2024/2025 Quality Payment Program Overview & Updates

Altarum Quality Improvement Advisor Services

December 4, 2024

Cheryl Budimir

Quality Improvement Advisor

With over 33 years of experience as a Practice Administrator, Ms. Budimir has successful implemented standardized workflows to significantly improve patient care and align with regulations and payor incentives.

Since joining Altarum, she has worked on various projects, including CMS's Transforming Clinical Practice Initiative project, the Quality Payment Program Technical Support Team, AHRQ's Healthy Hearts for Michigan program, Alcohol-Related Care, and HRSA's National Hypertension Control Initiative.

Ms. Budimir's commitment to improving patient outcomes is evident in her work. She is dedicated to supporting clinicians in navigating payer incentive programs and streamlining workflows, integrating value-based care initiatives aligning with federal and commercial carriers.

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Agenda

- Review the 2024 QPP End-of-Year Considerations and Timeline
- Exam 2025 QPP Program Changes
- High-level review of the three reporting options:
    - Traditional MIPS,
    - MIPS Value Pathways (MVP)
    - Alternative Payment Model (APM)(REACH)
- Create a 2025 QPP “To Do List.”
- Questions and Answers

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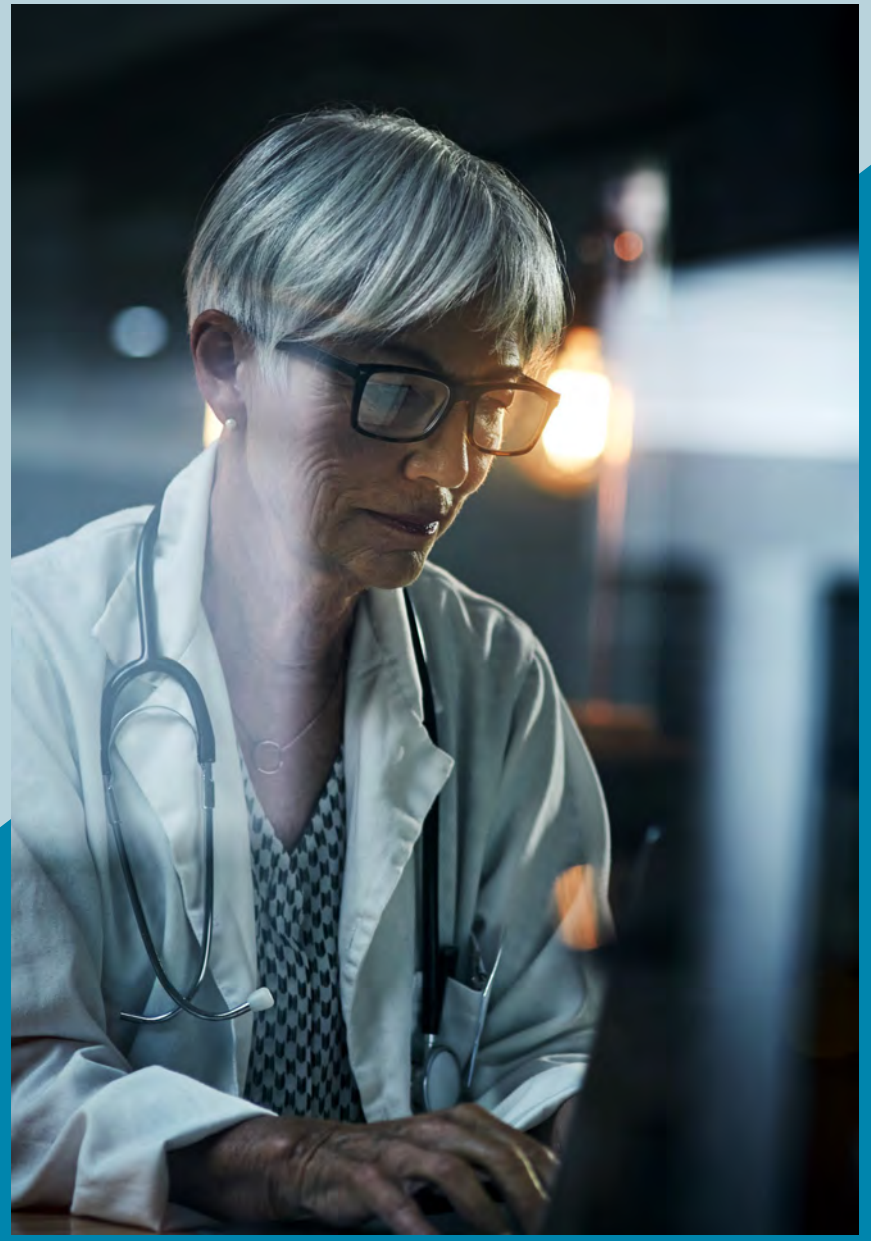
2024 QPP Performance Year

Traditional MIPS



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2024 QPP Participation Status

https://qpp.cms.gov/participation-lookup

December 2024: Updated PY 2024 MIPS eligibility special status based on analysis of claims and PECOS data: October 1, 2023 - September 30, 2024.

MIPS Eligible Clinicians exceed the low-volume threshold and **are required** to report

Opt-in clinicians can choose to participate but **are not required to report**

Qualifying MIPS APM Participant (QP) determinations and eligibility to report in the MIPS program are determined through four snapshots between January 1 and December 31.

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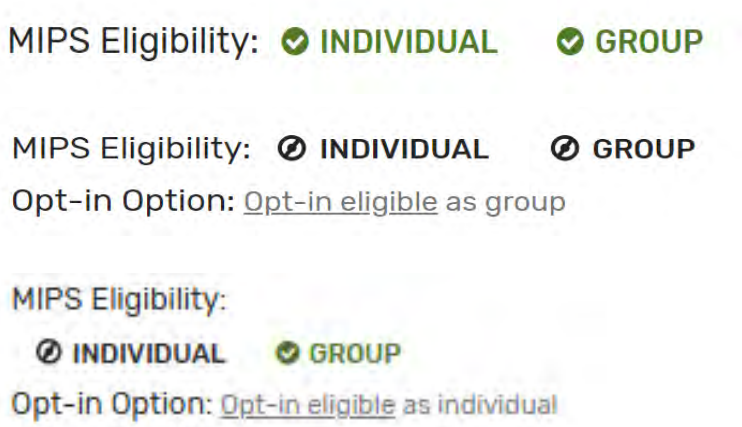
2024 MIPS Eligibility



Low-Volume Thresholds:

Clinician Level

- Medicare Patients exceed 200
- Allowed charges exceed $90,000.
- Covered services exceed 200

Practice Level

- Medicare Patients exceed 200
- Allowed charges exceed $90,000.
- Covered services exceed 200

MIPS Eligible Clinicians exceed three of the low-volume threshold and are required to report for MIPS

Opt-in clinicians are not required to report, they do not exceed all three low-volume threshold elements but exceed one or two of them.

Groups can report if they meet the low-volume threshold, but it is not mandatory.

* Always want to look at scoring both ways, individually and group scores. There are times when the group score is better than the individuals, and Medicare takes the highest score.

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2024 MIPS Performance Threshold & Payment Adjustments

Performance Threshold for 2024 is set at 75 points. This is for all MIPS-eligible clinicians, not just small practices.

75 points is the minimum score needed to avoid a negative payment adjustment.

2026 Payment Adjustment is based on 2024 Final Score	
2024 Final Score	**2026 Payment Adjustment**
75.01-100 points	• Positive adjustment greater than 0%
Performance Threshold: 75 points	• Neutral payment adjustment (0%)
18.76 – 74.99 points	• Negative payment adjustment between -9% and 0%
0 – 18.75 points	• Negative payment adjustment of -9%

You will always want to consider scoring individually and in groups, as sometimes the groups will score better together, and Medicare will take the highest score.

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2024 MIPS Performance Year Record Keeping

Quality Performance Category

2024 Quality Performance Category Quick Start Guide

- ❑ 12-month reporting period
- ❑ Select a minimum of Six (6) MIPS quality measures
  - ❑ One of the Six must be an outcome or a high-priority measure if there is no applicable outcome measure. **OR**
- ❑ Report One complete specialty measure set

  (Anesthesiology (5), Dentistry (2), Electrophysiology Cardiac Specialist (2), Hospitalists (4), Radiation Oncology (4)
- ❑ Each quality measure meets the case minimum of 20 cases.
- ❑ Each quality measure meets the data completeness requirement of 75%

https://qpp.cms.gov/mips/explore-measures

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2024 MIPS -Promoting Interoperability Performance Category

2024 Promoting Interoperability Quick Start Guide

- ❑ Electronic Health Record Software (EHR) meets certification criteria and is maintained and updated at 45 CFR 170.315
- ❑ EHR Certification Number: _____ (https://chpl.healthit.gov/#/search)
- ❑ 120-day reporting period (6-months)
- ❑ PI Category automatically reweighted to 0% for Small Practices
- ❑ Complete the self-assessment checklist in the High Priority Practices SAFER Guide (PDF) must submit a yes answer during attestation

https://qpp.cms.gov/mips/promoting-interoperability

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2024 MIPS Promoting Interoperability Objectives

Objectives	Measures		Measure Exclusions (If you meet the criteria below, you can claim an exclusion instead of reporting the measure)	Available Points (based on performance)
e-Prescribing	e-Prescribing		Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.	1 – 10 points
	Query of PDMP		(1) Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period; or (2) Any MIPS eligible clinician who does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period.*	10 points
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.	1 – 15 points
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.	1 – 15 points
	Option 2	HIE Bi-Directional Exchange	No exclusion available	30 points
	Option 3	Enabling Exchange under TEFCA	No exclusion available	30 points

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2024 MIPS Promoting Interoperability Objectives (Contd)

Objectives	Measures	Measure Exclusions (If you meet the criteria below, you can claim an exclusion instead of reporting the measure)	Available Points (based on performance)
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No exclusion available	1 – 25 points
Public Health and Clinical Data Exchange	Report to the following public health or clinical data registries: 1. Immunization Registry Reporting 2. Electronic Case Reporting	Each of these measures has their own exclusions; please refer to the 2024 Promoting Interoperability Measure Specifications (ZIP 3MB) for the exact exclusion criteria for each measure. Generally speaking, the exclusions are based on the following criteria: • Doesn't diagnose or directly treat any disease or condition associated with an agency/registry in their jurisdiction during the performance period. • Operates in a jurisdiction for which no agency/registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period. • Operates in a jurisdiction where no agency/registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.	25 points for the objective
	Option to report one of the following public health agency or clinical data registry measures: • Public Health Registry Reporting, OR • Clinical Data Registry Reporting, OR • Syndromic Surveillance Reporting	Optional measures (no exclusions available)	5 bonus points

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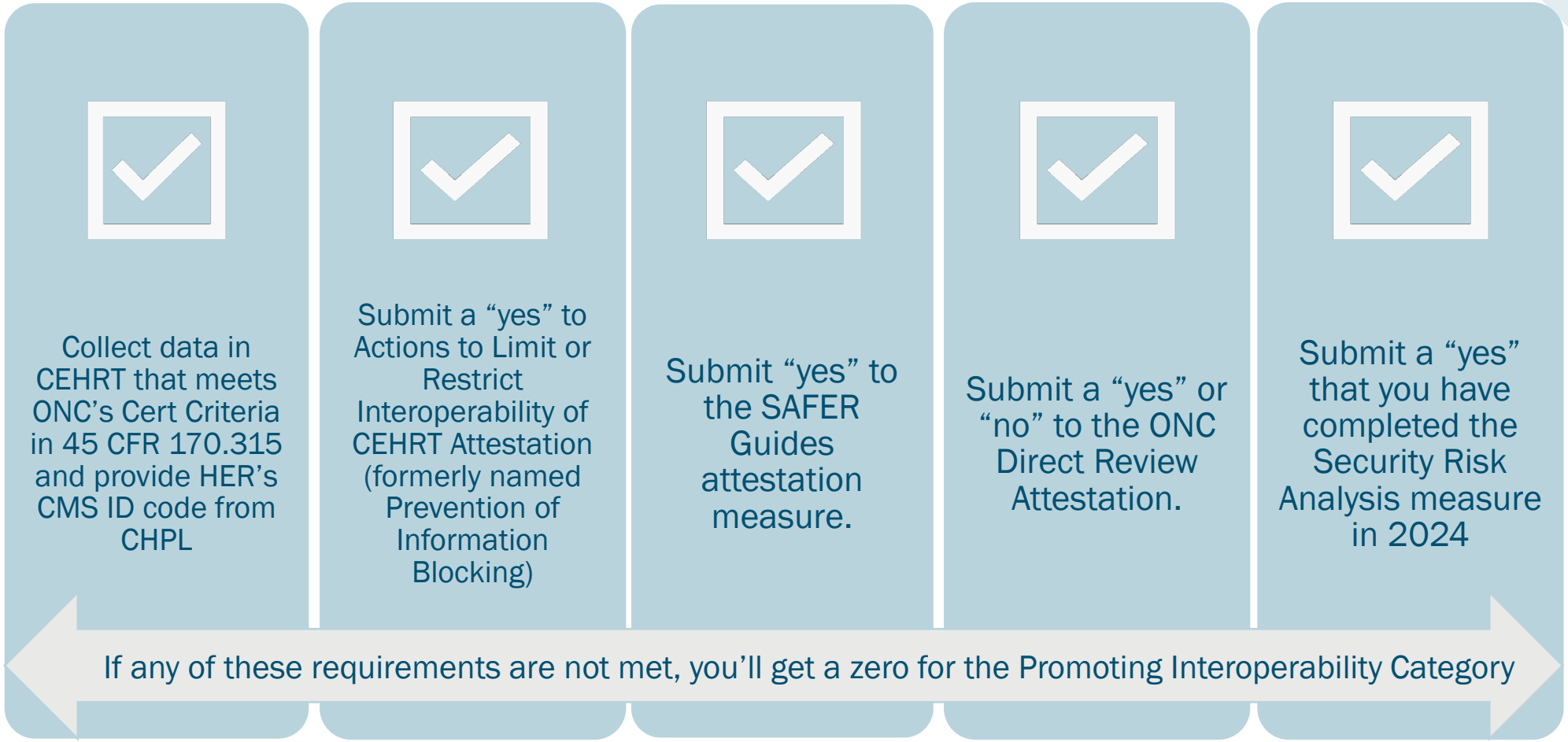
2024 MIPS Promoting Interoperability - Requirements



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2024 Security Risk Assessment Tool

https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

The Security Risk Assessment Tool-Overview for Small and Medium Practices

Disclaimer: *The Security Risk Assessment Tool at HealthIT.gov is provided for informational purposes only. Use of this tool is neither required by nor guarantees compliance with federal, state or local laws. Please note that the information presented may not be applicable or appropriate for all health care providers and organizations. The Security Risk Assessment Tool is not intended to be an exhaustive or definitive source on safeguarding health information from privacy and security risks. For more information about the HIPAA Privacy and Security Rules, please visit the HHS Office for Civil Rights Health Information Privacy website.*

NOTE: The NIST Standards provided in this tool are for informational purposes only as they may reflect current best practices in information technology and are not required for compliance with the HIPAA Security Rule's requirements for risk assessment and risk management. This tool is not intended to serve as legal advice or as recommendations based on a provider or professional's specific circumstances. We encourage providers, and professionals to seek expert advice when evaluating the use of this tool.

High Priority Practices Guide Attestation (From the SAFER Guides)

https://www.healthit.gov/topic/safety/safer-guides

HealthIT.gov

Safer EHRs: An Introduction to the SAFER Guides (Video)

Foundational Guides	•High Priority Practices* •Organizational Responsibilities*
Infrastructure Guides	•Contingency Planning* •System Configuration* •System Interfaces*
Clinical Process Guides	•Patient Identification* •Computerized Provider Order Entry with Decision Support* •Test Results Reporting and Follow-Up* •Clinician Communication*

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2024 MIPS -Improvement Activity Category

2024 Improvement Activities Performance Category Quick Start Guide

Small Practice ≤ 15 clinicians:

- ❑ 1 High-Weighted Activity **OR**
- ❑ 2 Medium-Weighted Activities

Large Practice >15 clinicians

- ❑ 2 High-Weighted Activities **OR**
- ❑ 4 Medium-Weighted Activities **OR**
- ❑ 1 High-Weighted **and**
  2 Medium-Weighted Activities

2024 Improvement Activities Inventory (ZIP,499KB).

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2024 MIPS -Cost Performance Category

2024 Cost Performance Category Quick Start Guide

- 27 MIPS Episode-Based Cost Measures in the 2024 Performance Period.
- CMS automatically evaluates and calculates data from administrative claims for measures that meet or exceed the established case minimum.
- What can we control:
  - ❑ Improve care coordination improves health outcomes, resulting in lower healthcare cost
  - ❑ Track your Admit, Discharge, and Transfer (ADT) notifications
  - ❑ Contact all hospital-discharged patients, arrange follow-up appointments in the office

2024 MIPS- Cost Performance Measures

Measure Name/Type	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	This population-based measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	Medicare Parts A and B claims data
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	This measure assesses the cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.	35 episodes	Medicare Parts A and B claims data
15 procedural episode-based measures	Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.	10 episodes for all procedural episode-based measures **except** the Colon and Rectal Resection measure which has a case minimum of 20 episodes	Medicare Parts A and B claims data
6 acute inpatient medical condition episode-based measures	Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures	Medicare Parts A and B claims data (all acute inpatient condition episode-based cost measures), Medicare Part D claims (Sepsis episode-based cost measure)
5 chronic condition episode-based measures	Assess the cost of care clinically related to the care and management of patients' specific chronic conditions provided during a total attribution window divided into episodes.	20 episodes for chronic condition episode-based measures	Medicare Parts A, B and D claims data
1 measure focusing on care provided in the emergency department setting (Emergency Medicine)	Evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period.	20 episodes	Medicare Parts A and B claims data

Cost Performance Measures Continued

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who receive an elective knee arthroplasty during the performance period.	Acute inpatient (IP) hospitals, hospital outpatient department (HOPDs), ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period.	ASCs, HOPDs, and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	• Pre-Trigger Period = 60 days • Post-Trigger Period = 90 days	Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.	ASCs and HOPDs
Screening/Surveillance Colonoscopy	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 14 days	Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.	ASCs, ambulatory/office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who receive an inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals

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Cost Performance Measures .....

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Primary Hip Arthroplasty	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who receive an elective primary hip arthroplasty during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Femoral or Inguinal Hernia Repair	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Hemodialysis Access Creation	Procedural	• Pre-Trigger Period = 60 days • Post-Trigger Period = 90 days	Patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period.	Ambulatory/office-based care centers, OP hospitals, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	• Pre-Trigger Period = 30 days • Post- Trigger Period = 90 days	Patients who undergo surgery for lumbar spine fusion during the performance period.	ASCs, HOPDs, and acute IP hospitals
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo partial or total mastectomy for breast cancer during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, and ASCs
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo a CABG procedure during the performance period.	Acute IP hospitals
Renal or Ureteral Stone Surgical Treatment	Procedural	• Pre-Trigger Period = 90 days • Post-Trigger Period = 30 days	Patients who receive surgical treatment for renal or ureteral stones during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Trigger Period = 90 days	Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.	Acute IP hospitals

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Cost Performance Measures .....

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...	Measures Can Be Triggered Based on Claims Data from the Following Settings:
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who present with STEMI indicating complete blockage of a coronary artery who emergently receive PCI as treatment during the performance period.	Acute IP hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Trigger Period = 60 days	Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.	Acute IP hospitals
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Tigger period = 35 days	Patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period.	Acute IP hospitals
Psychoses and Related Conditions	Acute inpatient medical condition	• Pre-Trigger Window: None • Post-Trigger Window: 45 days	Patients who receive inpatient treatment for psychoses or related conditions during the performance period.	Acute IP hospitals and inpatient psychiatric facilities (IPFs)
Melanoma Resection	Procedural	• Pre-Trigger Window: 30 days • Post-Trigger Window: 90 days	Patients who undergo an excision procedure to remove a cutaneous melanoma during the performance period.	ASCs, ambulatory/office-based care, and HOPDs.
Colon and Rectal Resection	Procedural	• Pre-Trigger Window: 15 days • Post-Trigger Window: 90 days	Patients who receive colon or rectal resection for either benign or malignant indications during the performance period.	ASCs, HOPDs, and acute IP hospitals
Sepsis	Acute inpatient medical condition	• Pre-Trigger Window: 0 days • Post-Trigger Window: 45 days	Patients who receive inpatient medical treatment for sepsis during the performance period.	Acute IP hospitals.

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Cost Performance Measures .....

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Diabetes	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat diabetes during the performance period.	The most frequent settings in which a Diabetes episode is triggered include: Office, skilled nursing facility (SNF), and OP hospital.
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat asthma or COPD during the performance period.	The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP hospital.
Depression	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients receiving medical care to manage and treat depression. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Depression episode.	The Depression measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with depression. The most frequent settings in which a Depression episode is triggered include: Office, nursing facility, SNF, and OP hospital.
Heart Failure	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients receiving medical care to manage and treat heart failure. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Heart Failure episode.	The Heart Failure measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with heart failure. The most frequent settings in which a Heart Failure episode is triggered include: office, OP hospital, and SNF.
Low Back Pain	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 120 days	Patients receiving medical care to manage and treat low back pain. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Low Back Pain episode.	The most frequent settings in which a Low Back Pain episode is triggered include: office, OP hospital, and ASC.
Emergency Medicine	Care Setting	• Pre-Trigger Window: 0 days • Post-Trigger Window: 14 days	Patients who have emergency department (ED) visit during the performance period.	Emergency department

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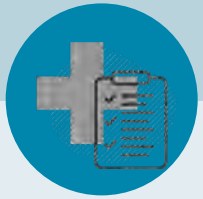
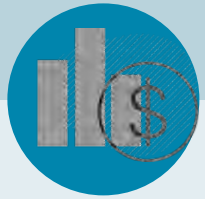
2024 MIPS Performance Category Weighting

2024 Standard weighting for Small Practices (Promoting Interoperability automatically reweighted)			
			
Quality	Promoting Interoperability	Improvement Activities	Cost
40% of MIPS Score	0% of MIPS Score	30% of MIPS Score	30% of MIPS Score
Weighting when both the cost and the Promoting Interoperability performance categories are reweighted:			
Quality	Promoting Interoperability	Improvement Activities	Cost
50% of MIPS Score	0% of MIPS Score	50% of MIPS Score	0% of MIPS Score

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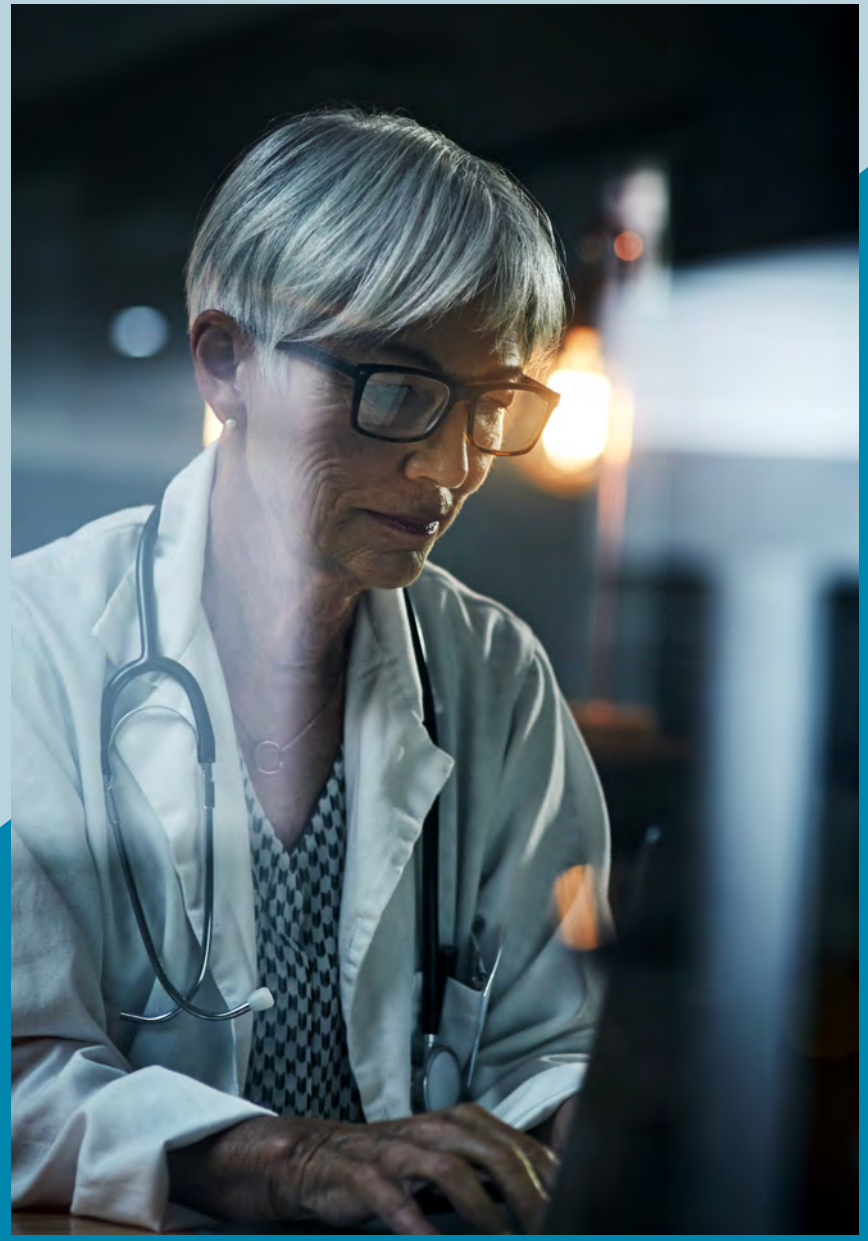
2024 QPP Performance Year

APM Participation



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2024 MIPS APM Qualifying Participant (QP) Status

https://qpp.cms.gov/participation-lookup

- **QP status** clinicians must receive at least **50%** of their Medicare Part P Payments or see at least **35%** of Medicare patients through an Advanced APM during the QP performance period (January 1 - August 31)
- Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (snapshot data generally available July 2024, October 2024, and **December 2024**)
- QPs receive a 1.88% APM Incentive Payment and an increased physician fee schedule update based on the QP conversion factor
- QPs are excluded from MIPS reporting and related payment adjustments
- QP Performance Year 2024 Incentive Payment Year 2026

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https://qpp.cms.gov/apms/advanced-apms

2024 MIPS APM Partial Qualifying Participant (Partial QP) Status

https://qpp.cms.gov/apms/advanced-apms

- Not all clinicians meet thresholds to achieve QP status, and they may become partial QPs.
- **Partial QP status** clinicians received at least **40%** of their Medicare Part P Payments or have seen at least **25%** of Medicare patients through an Advanced APM during the QP performance period (January 1- August 31)
- The benefit of achieving **Partial QP status** includes the option to choose whether to participate in MIPS.
  - If a Partial QP chooses not to report to MIPS:
    a. The clinician will not receive an MIPS payment adjustment.
  - If a Partial QP chooses to report to MIPS (meet or exceed the 75-point threshold)
    a. The clinician must fulfill all MIPS reporting requirements.
    b. The clinician must complete a submission to MIPS by reporting either:
       i. APM Performance Pathway (APP)
       ii. MIPS Value Pathway (MVP)(pre-registration required)
       iv. Traditional MIPS

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2024 MIPS APM Participant Status- QP Status Not Met

- Clinicians not meeting QP or a Partial QP status must participate in MIPS and submit performance category data.
- Subject to MIPS Incentives and Payment Adjustment unless otherwise excluded
- CMS recommends working with your APM directly to see the requirements, as each APM differs.
- If the APM is not reporting on behalf of the provider, the provider will need to report MIPS if they are eligible

2024 MIPS Reporting Timeline

December 2024

MIPS PY Eligibility Finalized

QP Status Determination

December 31, 2024

PY 2024 Ends

MIPS EUC Exception application closes

January 2, 2025

2024 Submission Window Opens

March 2025

MIPS APM Participation Information Available

March 31, 2025

Submission Window Closes for PY 2024

Late Summer 2025

Review

2025 Final Score

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2024 MIPS Audit File Checklist - Example

In accordance with the federal False Claims Act you are encouraged to keep QPP documentation for up to six (6) years and, as stated in the QPP Final Rule, the Centers for Medicare and Medicaid Services (CMS) may request any records or data retained for MIPS purposes for six (6) years for each year of attestation. In the event you receive an audit, you will need to supply information to substantiate your MIPS participation. An Audit File should be kept in hard copy, and/or electronic copy, either locally or via cloud. If you receive an audit request from the Centers for Medicare & Medicaid Services (CMS), your initial response is required within ten (10) business days to acknowledge the request. From the date of the initial request, you will have forty-five (45) calendar days to complete data sharing as requested, or an alternative timeframe that is agreed upon by Centers for Medicare & Medicaid Services (CMS) and the MIPS-eligible Clinician or Group. Federal False Claims Act or https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf

EHR Vendor & Product Name	Recommended Content for EC's Audit File	Content in Audit File?
PROOF OF CERTIFIED EHR TECHNOLOGY (CEHRT): https://chpl.healthit.gov/#/search **CMS EHR Certification ID:**_____	A copy of the purchase agreement/contract with the vendor from whom the CEHRT was purchased identifying the vendor name, product name and product version used for attestation.	☐ **Yes** ☐ **No** ☐ **N/A**
EHR Vendor: _____ **EHR Product:** _____ **EHR Version:** _____	If EHR reporting is used to submit Quality measure data, documentation to show all measures reported are certified by the EHR vendor (s) and meet the most recent electronic specification.	☐ **Yes** ☐ **No** ☐ **N/A**

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2024 MIPS Audit File Checklist

Quality Category	
List Quality Measures that were reported for MIPS Program Year 2022 Please refer to the 2022 MIPS Data Validation Criteria for suggested documentation details which can be found Here or at https://qpp.cms.gov/about/resource-library.	
Quality Measure/Quality Measure ID	**Documented on Quality Report?**
1.	☐ Y | ☐ N
2.	☐ Y | ☐ N
3.	☐ Y | ☐ N
4.	☐ Y | ☐ N
5.	☐ Y | ☐ N
6.	☐ Y | ☐ N
Additional Quality measure reported:	☐ Y | ☐ N
Additional Quality measure reported:	☐ Y | ☐ N
Recommended Content for EC's Audit File	**Content in Audit File?**
If you report via EHR, print out your quality submission on the CMS Quality Payment Program website, which includes the category score, the list of all measure(s) reported, and any earned bonus points, and whether you uploaded a QRDA III file or the EHR vendor submitted your information.	☐ **Yes** ☐ **No** ☐ **N/A**

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Questions?

2025 QPP Performance Year

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2025 QPP MIPS Participation Status

December 2024: Initial PY 2025 eligibility statuses based on claims analysis and PECOS data: October 1, 2023 - September 30, 2024.

PY 2025 eligibility status is updated throughout the year based on the following:
Analysis of claims and PECOS data from October 1, 2024 - September 30, 2025 (available December 2025)

Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (snapshot data generally available July 2025, October 2025, and December 2025)

https://qpp.cms.gov/participation-lookup

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2025 MIPS Performance Threshold, Data Completeness & Payment Adjustments

Performance Threshold for 2025 remains at 75 points. This is for all MIPS-eligible clinicians, not just small practices.

Data Completeness stays at 75% in the 2025 PY through the 2028 PY

Your 2025 Score	Payment Impact for MIPS Eligible Clinicians for the 2027 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	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality

You will always want to consider scoring individually and in groups, as sometimes the groups will score better together, and Medicare will take the highest score.

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2025 MIPS Quality Measure Inventory Updates

- Addition of 7 new Quality Measures:
  - #494 Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)*
  - #506: Positive PDL1 Biomarker Expression Test Result Prior to First Line Immune Checkpoint Inhibitor Therapy
  - #507: Appropriate Germline Testing for Ovarian Cancer Patients
  - #508: Adult COVID19 Vaccination Status
  - #509: Melanoma: Tracking and Evaluation of Recurrence
  - #510: First-Year Standardized Waitlist Ratio (FYSWR)
  - #511: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)

Explore Measures & Activities

2025 MIPS Quality Measure Changes & Removals

- Substantive changes to 66 quality measures
- Removed the following 10 Quality Measures from MIPS:
  - #104 Prostate Cancer: Combination Androgen Deprivation Therapy for High-Risk or Very High-Risk Prostate Cancer
  - #137 Melanoma: Continuity of Care – Recall System
  - #254 Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
  - #260 Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)
  - #409 Clinical Outcome Post Endovascular Stroke Treatment:
  - #433 Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair
  - #436 Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques
  - #439 Age-Appropriate Screening Colonoscopy
  - #452 Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti- Epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies
  - #472 Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

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Explore Measures & Activities

2025 MIPS Topped Out Measure Benchmarks

The benchmarking methodology has changed for specific topped-out measures, specifically those within specialty sets with limited options and in many topped-out measures where there is a lack of new measure development.

This practice strives to address challenges in meaningful MIPS participation in these areas. CMS will submit the exact measures this policy will apply each year and detail the related benchmarks.

Performance Rate	Available Points
84-85.9%	1-1.9
86-87.9%	2- 2.9
88-89.9%	3-3.9
90-91.9%	4-4.9
92-93.9%	5-5.9
94-95.9%	6-6.9
96-97.9%	7-7.9
98-99.9%	8-8.9
99-99.99%	9-9.9
100%	10

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2025 QPP MIPS Policy Changes

- Quality Measure subject to 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
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

2025 MIPS Improvement Activity Changes

- Two New Improvement Activities
  - IA_PM_24 Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake
  - IA_PM_25 Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk
- Removed of four Improvement Activities:
  - EPA_1 Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
  - ERP_4 Implementation of a Personal Protective Equipment (PPE) Plan
  - ERP_5 Implementation of a Laboratory Preparedness Plan
  - PSPA_27 Invasive Procedure or Surgery Anticoagulation Medication Management

2025 MIPS Improvement Activity Scoring Changes

CMS removed the weighting on Improvement Activities for the 2025 PY

- Traditional MIPS Reporting
  - Clinician, groups, and virtual groups within a small practice (15 or fewer clinicians), rural, non-patient facing, or health professional shortage area special status must attest to on activity
  - All other clinicians, groups, and virtual groups must attest to two activities
- MVP Reporting
  - Clinicians, groups, and subgroups (regardless of special status) must attest to one activity.

2025 MIPS Promoting Interoperability Changes

- CMS removed automatic reweighting for clinical social workers.
- 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 practices

2025 MIPS Promoting Interoperability Submission Criteria

- Promoting Interoperability data submissions must include
  - Performance Data
  - Required Attestations
  - A CMS EHR Certification ID
  - Six-month performance period dates

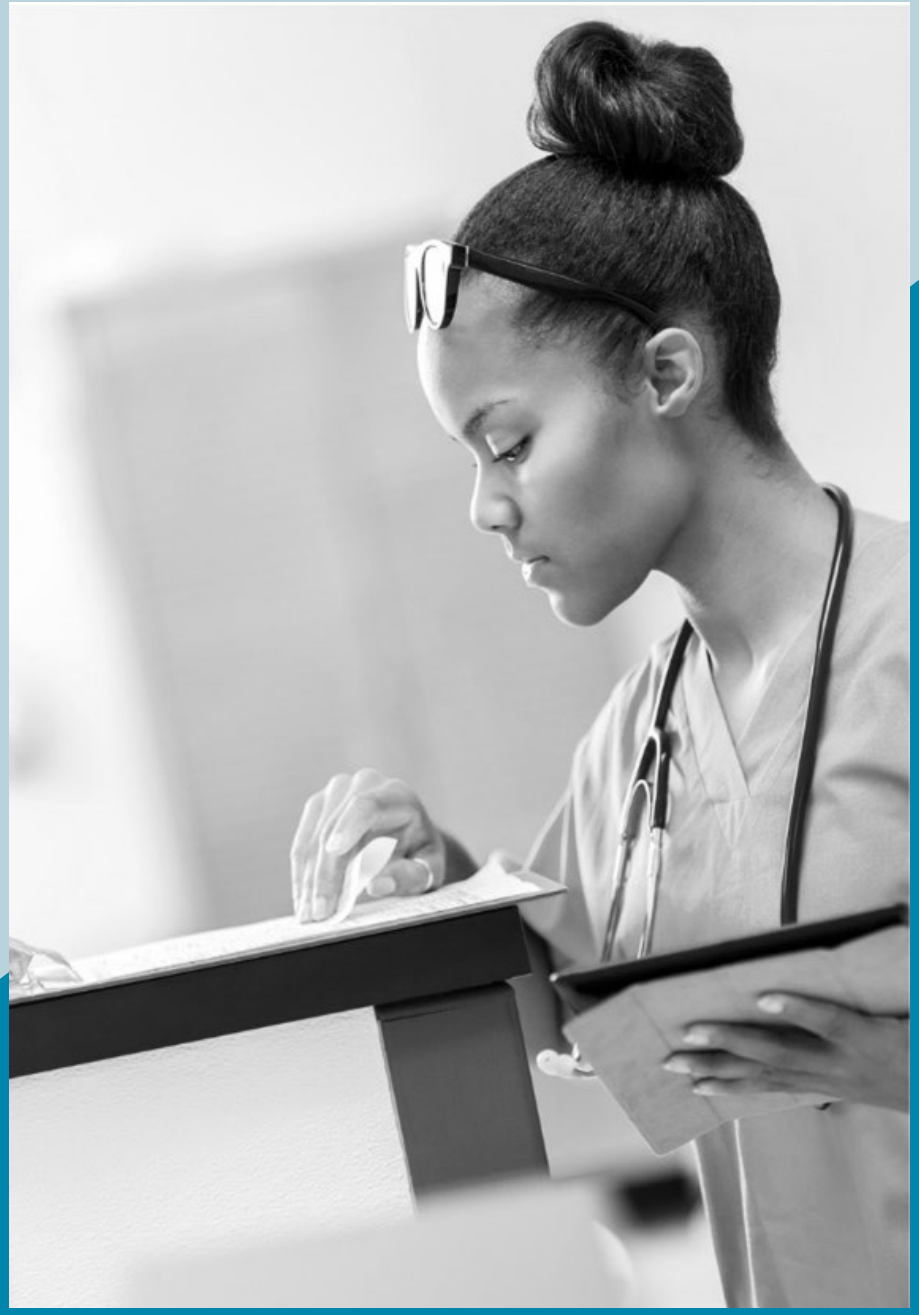
2025 MIPS Cost Category Changes

- CMS added Six Episode-based measures
  - One Acute Inpatient Medical Measure: Respiratory Infection Hospitalization
  - Five Chronic Condition Measures: Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis
- CMS made significant updates to two existing episode-based cost measures
  - Cataract Removal with Intraocular Lens (IOL) Implantation (formerly Routine Cataract with IOL Implantation)
  - Inpatient Percutaneous Coronary Intervention (PCI) (formerly ST-Elevation Myocardial Infarction [STEMI] PCI)

What questions do you have?

2025 QPP Performance Year

APM Participation



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2025 MIPS APM Qualifying Participant (QP) Status - Changes

https://qpp.cms.gov/participation-lookup

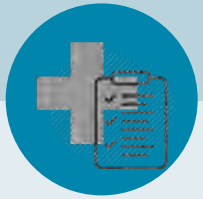
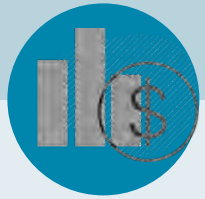
- **QP status** clinicians have received at least 75% of their Medicare Part P Payments or have seen at least 50% of Medicare patients through an Advanced APM during the QP performance period (January 1, 2025 - August 31, 2025)

- Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (snapshot data generally available July 2025, October 2025, and December 2025)

2025 MIPS APM Partial Qualifying Participant Status(Partial QP) Changes

- Not all clinicians achieve QP status; some may be eligible to become Partial QPs.
- Clinicians that reach **Partial QP status** received at least 50% of their Medicare Part P Payments or have seen at least 35% of Medicare patients through an Advanced APM during the QP performance period (January 1- August 31)
- The benefit of achieving **Partial QP status** includes choosing whether to participate in MIPS.
  - If clinicians choose not to report to MIPS:
    a. These clinicians will not receive an MIPS payment adjustment.
  - If clinicians choose to report to MIPS: (meet or exceed the 75-point threshold)
    a. These clinicians must fulfill all MIPS reporting requirements.
    b. These clinicians must complete a submission to MIPS by reporting either:
       i. APM Performance Pathway (APP)
       ii. Traditional MIPS

2025 MIPS Performance Category Weighting

2025 Standard weighting for Small Practices (Promoting Interoperability automatically reweighted)			
 Quality	 Promoting Interoperability	 Improvement Activities	 Cost
40% of MIPS Score	0% of MIPS Score	30% of MIPS Score	30% of MIPS Score
Weighting when both the cost and the Promoting Interoperability performance categories are reweighted:			
Quality	Promoting Interoperability	Improvement Activities	Cost
50% of MIPS Score	0% of MIPS Score	50% of MIPS Score	0% of MIPS Score

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Questions?

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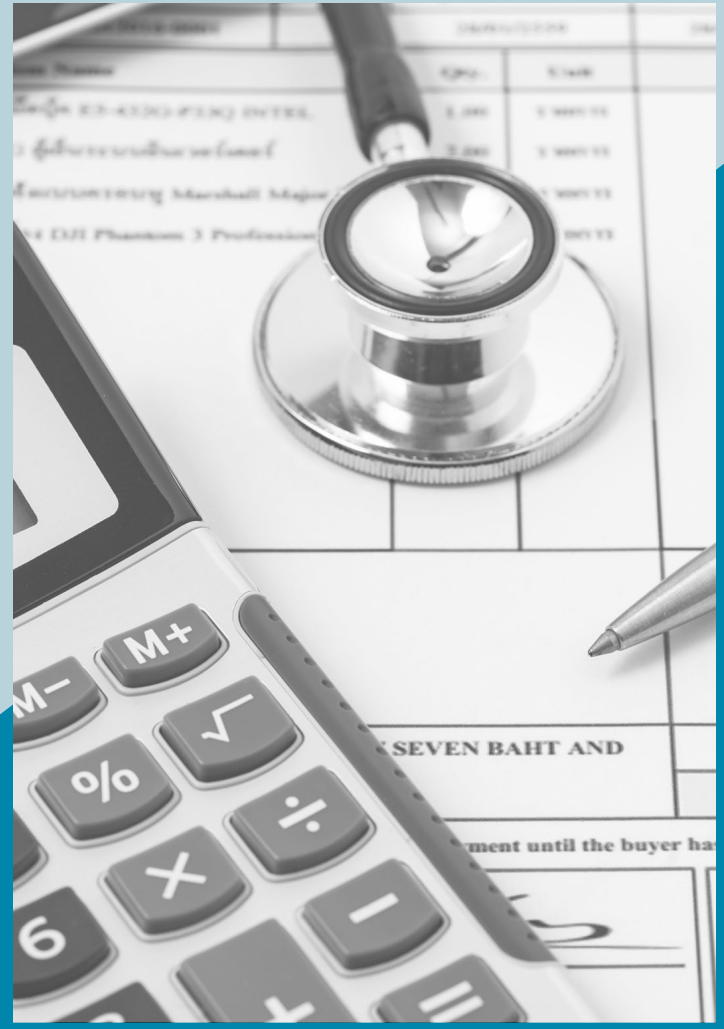
QPP reporting option:
MIPS Value Pathways (MVP)



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2025 MIPS Value Pathways (MVPs)

MVP Reporting Requirements

- Quality Performance Category
  - Select and submit 4 quality measures from those listed in the MVP
  - One measure must be an outcome measure (or a high priority in an outcome measure is not available or applicable)
- Improvement Activities Performance Category
  - For MVP reporting, clinicians, groups, and subgroups (regardless of special status) must attest to 1 activity. Clinicians may still choose to report IA_PCMH
- Cost Performance Category
  - CMS calculates performance exclusively on the cost measures included in the MVP using administrative claims data.

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2025 MIPS Value Pathways (MVPs) cont'd

MVP Foundational Layer

- Population Health Measures - calculated through administrative claims and scored as part of the quality performance category
  - Hospital-wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups
  - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
- Promoting Interoperability Performance Category
  - Submit the identical Promoting Interoperability measures mandatory under traditional MIPS unless you qualify for reweighting of the Promoting Interoperability performance category

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2025 MIPS Value Pathways (MVPs)

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2025 MVP Example-Complete Ophthalmologic Care MVP

Quality Measures

Q012: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
(Collection Type: eCQM Specifications)

(*)(!) Q019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
(Collection Type: eCQM Specifications)

(*) Q117: Diabetes: Eye Exam
(Collection Type: eCQM Specifications, MIPS CQM Specifications)

(*)(!) Q130: Documentation of Current Medications in the Medical Record
(Collection Type: eCQM Specifications, MIPS CQM Specifications)

(!!) Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
(Collection Type: Medicare Part B Claims Specifications, MIPS CQM Specifications)

(!!) Q191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
(Collection Type: eCQM Specifications, MIPS CQM Specifications)

Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
(Collection Type: Medicare Part B Claims, eCQM Specifications, MIPS CQM Specifications)

(!!) Q303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
(Collection Type: MIPS CQM Specifications)

(!) Q304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
(Collection Type: MIPS CQM Specifications)

(*)(!) Q374: Closing the Referral Loop: Receipt of Specialist Report
(Collection Type: eCQM Specifications, MIPS CQM Specifications)

(*)(!!) Q384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery
(Collection Type: MIPS CQM Specifications)

(!!) Q385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
(Collection Type: MIPS CQM Specifications)

(!!) Q389: Cataract Surgery: Difference Between Planned and Final Refraction
(Collection Type: MIPS CQM Specifications)

(~)(!) Q487: Screening for Social Drivers of Health
(Collection Type: MIPS CQM Specifications)

Q499: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy
(Collection Type: MIPS CQM Specifications)

(*) Q500: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
(Collection Type: MIPS CQM Specifications)

(*) Q501: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
(Collection Type: MIPS CQM Specifications)

(*)(!!) Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months
(Collection Type: MIPS CQM Specifications)

(!!) IRIS2: Glaucoma – Intraocular Pressure Reduction
(Collection Type: QCDR)

(!!) IRIS13: Diabetic Macular Edema – Loss of Visual Acuity
(Collection Type: QCDR)

(!!) IRIS39: Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure
(Collection Type: QCDR)

(!!) IRIS54: Complications After Cataract Surgery
(Collection Type: QCDR)

(!!) IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days
(Collection Type: QCDR)

(!!) IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery
(Collection Type: QCDR)

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Complete Ophthalmologic Care MVP

Improvement Activities

(~) IA_AHE_1: Enhance Engagement of Medicaid and Other Underserved Populations

(~) IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols

IA_BE_4: Engagement of patients through implementation of improvements in patient portal

IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings

IA_BE_25: Drug Cost Transparency

(~) IA_CC_9: Implementation of practices/processes for developing regular individual care plans

(~) IA_CC_10: Care transition documentation practice improvements

IA_CC_13: Practice improvements to align with OpenNotes principles

(**) IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways

IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation

IA_PM_13: Chronic care and preventative care management for empaneled patients

IA_PM_16: Implementation of medication management practice improvements

(*) IA_PM_26: Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B

(~) IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements

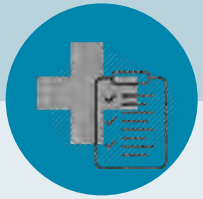
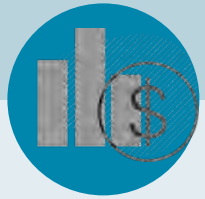
Complete Ophthalmologic Care MVP-cont'd

Cost

(*) Cataract Removal with Intraocular Lens (IOL) Implantation

Foundational Layer	
Population Health Measures	**Promoting Interoperability**
(!!) Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Groups (Collection Type: Administrative Claims) **(!!) Q484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions** (Collection Type: Administrative Claims)	• **Security Risk Analysis** • **High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)** • **e-Prescribing** • **Query of Prescription Drug Monitoring Program (PDMP)** • **Provide Patients Electronic Access to Their Health Information** • **Support Electronic Referral Loops By Sending Health Information** **AND** • **Support Electronic Referral Loops By Receiving and Reconciling Health Information** **OR** • **Health Information Exchange (HIE) Bi-Directional Exchange** **OR** • **Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)** • **Immunization Registry Reporting** • **Syndromic Surveillance Reporting (Optional)** • **Electronic Case Reporting** • **Public Health Registry Reporting (Optional)** • **Clinical Data Registry Reporting (Optional)** • **Actions to Limit or Restrict Compatibility or Interoperability of CEHRT** • **ONC Direct Review Attestation**

Placeholder-2025 MIPS MVP Performance Category Weighting

2025			
 Quality ?	 Promoting Interoperability ?	 Improvement Activities ?	 Cost ?
Quality ?	Promoting Interoperability ?	Improvement Activities ?	Cost ?

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2025 QPP MIPS To-Do List

Quality Performance

- ❑Check MIPS Participation Status
- ❑Select a minimum of Six (6) Quality Measures
- ❑One outcome measure or a high priority measure if there is no applicable outcome measure OR Report on one complete specialty measure set
- ❑Meet case minimum of 20
- ❑Monitor progress every month
- ❑At risk measures perform a PDSA on workflow

Improvement Activities

- ❑Clinician, groups, and virtual groups within a small practice (15 or fewer clinicians), rural, non-patient facing, or health professional shortage area special status must attest to on activity
- ❑All other clinicians, groups, and virtual groups must attest to two activities

Promoting Interoperability

- ❑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 practices
- ❑CEHRT Functionality meeting 45 CFR 170.315
- ❑Security Risk Assessment
- ❑Complete SAFER Guide

Questions?

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Happy Holidays

FROM ALL OF US AT

Please feel free to contact cheryl.budimir@altarum.org with any additional questions.