incorporate the remaining 5 Adult Universal Foundation quality measures for **a total of 11 measures** in the APP Plus quality measure set **by the 2028 performance period/**2030 payment year.
- We're also proposing that **Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) would be required to report the APP Plus** quality measure set, either as electronic clinical quality measures (eCQMs) or Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs), or a combination of eCQMs/Medicare CQMs.

Measure/Activity Inventories and Scoring Methodologies

- We're proposing 6 new episode-based cost measures.
- We're proposing revisions to 2 existing episode-based cost measures.
- We're proposing to **revise our cost measure scoring methodology** to assess clinician cost of care more appropriately in relation to national averages.
- We're proposing to revise our methodology for scoring topped out quality measures in specialty sets with limited measures.
- We're proposing changes to our policy governing our treatment of multiple data submissions received for the Promoting Interoperability performance category.
- We're proposing to remove improvement activity weighting and streamline the reporting requirements for the performance category.
- We're proposing **minimum criteria for a qualifying data submission (i.e., eligible for scoring)** in the quality, improvement activities, and Promoting Interoperability performance categories.

Maintaining Stability

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

Request for Information (RFI) Highlights

MVP Adoption and Subgroup Participation

When we introduced the concept of MVPs, we discussed our future intent to fully transition to MVPs; in CY 2022 PFS rulemaking, we cited 2028 as our potential target year to sunset traditional MIPS. The 2023 performance period was the first year for MVP reporting and subgroup participation with 12 available MVPs. Since then, we've expanded the inventory of MVPs each year and estimate that 80% of specialties will have an applicable MVP in the 2025 performance period if our current MVP proposals are finalized. Furthermore, specialties can choose measures within a MVP that are the most relevant for their clinical practice. Beginning in the 2026 performance period, multispecialty groups won't have the option to report an MVP at the group level, and instead would need to participate at the subgroup, individual, or (if applicable) APM Entity level.

In this RFI, we've identified the 2029 performance period as the potential timeline for completing the transition to MVPs (and sunsetting traditional MIPS) and are looking for insight into challenges you foresee with adopting

MVPs in this timeframe. **Please note that we're NOT proposing that traditional MIPS would sunset in the 2029 performance period.**

Specifically, we're seeking feedback on:

- Understanding clinician readiness to report MVPs with the eventual sunset of traditional MIPS.
- Ensuring applicable MVPs are available for all clinicians, including the possibility of creating broadly applicable MVP(s) or other alternatives for clinicians with limited quality and cost measures.
- Establishing subgroup composition criteria, including specific considerations for multispecialty small practices.
- Additional considerations for identifying the specialty composition of a group.

Public Health and Clinical Data Exchange Objective

This RFI focuses on how CMS can leverage the Public Health and Clinical Data Exchange Objective requirements under the Promoting Interoperability performance category to improve timely reporting, the quality and completeness of reported data, and overall participation in critical public health reporting. Among other items, this RFI is soliciting feedback on:

- Information on current reporting burden and challenges, such as variance in public health readiness and capacity/capabilities.
- Opportunities to further advance core objectives around timely, complete, quality data exchange.
- The best way to balance the vast array of public health reporting needs and the burden and loss of focus associated with too many measures.
- Opportunities for the Medicare Promoting Interoperability performance category to better incentivize the adoption of more advanced information exchange standards and mechanisms.

Principles for Patient-Reported Outcome Measures in Federal Models and Quality Reporting and Payment Programs

The Centers for Medicare & Medicaid Services (CMS) seeks to elevate the patient voice that is aligned with the CMS National Quality Strategy and strategy of the Center for Medicare and Medicaid Innovation (CMMI) by incorporating Patient- Reported Outcome Measures (PROMs) and Patient-Reported Outcome Performance Measures (PRO–PMs) in CMS quality reporting and payment programs and CMMI Models. As CMS incorporates more PROMs and PRO-PMs, we seek to obtain input and feedback from interested parties regarding the development of a set of guiding principles that would be utilized for the selection and implementation of PROMs and PRO-PMs.

Survey Modes for the Administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

CMS is seeking public comment on the potential expansion of the survey modes of the CAHPS for MIPS Survey. The current protocol is to administer the survey first through the mail and then by phone interview with non-respondents. The expansion to the protocol would include an initial administration of the survey by web, followed by mail, and then by phone. (CMS conducted a field test, using a "web first" survey administration protocol; the field test showed a 13% increase in response rates from the current protocol. Learn more about the field test in this report.) Specifically, in this RFI we're seeking public comment on:

- Whether a potential increase in survey response rates would outweigh a possible increase in the cost of survey administration.
- Whether it would be feasible for groups, virtual groups, subgroups, and APM Entities (including Shared Savings Program ACOs) to provide email addresses to vendors.

QPP Policy Comparison Table:

Current Policies vs. Proposed Policies

- MIPS Overview
- Advanced APMs Overview
- How Do I Comment on the Proposed Rule?

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 Proposed for the 2025 Performance Period and Future Years
- Appendix E: Quality Measures Proposed for Removal in the 2025 Performance Period and Future Years
- Appendix F: New Improvement Activities Proposed for the 2025 Performance Period and Future Years
- Appendix G: Improvement Activities Proposed for Removal in the 2025 Performance Period and Future Years

The 2025 Proposed and Modified MVPs Guide (PDF) documents information about the newly proposed MVPs and proposed changes to previously finalized MVPs.

The Medicare Shared Savings Program Proposals 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 Proposed and Modified MVPs Guide (PDF) for information about the new and modified MVPs proposed for the 2025 performance period.

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED 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're proposing a total of 196 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 proposals reflect: • Addition of 9 quality measures, including 2 patient-reported outcome measures. (See Appendix D). • Removal of 11 quality measures from the MIPS quality measure inventory. (See Appendix E). • Substantive changes to 66 existing quality measures.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		Please refer to Appendix B for new measures previously finalized 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're proposing 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. 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.	**Removal Criteria** In this proposed rule, we are proposing to codify at § 414.1330 these quality measure removal criteria.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	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 measures. 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. v. Whether the quality measure is designated as high priority or not. vi. Whether the quality measure has reached extremely topped out status. b. [Reserved]		

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	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 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.		
Quality Measure Scoring	**Topped Out Measure Benchmarks** There's a single benchmark methodology that applies to all topped out measures.	**Topped Out Measure Benchmarks** We're proposing to apply a flat benchmarking methodology to a subset of topped out measures:	• **Traditional MIPS** • **MVPs** • **APP**

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2025 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td></td><td></td><td>

Those 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’d propose the measures this policy would apply to during each year in rulemaking.

Specifically, we’d 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>98-99.9%</td><td>8-8.9</td></tr>
<tr><td>100%</td><td>10*</td></tr>
</table>
* We intentionally omitted the possibility of earning 9 – 9.9 points to hold the scoring of these measures to a high standard in achieving maximum points.
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POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measure Scoring	**Complex Organization Adjustment** No existing policy.	**Complex Organization Adjustment** We're proposing 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 proposal: • We'd **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**
Quality Measure Scoring	**Flat Benchmarks for Medicare CQMs** No existing policy.	**Flat Benchmarks for Medicare CQMs** We're proposing that Medicare CQMs (available only to Shared Savings Program ACOs) would be scored using flat benchmarks for the measures' first 2 performance periods in MIPS until historical data is available for establishing benchmarks.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
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're proposing 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. • A data submission with only a date and practice ID won't be considered a data submission and will be assigned a null score. This proposal is intended to mitigate the negative scoring impact on clinicians due to data submitted with only a practice ID, date, or measure ID included (no numerator or denominator) which results in a zero score.	• **Traditional MIPS** • **MVPs** • **APP**
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're proposing that the APP Plus quality measure set would be optional for MIPS eligible clinicians, groups, and APM Entities, except for Shared Savings Program ACOs which would be required to report the APP Plus quality measure set. To meet the reporting requirements of the APP Plus quality measure set, all measures in the APP	• **APP**

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		Plus quality measure set would be required to be reported.	
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), we're proposing to codify our existing process: • Calculate and score each submission received and assign the higher of the scores. For multiple data submissions received for an individual clinician, group, subgroup, or virtual group **from the same organization** (for example, by 2 practice administrators), we're proposing to codify our existing process: • Score the most recent submission. • The new submission would override a previous submission (of the same submission type) from the same organization. **NOTE:** This proposal wouldn't apply to different submission types by the same organization. For example, a small practice can report some quality measures through Medicare Part B claims, and some through a file upload.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		The measures submitted via file upload wouldn't override the measures submitted via Medicare Part B claims, as these are distinct submission types.	
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're proposing 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. • If finalized, MVP participants would 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.	**APP Plus Quality Measure Set** We're proposing to establish the APP Plus quality measure set under the APP, which would be an optional measure set for MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM but **required for Shared Savings Program ACOs**.	

POLICY AREA	EXISTING POLICY	CY 2025 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	Beginning with the 2025 performance period, Shared Savings Program ACOs must submit: • Diabetes: Hemoglobin A1c (HbA1c) Poor Control (Quality ID 001) • 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 CQM, or any combination of these 3 collection types. Additionally, ACOs must administer: • Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey / Quality ID 321 Finally, Shared Savings Program ACOs will be automatically evaluated on the following administrative claims-based measures: • Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate	The existing APP quality measure set would still be available for MIPS APM participants **except** for Shared Savings Program ACOs. Under our proposal for the **new APP Plus quality measure set**: • We'd **add** the remaining **5** Adult Universal Foundation **measures incrementally between the 2025 and 2028 performance periods** to the 6 measures in the existing APP quality measure set, for a total of 11 measures in the APP Plus quality measure set in the 2028 performance period. • Shared Savings Program ACOs would be required to report the APP Plus quality measure set and to submit their measures through the eCQM or Medicare CQM collection types (or a combination of the 2); they wouldn't have the option to report the MIPS CQM collection type beginning with the 2025 performance period. We're also proposing the following timeline for adding the 5 Adult Universal Foundation quality measures to the APP Plus quality measure set, to allow time for eCQM and Medicare CQM specifications to be developed:	

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2025 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td></td><td>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)
(As previously finalized, the 2024 performance period is the final year for Shared Saving Program ACOs to report the 10 CMS Web Interface measures under the APP.)</td><td><table><tr><th>Measure Name/ID</th><th>Proposed Performance Period</th></tr><tr><td>Breast Cancer Screening (Quality ID 112)</td><td>2025</td></tr><tr><td>Colorectal Cancer Screening (Quality ID 113)</td><td>2025</td></tr><tr><td>Initiation and Engagement of Substance Use Disorder Treatment (Quality ID 305)</td><td>2026</td></tr><tr><td>Screening for Social Drivers of Health (Quality ID 487)</td><td>2028</td></tr><tr><td>Adult Immunization Status (Quality ID 493)</td><td>2028</td></tr></table></td><td></td></tr>
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POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED 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're proposing to add 6 episode-based cost measures beginning with the 2025 performance period for implementation at the group (TIN) and	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		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, and Rheumatoid Arthritis). We're also proposing 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 proposed cost measure (new or modified).	

Cost Measures	**Removal Criteria** No finalized criteria for removing cost measures from MIPS.	**Removal Criteria** We're proposing 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. 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're also proposing 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.	• **Traditional MIPS** • **MVPs**

<table>
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<td>Cost Measure Scoring</td>
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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.

<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>4 - 4.9</td><td>70th – 61st</td></tr>
<tr><td>5 - 5.9</td><td>60th – 51st</td></tr>
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Benchmarks

We’re proposing to revise the cost scoring benchmarking methodology starting in 2024 performance period/2026 MIPS payment year. (If finalized, these changes would take effect when 2024 final scores are released in summer 2025.)

The proposed cost scoring methodology would use a new distribution for cost scoring in which the median cost for a measure would 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 would be set at 7.5, the performance threshold equivalent. The cut-offs for benchmark point ranges would then be calculated based on standard deviations from the median.

The proposed benchmark methodology would more appropriately incentivize or penalize clinicians with below or above national average spending.

<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>
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<td>

Traditional MIPS
MVPs

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</table>

6 - 6.9	50th – 41st
7 - 7.9	40th – 31st
8 - 8.9	30th – 21st
9 - 9.9	20th – 11th
10	10th – 1st (lowest costs)

4 - 4.9	Median cost ($) + (2 x standard deviation ($))
5 - 5.9	Median cost ($) + (1.5 x standard deviation ($))
6 - 6.9	Median cost ($) + (1 standard deviation ($))
7 - 7.9	Median cost ($) + (0.5 x standard deviation ($))
8 - 8.9	Median cost ($) - (0.5 x standard deviation ($))
9 - 9.9	Median cost ($) – (1 x standard deviation ($))
10	Median cost ($) - (1.5 x standard deviation ($))

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 proposed benchmark methodology would 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 **proposed methodology**, **she'd 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 2024 PROPOSED 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're proposing the following changes to the improvement activities inventory for the 2025 performance period: • Addition of 2 new activities (See Appendix F) • Modification of 2 existing activities • Removal of 8 activities (See Appendix G)	• 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. 3. Activity does not align with current clinical guidelines or practice. 4. Activity does not align with at least one meaningful measure area.	**Removal Criteria** In this proposed rule, we are proposing to codify at § 414.1355 these improvement activity removal factors.	• Traditional MIPS • MVPs

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	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're proposing to remove activity weightings to simplify scoring and complement our ongoing efforts to refine and improve the Inventory.	• Traditional MIPS • MVPs
Improvement Activities Reporting Requirements	**Number of Required Activities** Most clinicians must submit 2 to 4 improvement activities to receive the maximum improvement activities score of 40 points for the 2024 performance year.	**Number of Required Activities** We're proposing to simplify requirements by reducing the number of activities clinicians are required to attest to completing. **MVP Reporting**	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	The number of improvement activities submitted is dependent on special status, APM participation and activity weight.	• 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.	
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're proposing 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. This proposal is intended to mitigate the negative scoring impact on clinicians due to data submitted with only a practice ID, date, or activity ID included (no "yes" or affirmative attestation) which results	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		in a zero score for the performance category for which data is submitted.	
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), we're proposing to codify our existing process: • Calculate and score each submission received and assign the higher of the scores. For multiple data submissions received for an individual clinician, group, subgroup, or virtual group **from the same organization** (for example, by 2 practice administrators), we're proposing to codify our existing process: • Score the most recent submission. • The new submission would override a previous submission (of the same submission type) from the same organization. **NOTE:** This proposal wouldn't apply to different submission types by the same organization. For example, a group reporting traditional MIPS can submit one improvement activity via	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		attestation (manual entry), and a second through a file upload. The activity submitted via file upload wouldn't override the activity submitted via attestation, as these are distinct submission types.	
POLICY AREA	**EXISTING POLICY**	**CY 2024 PROPOSED 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** (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	**We're not proposing any changes to these policies.** Please note that we're not proposing 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 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	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	• Hospital-based • Non-patient facing • Small practice	• 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're proposing 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 measures in each objective, as specified by CMS; • 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 wouldn't be considered a data submission and would be assigned a null score; it wouldn't	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		override reweighting of the Promoting Interoperability category. This proposal is intended to mitigate the negative scoring impact on clinicians due to accidental submissions – data submitted with only a practice ID, date, or measure ID included (no numerator or denominator or attestation response) which results in a zero score for the performance category for which data is submitted.	
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're proposing that, for multiple data submissions received, CMS would calculate a score for each data submission received and assign the highest of the scores.	• **Traditional MIPS** • **MVPs** • **APP**
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're proposing 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 2024 PROPOSED 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're proposing to allow clinicians to **request reweighting** for quality, improvement activities, and/or Promoting Interoperability performance category(ies) 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. In determining whether to apply reweighting to the affected performance category(ies), 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; and • Whether the issue between the clinician and their third party intermediary caused no data to be submitted.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
		As proposed: • These requests would 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 could 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 MIPS payment year, the performance threshold was set at 75 points.	**Performance Threshold** We're proposing to continue using the mean as the methodology for determining the performance threshold for the CY 2025 performance period/2027 MIPS payment year through CY 2027 performance period/2029 MIPS payment year. We're also proposing to continue using the mean final score from the CY 2017 performance period/2019 MIPS payment year. On this basis, we are proposing to **set the performance threshold at 75 points** for the CY 2025 performance period/2027 MIPS payment year.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED 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're proposing that survey vendors must submit the best estimate of the cost of their services to CMS. These **costs would be published** to increase transparency on the cost of participation in the program and increase consistency across requirements.	• Traditional MIPS • MVPs • APP

Advanced APMs Overview

POLICY AREA	EXISTING POLICY	CY 2024 PROPOSED POLICY
Qualifying APM Participant (QP) Determinations	**Establishing Patient Threshold Score: Attribution-Eligible Beneficiaries** Attribution-eligible beneficiaries are only calculated for beneficiaries who are determined attribution-eligible by applying six criteria for a beneficiary to be attributed to an APM: 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.	**Establishing Patient Threshold Score: Attribution-Eligible Beneficiaries** We're proposing to amend the 6th criterion to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs, beginning with performance year 2025.

How Do I Comment on the CY 2025 Proposed Rule?

The proposed rule includes directions for submitting comments. We must receive comments within the 60-day comment period. When commenting, refer to file code: CMS-1807-P.

We don't accept FAX transmissions.

Use 1 of the 3 following ways to officially submit your comments:

- **Electronically**: www.regulations.gov
- **Regular mail**: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1807-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- **Express or overnight mail**: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1807-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

You can access the proposed rule through the "Regulatory Resources" section of the QPP Resource Library.

Contact Us

We encourage clinicians to contact the QPP Service Center. Contact the Quality Payment Program 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.

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 Measures 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 Measures Previously Finalized for Removal in 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 Proposed for the 2024 Performance Period and Future Years

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
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 would address timely biomarker testing for patients with a diagnosis of metastatic non-small cell lung cancer or squamous cell carcinoma that impacts treatment decisions and 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.
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 would address 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 that could allow for more personalized diagnostic, predictive, prognostic, and therapeutic strategies for the patient. This measure could be considered for inclusion within the Advancing Cancer Care MVP in the future and would fill a current quality measure inventory gap within the oncologic clinical topic. It would add a specialty specific measure to the MIPS Oncology/Hematology specialty set.
Patient-Reported Pain Interference Following Chemotherapy	The PRO-PM will assess pain interference following chemotherapy administered with	MIPS CQM Specifications	Patient-Reported Outcome-based	This measure would address a CMS high priority as a PRO-PM and would fill a gap by providing the patient's experience of care related to breakthrough pain after

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
among Adults with Breast Cancer Purchaser Business Group on Health	curative intent to adult female patients with breast cancer.		Performance Measure (PRO-PM) High Priority	chemotherapy for breast cancer to inform practice improvement. This measure could be considered for inclusion within the Advancing Cancer Care MVP as it would fill a current quality measure inventory gap within the oncologic clinical topic and would add a specialty specific measure to the MIPS Oncology/Hematology specialty set. This would be the first outcome specialty specific oncology measure to address the patient experience of care.
Adult COVID-19 Vaccination Status Centers for Medicare & Medicaid Services	Percentage of patients aged 18 years and older seen for a visit during the performance period that are up-to-date on their COVID-19 vaccinations as defined by Centers for Disease Control and Prevention (CDC) recommendations on current vaccination.	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 reviews, there is general agreement about the safety and efficacy of the COVID-19 vaccine, preventing costly and potentially harmful hospitalizations.
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	MIPS CQM Specifications	Outcome High Priority	This measure would evaluate 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 and would address 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 would allow for the development of a system

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
	diagnoses the patient for recurrence of melanoma.			in which melanomas can be accurately tracked to increase the understanding of the effectiveness of care.
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 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.	MIPS CQM Specifications	Process	This measure would address 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 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.
Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients	The measure tracks dialysis patients who are under the age of 75 in a practitioner group and on the kidney or kidney-pancreas	MIPS CQM Specifications	Process	This measure would address 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

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Waitlisted in Active Status (aPPPW) Centers for Medicare & Medicaid Services	transplant waitlist (all patients or patients in active status). This measure is a risk-adjusted percentage of waitlist events among dialysis patients.			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 Proposed for Removal in 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 proposed for 2025. The new measure is an outcome measure that would provide a more meaningful impact to quality improvement.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
144	MIPS CQM Specifications/ Process	Yes	**Oncology: Medical and Radiation – Plan of Care for Pain:** Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.	American Society of Clinical Oncology	Measure is duplicative to current MIPS measure Q143: Oncology: Medical and Radiation – Pain Intensity Quantified, which is a more robust measure. Additionally, measure Q143 is available for reporting within the eCQM collection type allowing clinicians more measure options for reporting eCQMs.
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 would be duplicative of current MIPS measure Q344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) if the proposed

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
					changes to measure Q344 are finalized.
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.
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 would be duplicative of current MIPS measure Q432: Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair if the proposed changes to measure Q432 are finalized.
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.

Quality #	Collection Type / Measure Type	High Priority	Measure Title and Description	Measure Steward	Rationale for Removal
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 similar measures, measure Q451 is more clearly worded than measure 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 Proposed for the 2025 Performance Period and Future Years

Activity Title	Subcategory	Activity Description

Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake	Population Management	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)

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

Activity Title	Subcategory	Activity Description
Screening and Treatment for Cardiovascular Disease Risk		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 Proposed for Removal in the 2025 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
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.
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
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.

Activity ID	Subcategory	Activity Title and Description
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.
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)
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 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.

Activity ID	Subcategory	Activity Title and Description
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).
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.