Quality Payment PROGRAM

Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) Final Rule: Finalized (New and Updated) Qualified Clinical Data Registry (QCDR) and Qualified Registry Policies

January 12, 2024

- This fact sheet summarizes policy updates finalized in the CY 2024 Medicare PFS Final Rule (PDF), as it pertains to third party intermediaries, QCDRs, and qualified registries for the CY 2024 performance period/2026 Merit-based Incentive Payment System (MIPS) payment year. For broader Quality Payment Program (QPP) policy changes, including changes to the quality, improvement activities, Promoting Interoperability, and cost performance categories, please reference the 2024 QPP Policies Final Rule Resources (ZIP, 1,794 KB).

CY 2024 Performance Period/2026 MIPS Payment Year

Highlights for 2024 include:

- Introducing 5 new MIPS Value Pathways (MVPs) for the 2024 performance year and modifying the 12 previously finalized MVPs through the MVP maintenance process.
- Maintaining the performance threshold at 75 points for the CY 2024 performance period.
- Maintaining the data completeness threshold at 75% for the CY 2024 and CY 2025 performance periods for electronic clinical quality measures (eCQMs), MIPS clinical quality measures (CQMs), Medicare Part B claims measures, and QCDR measures.

MIPS Quality Measures, Improvement Activities, and Promoting Interoperability Measures and Objectives that are Added/Removed

- The following 11 MIPS quality measures were added as new measures starting with the CY 2024 performance period/2026 MIPS payment year.
- Measure Q494 was finalized with a 1-year delay in implementation to CY 2025.

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
494	High-Priority (Outcome)	eCQM Specifications	Intermediate Outcome	Excessive Radiation Dose or Inadequate Image Quality or Diagnostic Computed Tomography (CT) in Adults (Clinician Level) Note: This measure was finalized with 1-year delay in implementation to CY 2025.
495	High-Priority (Outcome)	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
496	N/A	MIPS CQMs Specifications	Process	Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument
497	N/A	MIPS CQMs Specifications	Process	Preventive Care and Wellness (composite)
498	High-Priority (Equity)	MIPS CQMs Specifications	Process	Connection to Community Service Provider
499	N/A	MIPS CQMs Specifications	Process	Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
500	N/A	MIPS CQMs Specifications	Process	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
501	N/A	MIPS CQMs Specifications	Process	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
502	High-Priority (Outcome)	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder
503	High-Priority (Outcome)	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	Gains in Patient Activation Measure (PAM®) Scores at 12 Months
504	High-Priority (Safety)	MIPS CQMs Specifications	Process	Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk
505	High-Priority (Outcome)	MIPS CQMs Specifications	Patient-Reported Outcome-based Performance Measure (PRO-PM)	Reduction in Suicidal Ideation or Behavior Symptoms

- The following 11 MIPS quality measures were removed starting with the CY 2024 performance period/2026 MIPS payment year.
- Measure Q436 was finalized for removal with a 1-year delay to CY 2025 due to the 1-year delay in implementation to CY 2025 for measure Q494.

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
014	N/A	MIPS CQMs Specifications	Process	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
093	High-Priority (Appropriate Use)	MIPS CQMs Specifications	Process	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
107	N/A	eCQM Specifications	Process	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
110	N/A	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Preventive Care and Screening: Influenza Immunization
111	N/A	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Pneumococcal Vaccination Status for Older Adults
138	High-Priority (Care Coordination)	MIPS CQMs Specifications	Process	Melanoma: Coordination of Care
147	High-Priority (Care Coordination)	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
283	N/A	MIPS CQMs Specifications	Process	Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management
324	High-Priority (Efficiency)	MIPS CQMs Specifications	Efficiency	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
391	High-Priority (Care Coordination)	MIPS CQMs Specifications	Process	Follow-Up After Hospitalization for Mental Illness (FUH)
402	N/A	MIPS CQMs Specifications	Process	Tobacco Use and Help with Quitting Among Adolescents
436	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques Note: This measure was finalized for removal with a 1-year delay to CY 2025.

- The following 3 MIPS quality measures were partially removed from traditional MIPS starting with the CY 2024 performance period/2026 MIPS payment year and retained for use in MVPs. Additionally, MIPS 112 and MIPS 113 have been retained for use within the CMS Web Interface collection type available to Shared Savings Program ACOs reporting through the APP.

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
112	N/A	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Breast Cancer Screening
113	N/A	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Colorectal Cancer Screening
128	N/A	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan

- The following 5 improvement activities were added as new activities starting with the CY 2024 performance period/2026 MIPS payment year:

MIPS Improvement Activity ID	MIPS Improvement Activity Title
IA_BMH_14	Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women
IA_BMH_15	Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults
IA_MVP	Practice-Wide Quality Improvement in MIPS Value Pathways
IA_PM_22	Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
IA_PM_23	Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines

- The following 3 improvement activities were removed as activities starting with the CY 2024 performance period/2026 MIPS payment year:

MIPS Improvement Activity ID	MIPS Improvement Activity Title
IA_BMH_6	Implementation of co-location PCP and MH services
IA_BMH_13	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder
IA_PSPA_29	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

- There were policy updates to the Promoting Interoperability performance category but no new or removed promoting interoperability measures for the CY 2024 performance period/2026 MIPS payment year (for policy updates on this category see 88 FR 79351 through 79365).

Program Impacts

- For further details on the items below, please consult the CY 2024 Medicare Physician Fee Schedule Final Rule.

Updates for CY 2024 Performance Period/2026 MIPS Payment Year

Codification of Previously Finalized Policies from Preamble (88 FR 79382)

- In this final rule, CMS codifies policies that apply to third party intermediaries that were finalized through prior rulemaking but were not codified in the Code of Federal Regulations (CFR).

General Requirements (88 FR 79382 through 79383)

- ***Requirement to Obtain Documentation***: CMS finalized to codify these requirements at § 414.1400(b)(3)(xii) and (xiii):
  - In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77367 through 77369 and 77384 and 77385), CMS established requirements that QCDRs and qualified registries obtain signed documentation from clinicians and groups regarding their authority to handle and submit data on the clinician and group's behalf. CMS established that QCDRs and qualified registries must enter into appropriate Business Associate Agreements with MIPS eligible clinicians.
  - QCDRs and qualified registries must obtain signed documentation that each holder of a national provider identifier (NPI) has authorized the third party intermediary to submit "quality measure results, improvement activities measure and activity results, advancing care information (now known as promoting interoperability) objective results and numerator and denominator data or patient-specific data on Medicare and non-Medicare beneficiaries to CMS for the purpose of MIPS participation." The documentation should be annually obtained at the time the clinician or group enters into an agreement with the QCDR or qualified registry for the submission of MIPS data to the QCDR or qualified registry.
  - A group, subgroup, Virtual Group, or APM Entity may have their authorized representative give permission to the third party intermediary to submit their data. Additionally, in the CY 2018 Medicare Physician Fee Schedule Final Rule (82 FR 53812), CMS clarified that Business Associate Agreements must comply with the HIPAA Privacy and Security Rules. Records of the authorization must be maintained for 6 years after the performance period ends (81 FR 77370).
- ***Criteria for Data Submission***: At § 414.1400(a)(2)(i)(C), CMS requires that all data submitted by a third party intermediary must be submitted in the form and manner specified by CMS.

- CMS specified that these requirements include the obligation for a third party intermediary to:
  1. Report the number of eligible instances (reporting denominator);
  2. Report the number of instances a quality service is performed (performance numerator);
  3. Report the number of performance exclusions, meaning the quality action was not performed for a valid reason as defined by the measure specification;
  4. Comply with a CMS-specified secure method for data submission, such as submitting the QCDR's data in an XML file;
  5. Be able to calculate and submit measure-level reporting rates or the data elements needed to calculate the reporting and performance rates by taxpayer identification number (TIN)/NPI and/or TIN;
  6. Be able to calculate and submit a performance rate (that is the percentage of a defined population who receive a particular process of care or achieves a particular outcome based on a calculation of the measures' numerator and denominator specifications) for each measure on which the TIN/NPI or TIN reports;
  7. Provide the performance period start date the QCDR will cover;
  8. Provide the performance period end date the QCDR will cover;
  9. Report the number of reported instances, performance not met (meaning the quality actions was not performed for no valid reason as defined by the measure specification; and
  10. Submit quality, advancing care information, or improvement activities data and results to us in the applicable MIPS performance categories for which the QCDR is providing data (81 FR 77367 through 77369 and 77384 through 77385).
- ***Reporting on All Patients, Including Non-Medicare Patients***: CMS finalized a revision to the definition of the term “collection type” to allow Shared Saving Program Accountable Care Organizations (ACOs) meeting the reporting requirements under the APM Performance Pathway (APP) to report on a subset of patients that’s partially defined by having the payer of Medicare. CMS also finalized to codify its previously established requirement that data submitted by third party intermediaries must include data on all of the MIPS eligible clinician’s patients regardless of payer, with the addition of the phrase “unless otherwise specified by the collection type” at § 414.1400(a)(3)(ii)(A) (also see 81 FR 77367 through 77369 and 77384 through 77385).

Requirements for QCDRs and Qualified Registries (88 FR 79383 through 79388)

Self-Nomination and Program Requirements

- ***Subgroup reporting***: CMS finalized new language to codify and revise § 414.1400(b)(1)(iii) that beginning with the CY 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries must support subgroup reporting because it would allow for clinicians to meaningfully report MVPs (also see 86 FR 65544).
- ***Simplified Self-Registration Process for Existing QCDRs and Qualified Registries in MIPS, That Are in Good Standing***: CMS finalized to revise § 414.1400(b)(2) to reflect that QCDRs and qualified registries that are in good standing are still required to submit their self-nomination form even if they utilize the simplified self-nomination process as there may be new sections to fill out and they need to respond to attestations within the course of the application. CMS also finalized to revise the last sentence of § 414.1400(b)(2) from "For the CY 2019 performance period/2021 MIPS payment year and future years, existing QCDRs and qualified registries that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the applicable performance period" to state, "For the CY 2019 performance period/2021 MIPS payment year and future years, an existing QCDR or qualified registry that is in good standing may use the simplified self-nomination process during the self-nomination period, from July 1 and September 1 of the CY preceding the applicable performance period."
- ***Measure Numbers and Identifiers and Titles for the Improvement Activities Performance Category, the Promoting Interoperability Performance Category, and MVPs***: CMS finalized to codify the following previously finalized provision at § 414.1400(b)(3)(ix): In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77367 through 77369 and 77384 through 77385), CMS established that QCDRs and qualified registries must provide the measure numbers for the MIPS quality measures on which the QCDR and qualified registry is reporting. CMS also finalized that § 414.1400(b)(3)(ix) would additionally require QCDRs and qualified registries to submit to CMS the identifiers for the improvement activities performance category, the Promoting Interoperability performance category measures, and titles for MVPs.
- ***Quality Measures***: CMS finalized to codify the following previously finalized provision at § 414.1400(b)(3)(x): In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77367 through 77369 and 77384 through 77385), CMS established that one criterion for data submission for QCDRs and qualified

registries is that they must be able to submit results to CMS for at least six individual quality measures with at least one outcome measure during self-nomination. If an outcome measure is not available, a QCDR or qualified registry must be able to submit to CMS results for at least one other high priority measure.

- ***Qualified Posting Attestation***: CMS finalized to add § 414.1400(b)(3)(xiv), which would require that QCDRs and qualified registries attest that the information listed on the qualified posting is accurate. The qualified posting contains information is published every performance period to help clinicians, groups, subgroups, virtual groups, APM Entities determine the services, cost, reporting options, measures/activities, etc. that a CMS-approved intermediary supports (see CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77367 through 77369 and 77384 through 77385). CMS also finalized to define qualified posting as the document made available by CMS that lists QCDRs or qualified registries available for use by MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities at § 414.1305.
- ***Data Access Capabilities***: CMS finalized to codify the following previously finalized provision at § 414.1400(b)(3)(xv): In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77367 through 77369 and 77384 through 77385), CMS established that QCDRs and qualified registries must comply with any request by CMS to review data submitted by a third party intermediary for purposes of MIPS.
- ***Attestation of Data Access Capabilities***: CMS finalized to add § 414.1400(b)(3)(xvi)(A) to require that a QCDR or a qualified registry attest that it has required each MIPS eligible clinician on whose behalf it reports to provide the QCDR or qualified registry with all documentation necessary to verify the accuracy of the data on quality measures that the eligible clinician submitted to the QCDR or qualified registry (also see 81 FR 77367 through 77369 and 77384 through 77385). CMS also finalized to add § 414.1400(b)(3)(xvi)(B) to require that a QCDR or a qualified registry must attest that it has required each MIPS eligible clinician to permit the QCDR or qualified registry to provide the information described in § 414.1400(b)(3)(xvi)(A) to CMS upon request to ensure that data can be accessed by the third party intermediary for auditing purposes.
- ***Third Party Intermediary Support of MVPs***: CMS finalized to add a sentence at the end of § 414.1400(b)(1)(ii) that a QCDR or a qualified registry is required to support MVPs pertinent to the specialties they support (also see 86 FR 65543). The finalized addition states that a QCDRs or a qualified registry must support all measures and improvement activities available in the MVP with two exceptions.
    1. The first finalized exception to this requirement at § 414.1400(b)(1)(ii)(A) is that if an MVP includes several specialties, then a QCDR or a qualified registry is

only expected to support the measures that are pertinent to the specialty of their clinicians.

2. The second finalized exception at § 414.1400(b)(1)(ii)(B) is that QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR does not own the QCDR measures in the MVP, the QCDR may only support the QCDR measures if they have the appropriate permissions.

- ***Readiness to Accept Data***: CMS finalized to codify at § 414.1400(b)(3)(xvii) the requirement that a QCDR or a qualified registry must be able to accept and retain data by January 1 of the applicable performance period (also see 83 FR 59761).
- ***Duration of Services Provided***: Regarding the requirements for a transition plan for cases in which organizations are not able to provide services throughout the entire year, CMS finalized to modify this requirement to state the organization must certify it intends to provide services throughout the entire performance period and applicable data submission period (also see 84 FR 63053). CMS also finalized to make this change at § 414.1400(a)(2)(i)(C) as a result of its proposal to divide requirements for self-nomination from programmatic requirements.
- ***Transition Plan Requirements***: At § 414.1400, CMS finalized to redesignate and revise paragraph (a)(2)(i)(F) to paragraph (a)(3)(iv) that, prior to discontinuing services to any MIPS eligible clinician, group, virtual group, subgroup, or APM Entity during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, virtual group, subgroup, or APM Entity to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan by a date specified by CMS. The transition plan must address the following issues outlined below under paragraphs (a)(3)(iv)(A) through (E), unless different or additional information is specified by CMS (also see 84 FR 63052 through 63053).
    - CMS finalized to add § 414.1400(a)(3)(iv)(A) to require that the transition plan state the issues that contributed to the withdrawal mid-performance period or discontinuation of services mid-performance period.
    - CMS finalized to add § 414.1400(a)(3)(iv)(B), which would require that the transition plan state the number of clinicians, groups, virtual groups, subgroups or APM entities inclusive of MIPS eligible, opt-in and voluntary participants that would need to find another way to report and as applicable, and identify any QCDRs that were granted licenses to QCDR measures which would no longer be available for reporting due to the transition.
    - CMS finalized to add paragraph (a)(3)(iv)(C) to state the steps the third party intermediary will take to ensure that the clinicians, groups, virtual groups, subgroups, or APM Entities identified in § 414.1400(a)(3)(iv)(B)(1) are notified

of the transition in a timely manner and successfully transitioned to an alternate third party intermediary, submitter type, or, for any measure or activity on which data has been collected, collection type, as applicable.
    - CMS finalized at paragraph (a)(3)(iv)(D) to require that the transition plan include a detailed timeline of when the third party intermediary will take the steps identified in paragraph (a)(3)(iv)(C), including notification of affected clinicians, groups, virtual groups, subgroups, or APM Entities, the start of the transition, and the completion of the transition.
    - CMS finalized to add at paragraph (a)(3)(iv)(E) that the third party intermediary must communicate to CMS that the transition was completed by the date included in the detailed timeline.

Submission Requirements

- ***Risk-adjusted Measures***: CMS finalized to codify the following previously finalized provision at § 414.1400(b)(3)(xi): In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77384 through 77385), CMS established that qualified registries "submitting MIPS quality measures that are risk-adjusted . . . must submit the risk-adjusted measure results to CMS when submitting the data for these measures."
- ***Data Validation Audit Requirements***: CMS finalized to revise § 414.1400(b)(3)(v)(E)(1) and (2) to replace references to TIN/NPI with "a combination of individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM Entities." The new text states: (1) Uses a sample size of at least 3 percent of a combination of individual clinicians, groups, virtual groups, subgroups and APM Entities for which the QCDR or qualified registry will submit data to CMS, except that if the sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups and APM Entities, and no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM Entities, the QCDR or qualified registry may use a sample size of a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM Entities; and (2) Uses a sample that includes at least 25 percent of the patients of each individual clinician, group, virtual group, subgroup or APM Entity in the sample, except that the sample for each individual clinician, group, virtual group, subgroup or APM Entity must include a minimum of 5 patients and need not include more than 50 patients.

Requirements Specific to QCDRs (88 FR 79388 through 79390)

QCDR Measure Self-nomination Requirements

- ***New QCDR Measures May Not be Submitted after Self-Nomination***: CMS finalized at § 414.1400(b)(4)(iv)(O) to add "measures submitted after self-nomination" to the agency's list of reasons for rejecting a QCDR measure.
- ***Limitations on Number of QCDR Measures Submitted for Self-Nomination***: CMS finalized to add at § 414.1400(b)(4)(iv)(P) that a QCDR measure may be rejected if the QCDR submits more than 30 quality measures not in the annual list of MIPS quality measures for CMS consideration. CMS will continue to evaluate individual measures on their merits as specified in its requirements at § 414.1400(b)(4)(iii) and (iv).
- ***Requirements for Previous Data on QCDR Measures***: CMS finalized to codify the following previously finalized provision at § 414.1400(b)(4)(i)(C): In the CY 2017 Medicare Physician Fee Schedule Final Rule (81 FR 77368), CMS established a requirement that for non-MIPS measures the QCDR must provide CMS, if available, data from years prior to the start of the performance period.
- ***Requirement for QCDR Measure Specifications to Remain Published through the Performance Period and Data Submission Period***: CMS finalized to revise § 414.1400(b)(4)(i)(B) to add a provision that the approved QCDR measure specifications must remain published through the performance period and data submission period (also see 81 FR 77375 through 77376). Measure specifications must be available throughout the duration of measure use for interested parties to understand the target population of the measure, how the measure is built and calculated, and to identify existing measure gaps. CMS also finalized to make a technical update to the language removing the reference to providing the National Quality Forum (NQF) number due to changes in the contractor that CMS uses for measure endorsement.

Health IT Vendors (88 FR 79390 through 79391)

- CMS finalized to eliminate the health IT vendor category beginning with the CY 2025 performance period and by revising § 414.1400(a)(1)(iii) to remove gaps in third party intermediary requirements and improve data integrity.
- Removing Health IT vendors from the definition of third party intermediary will not preclude the vendors from assisting MIPS eligible clinicians with reporting under the program. In order to submit data on behalf of clinicians, a health IT vendor would 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.

- Eliminating the category of Health IT vendor as a distinct type of third party intermediary will create a clearer distinction between those vendors that are submitting data to CMS for the purposes of MIPS and must meet the requirements of a qualified registry or QCDR and those vendors that work with clinicians through the sale and support of health IT that permits the clinician or group to submit the data.

Remedial Action and Termination of Third Party Intermediaries (88 FR 79391 through 79394)

Additional Basis for Remedial Action

- ***Failure to Maintain Correct Contact Information***: CMS finalized an additional provision at § 414.1400(e)(2)(iv) to allow CMS to immediately or with advance notice terminate a third party intermediary that has not maintained current contact information for correspondence.
- ***Consecutive Years on Remedial Action***: CMS finalized to add at § 414.1400(e)(2)(v) that CMS may terminate third party intermediaries that are on remedial action for 2 consecutive years. This will minimize risk within the Quality Payment Program by terminating third party intermediaries that are consistently deemed as non-compliant (also see remedial action policies at 81 FR 77387 through 77389).

Revised Corrective Action Plan Requirements

- CMS finalized to add at § 414.1400(e)(1)(i)(F) an additional requirement for a third party intermediary under a corrective action plan to communicate the final resolution to CMS once the resolution is complete, and to provide an update, if any, to the monitoring plan provided under § 414.1400(e)(1)(i)(C).

Public Posting of Deficiencies

- CMS finalized to add a new provision at § 414.1400(e)(1)(ii)(B) that CMS may, beginning with the CY 2025 performance period/2027 MIPS payment year, publicly disclose on the CMS website that CMS took remedial action against or terminated the third party intermediary (also see 81 FR 77386 through 77388).
- CMS finalized to modify § 414.1400(e)(1)(ii) by redesignating it as § 414.1400(e)(1)(ii)(A) and ending this policy after the CY 2025 performance period/2027 MIPS payment year. CMS also finalized to remove this policy because it would be superseded by the proposal included in § 414.1400(e)(1)(ii)(B).

Considering Past Performance in Approving Third Party Intermediaries

- While CMS has established criteria for approval of third party intermediary at § 414.1400(a)(2)(ii)(A) which state its determination to approve a third party intermediary may take into account whether the entity failed to comply with the requirements for a previous MIPS payment year, CMS clarified that the consideration of past compliance can also include remedial actions.
- While CMS already has the ability to consider whether the entity failed to comply with certain requirements, it does not believe that the existing requirements are

explicit enough for third party intermediaries to understand that a history of remedial actions, even if addressed such that the third party intermediary was not terminated could result in CMS not approving future approval.

Terms of Audits

- CMS finalized at § 414.1400(f) that third party intermediaries may be randomly selected for compliance evaluation or may be selected at the suggestion of CMS if there is an area of concern regarding the third party intermediary (also see 81 FR 77389 through 77390).
- CMS finalized to redesignate the existing section § 414.1400(f) (which includes paragraphs (f)(1), (2), and (3)) as paragraph (a)(3)(v) with minor changes in the text for clarity.

Technical Changes

CMS finalized the following technical changes to § 414.1400 to improve clarity as denoted below:

- At paragraph (a)(2), clarified that an organization may only become a third party intermediary for the purposes of MIPS by meeting the approval criteria by replacing the term "third party intermediary" with "organization".
- Redesignated paragraph (a)(3) to delineate third party intermediary approval criteria from requirements for third party intermediaries as they participate in the Quality Payment Program. CMS finalized the following redesignations:
    - § 414.1400(a)(3) redesignated as § 414.1400(a)(3)(i);
    - § 414.1400(a)(2)(i)(C) redesignated as § 414.1400(a)(3)(ii);
    - § 414.1400(a)(2)(i)(D) redesignated as § 414.1400(a)(3)(iii);
    - § 414.1400(a)(2)(i)(F) redesignated as § 414.1400(a)(3)(iv); and
    - § 414.1400 (a)(2)(iii) redesignated as § 414.1400(a)(3)(vi).
- There is a conforming change to reference section IV.A.4.k.(3) at § 414.1400(e)(1).
- At § 414.1400(e)(3), removed the word "total" from the phrase "total clinicians" as this word was included in error.
- At § 414.1400(e)(4), improved clarity and removed a paragraph.

MVPs Effective with the CY 2024 Performance Period/2026 MIPS Payment Year

- 16 MVPs will be available for voluntary reporting beginning with the CY 2024 performance period/2026 MIPS payment year.
- MVPs that have QCDR measures are indicated below.
- See 88 FR 79981 through 80007 for the complete list of measures and activities for the five MVPs finalized in 2024 rulemaking.
- See 88 FR 80008 through 80047 for the complete list of measures and activities for MVPs finalized in previous rulemaking that were updated in 2024 rulemaking using the MVP maintenance process.
- Note in the table below that previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs have been consolidated into a single MVP titled Value in Primary Care.
- See the 2024 QPP Final Rule MVP Guide (PDF, 822 KB) for more information on MVP policies.

MVP Name	Includes QCDR Measures	Original Year of Finalization
Focusing on Women's Health	Yes	2024 Medicare Physician Fee Schedule Final Rule
Quality Care for the Treatment of Ear, Nose, and Throat Disorders	Yes	2024 Medicare Physician Fee Schedule Final Rule
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV	No	2024 Medicare Physician Fee Schedule Final Rule
Quality Care in Mental Health and Substance Use Disorders	Yes	2024 Medicare Physician Fee Schedule Final Rule
Rehabilitative Support for Musculoskeletal Care	No	2024 Medicare Physician Fee Schedule Final Rule
Advancing Cancer Care	Yes	2023 Medicare Physician Fee Schedule Final Rule
Optimal Care for Kidney Health	No	2023 Medicare Physician Fee Schedule Final Rule
Optimal Care for Patients with Episodic Neurological Conditions	Yes	2023 Medicare Physician Fee Schedule Final Rule
Supportive Care for Neurodegenerative Conditions	Yes	2023 Medicare Physician Fee Schedule Final Rule
Advancing Care for Heart Disease	No	2022 Medicare Physician Fee Schedule Final Rule

MVP Name	Includes QCDR Measures	Original Year of Finalization
Advancing Rheumatology Patient Care	Yes	2022 Medicare Physician Fee Schedule Final Rule
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine	Yes	2022 Medicare Physician Fee Schedule Final Rule
Improving Care for Lower Extremity Joint Repair	No	2022 Medicare Physician Fee Schedule Final Rule
Patient Safety and Support of Positive Experiences with Anesthesia	Yes	2022 Medicare Physician Fee Schedule Final Rule
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes	No	2022 Medicare Physician Fee Schedule Final Rule
Value in Primary Care	No	2024 Medicare Physician Fee Schedule Final Rule (modification of 2 previously finalized MVPs)

New Medicare Clinical Quality Measures (Medicare CQMs) for Accountable Care Organizations Participating in the Medicare Shared Savings Program Collection Type

- The Medicare CQMs for ACOs collection type was added to the 3 measures below to be used by ACOs participating in the Shared Savings Program reporting through the APM Performance Pathway (APP).
- See 88 FR 79097 through 79113 for further discussion on this collection type.
- To distinguish between the submission of data for a Medicare CQM and a MIPS CQM to CMS for the following MIPS quality measures: 001, 134, and 236, Medicare CQM identifiers must be included in the submission files. For the reporting of Medicare CQMs, the identifiers are as follows: 001SSP, 134SSP, and 236SSP.

MIPS Quality ID #	Medicare CQM Submission File Identifier	Collection Type	MPS Quality Measure Title
001	001SSP	Medicare CQMs Specifications	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
134	134SSP	MIPS CQMs Specifications	Preventive Care and Screening: Screening for Depression and Follow-up Plan
236	236SSP	MIPS CQMs Specifications	Controlling High Blood Pressure