Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2025 Promoting Interoperability Quick Start Guide

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Purpose: This resource focuses on the Promoting Interoperability performance category, providing high-level requirements about data collection and submission for the 2025 performance year for individual, group, virtual group, subgroups, and Alternative Payment Model (APM) Entity participation. Promoting Interoperability requirements are the same for all reporting options: traditional MIPS, the APM Performance Pathway (APP), and MIPS Value Pathways (MVPs).

Already know what MIPS is? Skip ahead by clicking the links in the Table of Contents.

How to Use This Guide

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Click this icon (on the bottom left of each page) **to return to the table of contents.** 

Hyperlinks

Hyperlinks to the Quality Payment Program website and downloadable resources are included throughout the guide to direct the reader to more information and resources.

Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Overview

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

If you're eligible for MIPS in **2025**:

- You have to report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances or hardship exception. Detailed information will be available in the forthcoming 2025 Traditional MIPS Scoring Guide, 2025 APP Scoring Guide and 2025 MIPS Value Pathways Implementation Guide. These will be posted to the QPP Resource Library.
- We collect and calculate data for the cost performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances and whether or not you meet case minimum for any cost measures.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - Positive payment adjustment for clinicians with a 2025 final score above 75.
  - Neutral payment adjustment for clinicians with a 2025 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2025 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2025 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2027.

Quality Payment PROGRAM

To Learn More About MIPS Eligibility And Participation Options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

What is the Merit-based Incentive Payment System (Continued)

There are **3 reporting options** available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Traditional MIPS Overview webpage to learn more.	• The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM)**. • Visit the APM Performance Pathway webpage to learn more.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

What is the MIPS Promoting Interoperability Performance Category?

Interoperability, or the use of technology to exchange and make use of information, makes communicating patient information less burdensome and improves outcomes. The MIPS Promoting Interoperability performance category emphasizes the electronic exchange of health information using certified electronic health record technology (CEHRT) to improve:

- Patient access to their health information;
- The exchange of information between clinicians and pharmacies; and
- The systematic collection, analysis, and interpretation of healthcare data.

The MIPS performance categories have different "weights" and the scores from each of the categories are added together to give you a MIPS final score.

Individual, Group, Subgroup*, and Virtual Group** Participation

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

*Available for MVP reporting only.
**Available for traditional MIPS reporting only.

MIPS APM Entity Participation

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
55% of MIPS Score	0% of MIPS Score	15% of MIPS Score	30% of MIPS Score

MIPS APM participants may also choose to report the APM Performance Pathway (APP). Please reference the APP performance category weight slide in this guide.

Standard Weighting for Small Practices

(Promoting Interoperability Automatically Reweighted)

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

Individual, Group, and APM Entity Participation

APM Performance Pathway (APP) Performance Category Weights in 2025:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
50% of MIPS Score	0% of MIPS Score	20% of MIPS Score	30% of MIPS Score

For additional information about the Promoting Interoperability performance category under the APP, please refer to the Promoting Interoperability: APP Requirements webpage, MIPS Promoting Interoperability Performance Category CEHRT Frequently Asked Questions, and the 2025 APP Toolkit (ZIP), which will be available in the Quality Payment Program Resource Library later in 2025.

What's New with Promoting Interoperability in 2025?

1. We **discontinued automatic reweighting** for clinical social workers, which only applied through calendar year (CY) 2024 performance period/2026 MIPS payment year and wasn't extended for the 2025 performance period/2027 MIPS payment year. Therefore, automatic reweighting will only apply to MIPS eligible clinicians, groups, and virtual groups with the following special statuses for the 2025 performance period/2027 MIPS payment year:
   - Ambulatory Surgical Center (ASC)-based
   - Hospital-based
   - Non-patient facing
   - Small practice
2. We **updated** the minimum criteria for a Promoting Interoperability data submission. A qualifying data submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period. This update was finalized in the CY 2025 Medicare Physician Fee Schedule Final Rule to begin with the CY 2024 performance period/2026 MIPS payment year. Only qualifying data submissions will override reweighting.
3. We **updated** the scoring policy for multiple Promoting Interoperability data submissions received to calculate a score for each data submission and assign the highest of scores. This update was finalized in the CY 2025 Medicare Physician Fee Schedule Final Rule to begin with the CY 2024 performance period/2026 MIPS payment year.
4. We'll **continue** our policy requiring an MVP Participant that is a subgroup to submit its affiliated group's data for the Promoting Interoperability performance category.
5. The Medicare Shared Savings Program (Shared Savings Program) requirement to report the MIPS Promoting Interoperability performance category is effective for performance years beginning on or after January 1, 2025.

What's New with Promoting Interoperability in 2025? (Continued)

Electronic Case Reporting Measure Suppression

The Centers for Disease Control and Prevention (CDC) has temporarily paused electronic case reporting registration (learn more in this fact sheet) and onboarding of new health care organizations (HCOs) to establish a more efficient and automated onboarding process. As a result, some MIPS eligible clinicians may be unable to meet the electronic case reporting registration and onboarding requirements by the end of the 2025 performance period.

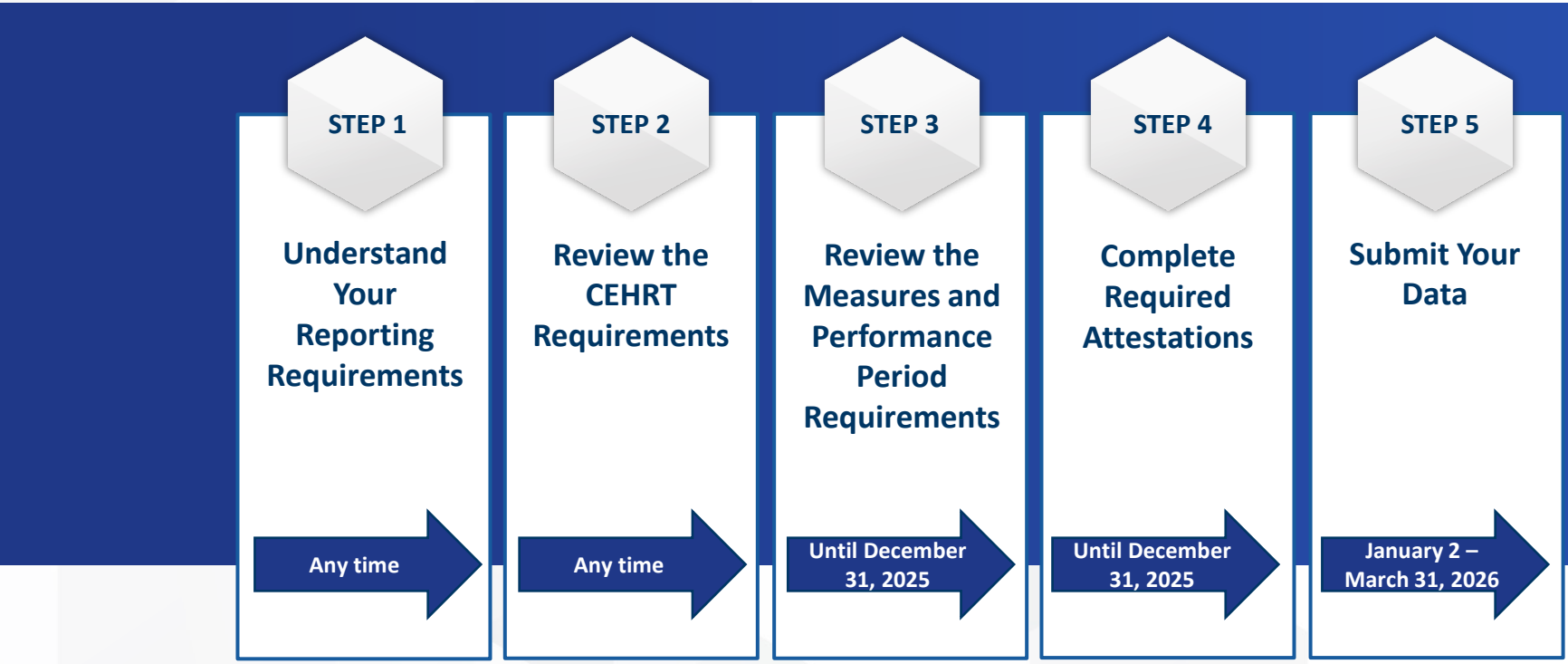
To avoid adverse consequences beyond the MIPS eligible clinicians' control, **we're suppressing the Electronic Case Reporting measure** for the MIPS Promoting Interoperability performance category for the CY 2025 performance period/2027 MIPS payment year.

The measure must still be reported. MIPS eligible clinicians will meet the measure requirements by attesting either "Yes" or "No" to being in active engagement with a public health agency, or claiming an applicable exclusion. MIPS eligible clinicians who report the suppressed Electronic Case Reporting measure will receive full credit for the measure.

Note: Even though the Electronic Case Reporting measure is suppressed, MIPS eligible clinicians who don't report the Electronic Case Reporting measure (or claim an applicable exclusion) will earn zero points for the Promoting Interoperability performance category.

Get Started with Promoting Interoperability in 5 Steps

Overview


STEP 1
Understand Your Reporting Requirements
Any time
STEP 2
Review the CEHRT Requirements
Any time
STEP 3
Review the Measures and Performance Period Requirements
Until December 31, 2025
STEP 4
Complete Required Attestations
Until December 31, 2025
STEP 5
Submit Your Data
January 2 – March 31, 2026

Step 1. Understand Your Reporting Requirements

Certain MIPS eligible clinicians and groups aren't required to report data for this performance category.

- In this case, the category weight (or contribution to your final score) is redistributed to another performance category (or categories) unless you choose to submit data.
- MIPS eligible clinicians, groups, virtual groups, and subgroups that qualify for reweighting will be scored in this performance category if they submit qualifying Promoting Interoperability performance category data.

Helpful Reminders: When participating in MIPS at the APM Entity level, APM Entities can choose to report Promoting Interoperability data at the APM Entity level. However, APM Entities still have the option to report this performance category at the individual and group level.

You can't combine performance data submitted between different reporting options (e.g., traditional MIPS and MVPs) into a single final score or submit performance data for one performance category and count it for both reporting options.

For example, Promoting Interoperability data can't be reported for traditional MIPS and count towards the Promoting Interoperability category for an MVP. The Promoting Interoperability data may be the same, however, there must be 2 separate submissions: one for traditional MIPS and one for MVP reporting (with the appropriate MVP identifier, and subgroup identifier if applicable.)

Applicable to MVPs Only: If you're reporting an MVP as a subgroup, you'll submit your affiliated group's data for the Promoting Interoperability performance category.

Step 1. Understand Your Reporting Requirements (Continued)

Shared Savings Program Requirement to Report the MIPS Promoting Interoperability Performance Category

Unless excluded, for performance years beginning on or after January 1, 2025, an Accountable Care Organization (ACO) participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP), or Partial Qualifying APM Participant (Partial QP) must:

- Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS at the individual, group, virtual group, or APM Entity level (i.e., ACO reports on behalf of its clinicians); and
- Earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level.

This requirement applies regardless of the Shared Savings Program track in which the ACO participant, ACO provider/supplier, or ACO professional participates. Review Frequently Asked Questions on the Shared Savings Program Requirement to Report Objectives and Measures for the MIPS Promoting Interoperability Performance Category (271KB, PDF) for more information.

Step 1. Understand Your Reporting Requirements (Continued)

To confirm your special status, follow the instructions below:

Individual

Participating as an individual?

Check the QPP Participation Status Tool or sign in to the QPP website for any special statuses assigned at the Clinician Level.

Group

Participating as a group?

Check the QPP Participation Status Tool or sign in to the QPP website for any special statuses assigned at the Practice Level.

Virtual Group**

Participating as a virtual group?

Sign in to the QPP website to check for any special statuses assigned to the virtual group.

Subgroup*

Participating as a subgroup?

You inherit your affiliated group's special status.
Check the QPP Participation Status Tool or sign in to the QPP website for any special statuses assigned at the Practice Level.

APM Entity

Participating as an APM Entity?

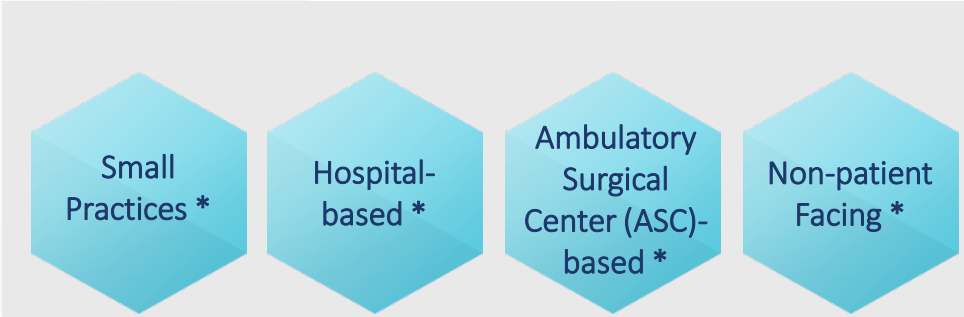
Sign in to the QPP website to check if the small status was assigned to the APM Entity. Small status designation for APM Entities will be available in mid-2025.

*Available for MVP reporting only.
**Available for traditional MIPS reporting only.

Step 1. Understand Your Reporting Requirements (Continued)

The graphic below outlines the special statuses that are automatically reweighted to 0% of your final score, which would mean that you **don't** have to submit Promoting Interoperability data.

If you're one of the following special statuses*, you're automatically excepted from having to submit data for this performance category.



Action Required:
If you're not automatically reweighted, you may submit a 2025 Promoting Interoperability Performance Category Hardship Exception application by December 31, 2025. (Your application must be approved by CMS to qualify for reweighting.)

- Learn More

However, a qualifying data submission will **void a hardship exception and cancel automatic reweighting**, and you'll be scored in this performance category. A qualifying submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period.

You qualify for a Promoting Interoperability Performance Category Hardship Exception when you:

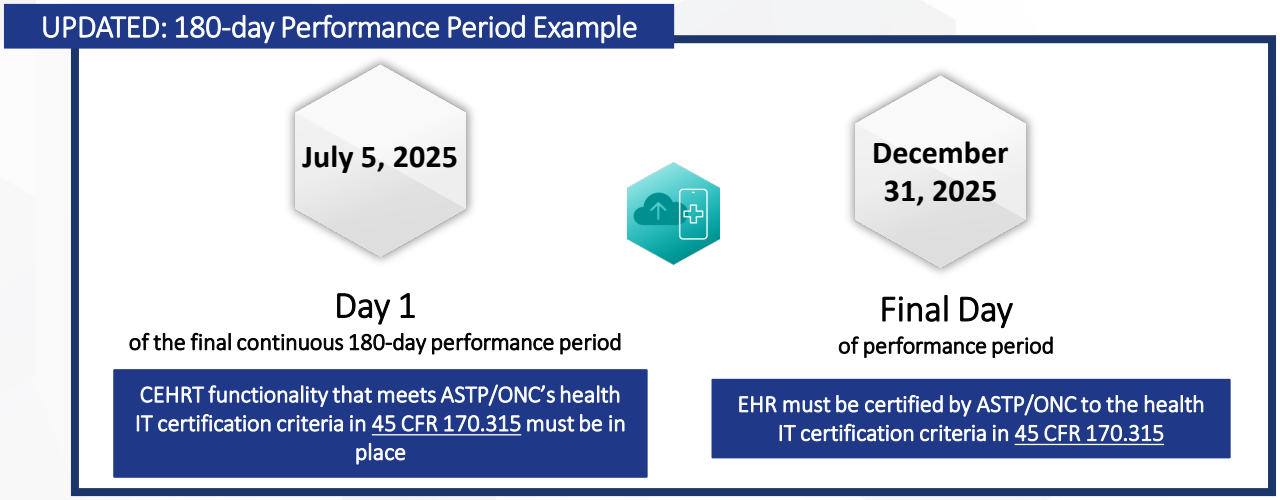
- Have decertified EHR technology (decertified under the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC) Health IT Certification Program)
- Have insufficient internet connectivity
- Face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress, or vendor issues
- Lack control over availability of CEHRT

Step 2. Review the CEHRT Requirements

To meet the CEHRT requirements for 2025 Promoting Interoperability performance category objective and measure reporting, you'll need to:

- Have CEHRT **functionality** that meets ONC's health IT certification criteria in 45 CFR 170.315 in place by **the first day of your MIPS Promoting Interoperability performance period;**
- Have your EHR **certified by ONC** to the health IT certification criteria in 45 CFR 170.315 by the **last day of your performance period**; and
- Provide your EHR's CMS identification code from the Certified Health IT Product List (CHPL), available on HealthIT.gov, when you submit your data.

If you're not sure if your EHR is meeting the certification criteria, work with your practice's technology support team or contact your EHR vendor to verify that your system is on track to meet CEHRT requirements by the last day of your performance period.



Step 3. Review the Measures and Performance Period Requirements

The 2025 Promoting Interoperability performance category focuses on the following objectives:

- e-Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

Within these objectives, **there are 6 to 7 required measures** (dependent upon which measure(s) you choose to report for the HIE objective) in addition to required attestations.

Some of these measures have exclusions; if you qualify, you can claim (submit) the exclusion instead of reporting the measure. See the Appendix for a list of these measures and exclusions.

- You must collect data for all required measures (unless you can claim an exclusion(s)) for the same **minimum continuous 180-day period in CY 2025.**
- The last 180-day performance period begins on **July 5, 2025.**

Reminder: For the HIE objective, you have the option to report data for the 2 existing HIE measures and associated exclusions **OR** the HIE Bi-Directional Exchange measure **OR** the Enabling Exchange under TEFCA measure.

Step 4. Complete Required Attestations

Step 4a.
Perform or Review a Security Risk Analysis

You must conduct or review a security risk analysis on your CEHRT functionality (that meets ONC's health IT certification criteria in 45 CFR 170.315) on an annual basis, within the calendar year of the performance period.

- For example, if you have your CEHRT functionality that meets ONC's health IT certification criteria in place on January 1, 2025, you can perform your security risk assessment on March 1, 2025, and select a 180-day performance period of July 5, 2025 – December 31, 2025.

Additional guidance on conducting a security risk analysis is available on the Health Information Privacy webpage on HHS.gov.

Step 4b.
Perform an Annual Assessment of the High Priority Guide (from the SAFER Guides)

You must conduct an annual self-assessment using the High Priority Practices Guide (a part of the SAFER Guides), within the calendar year of the performance period.

- To complete the self-assessment, you must complete a review and mark the associated checkboxes (fully, partially, or not implemented) of recommended practices included in the beginning of the Guide.
- Detailed worksheets with the rationale for, and examples of how to implement each recommended practices follows the checklist section of the Guide.
  - These worksheets include likely sources of information that your practice may reference to complete your assessment of a recommended practice, as well as fillable note fields to record follow-up actions.
- **A "yes" response is required**. A "no" response won't satisfy this measure.

Additional guidance on completing the self-assessment is available on the SAFER Guides webpage on HealthIT.gov.

Step 4. Complete Required Attestations (Continued)

Step 4c.
Complete the Actions to Limit or Restrict Interoperability of CEHRT Attestation

This attestation statement aims to identify whether you or your health IT vendor acted in good faith and took necessary steps to prevent limiting or restricting the compatibility or interoperability of CEHRT.

- To complete this attestation, you will attest to the statement by entering a "yes" (certify that you acted in good faith when implementing and using your CEHRT to exchange electronic health information) or "no" (you don't certify that you acted in good faith when implementing and using your CEHRT to exchange electronic health information) response.

Failure to attest "yes" to the following will result in a score of 0 for the Promoting Interoperability performance category:

- I (A) did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology. (B) Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times: (1) Connected in accordance with applicable law; (2) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; (3) Implemented in a manner that allowed for timely access by patients to their electronic health information; and (4) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors. (C) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

Step 4. Complete Required Attestations (Continued)

Step 4d.
ONC Direct Review Attestation

To complete the attestation, you must attest "yes" to the following:

- I (1) Acknowledge the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

Step 5. Submit Your Data

You'll need to report the required Promoting Interoperability performance category data during the 2025 submission period (1/2/2026 – 3/31/2026).

Did You Know?

- If your practice has several EHRs and not all are certified to ONC's health IT certification criteria in 45 CFR 170.315, you'll **submit only the data collected in CEHRT with functionality that meets ONC's certification criteria.**
- If your practice is participating as a group or virtual group:
  - You'll aggregate the measure numerators and denominators for all MIPS eligible clinicians with data in your **CEHRT that meets ONC's health IT certification criteria in 45 CFR 170.315.**
  - You can submit a "yes" for the 2 required measures in the Public Health and Clinical Data Exchange objective if one MIPS eligible clinician is in active engagement with each registry.
- If your practice is participating as a subgroup:
  - You'll **submit the aggregated data of the affiliated group.**

Important Reminder for MVPs:

- Each MVP submission must include the related MVP ID, signaling your intent to report the Promoting Interoperability data for your selected MVP. **Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of the MVP.**
- If participating as a subgroup, you'll also need to include the subgroup identifier given to you by CMS for your MVP submission.

Step 5. Submit Your Data (Continued)

Did You Know?

The level at which you participate in MIPS (individual, group, subgroup, or virtual group) applies to all performance categories. **We won't combine data submitted at the individual, group, subgroup, and/or virtual group level into a single final score.** There is one exception to this rule, which is noted at the bottom of this page.

- For example:
  - If you submit any data as an individual, you will be evaluated for all performance categories as an individual.
  - If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
  - If data is submitted both as an individual and a group, you will be evaluated as an individual and as a group for all performance categories, but your payment adjustment will be based on the higher score.
- Exception:
  - When participating as an APM Entity, the APM Entity will submit quality measures (and improvement activities if reporting traditional MIPS or an MVP). MIPS eligible clinicians in the APM Entity may submit Promoting Interoperability data as individuals or as a group and we'll calculate an average score for this performance category. However, APM Entities also have the option to choose to report Promoting Interoperability data at the APM Entity level.

Note:

- You can't combine performance data submitted between different reporting options (e.g., traditional MIPS and MVPs) into a single final score or submit performance data for one performance category and count it for both reporting options.
- For example, if your group is reporting both traditional MIPS and an MVP (as a subgroup), the group would need to submit Promoting Interoperability data for traditional MIPS and then separately submit your affiliated group's Promoting Interoperability data for their selected MVP (as a subgroup). This is required even if you're submitting the same Promoting Interoperability data for both traditional MIPS and MVP reporting.

Step 5. Submit Your Data (Continued)

To submit data, you or your third-party representative will need QPP credentials and authorization. See the Quality Payment Program Access User Guide (ZIP, 4MB) for more information.

There are **3 ways to submit** your Promoting Interoperability performance category data:

You	You or a Third Party	Third Party
Sign in to the QPP website and **attest to (manually enter)** your information.	Sign in to the QPP website and **upload a file** with your data.	Perform a direct submission on your behalf, using our **submissions Application Programming Interface (API).**

Important Note: Update finalized in the CY 2025 Medicare Physician Fee Schedule Final Rule- When there are multiple Promoting Interoperability submissions for an individual, group, virtual group or subgroup, we'll score each submission and assign the highest of scores.

You don't need to include supporting documentation when you attest to your Promoting Interoperability performance category data, but **you must keep documentation for 6 years** after submission.

Documentation guidance for each measure and attestation will be available in early 2025 in the Quality Payment Program Resource Library as part of the 2025 MIPS Data Validation Criteria. We suggest reviewing this validation document to ensure you document your work appropriately.

Step 5. Submit Your Data (Continued)

If the following reporting and submission requirements aren't met, you'll get a **zero** for your Promoting Interoperability performance category score:

- Collect your data in CEHRT with the functionality that meets ONC's health IT certification criteria in 45 CFR 170.315 (certified by the last day of the performance period) for a minimum of any continuous 180-day period in 2025;
- Submit a "yes" to the Actions to Limit or Restrict Interoperability of CEHRT Attestation (formerly named Prevention of Information Blocking);
- Submit a "yes" to the SAFER Guides attestation measure. Additional information is available on the SAFER Guides webpage on HealthIT.gov;
- Submit a "yes" to the ONC Direct Review Attestation;
- Submit a "yes" that you have completed the Security Risk Analysis measure in 2025;
- Report the 6 to 7 required measures or claim their exclusion(s); and
  - For measures that require a numerator and denominator (as defined in the measure specifications), you must submit at least a '1' in the numerator;
- Submit your level of active engagement for the Public Health and Clinical Data Exchange measures you're reporting;
- Provide your EHR's CMS identification code from the Certified Health IT product List (CHPL), available on HealthIT.gov.

Help and Version History

Where Can You Go for Help?

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 through Friday, 8 a.m. – 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

Version History

If we need to update this document, changes will be identified here.

Date	Description
12/8/2025	Noted that the **Electronic Case Reporting** measure is suppressed for the CY 2025 performance period (p. 13).
08/18/2025	Noted **that the** Electronic Case Reporting measure is proposed to be suppressed **for the CY 2025 performance period (p. 13)**.
01/13/2025	Original Posting.

Appendix

Promoting Interoperability Objectives and Measures

The table below outlines the 2025 objectives, measures, and available exclusions. Complete Promoting Interoperability measure specifications are available in the Quality Payment Program Resource Library. The **2025 MIPS Data Validation Criteria**, available in early 2025 in the Quality Payment Program Resource Library, will include the Promoting Interoperability documentation requirements for reporting measures and claiming exclusions.

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

Did You Know? If you claim an exclusion for the e-Prescribing measure, you will need to claim one of the Query of PDMP exclusions that is most applicable to you.

Promoting Interoperability Objectives and Measures

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 (Suppressed for the CY 2025 performance period; refer to p. 13 for more information.)	Each of these measures has their own exclusions; please refer to the 2025 Promoting Interoperability Measure Specifications (ZIP, 4MB) 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