OMB control number: 0938-1314
Expiration Date: 02/28/2027

Quality Payment PROGRAM

Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) Final Rule: Finalized (New and Updated) Qualified Clinical Data Registry (QCDR) and Qualified Registry Policies

December 31, 2024

- This fact sheet summarizes policy updates finalized in the CY 2025 Medicare PFS Final Rule (PDF), as it pertains to third-party intermediaries, QCDRs, and Qualified Registries for the 2025 performance period/2027 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 Calendar Year (CY) 2025 QPP Policies Final Rule Fact Sheet (PDF, 2MB).

2025 Performance Period/2027 MIPS Payment Year

Highlights for 2025 include:

- Introducing 6 new MIPS Value Pathways (MVPs) for the 2025 performance year and modifying the 16 previously finalized MVPs through the MVP maintenance process.
- Maintaining the performance threshold at 75 points for the 2025 performance period.
- Maintaining the data completeness threshold at 75% for the 2027 and 2028 performance periods for electronic clinical quality measures (eCQMs), MIPS clinical quality measures (CQMs), Medicare Part B claims measures, and QCDR measures.
- Applying a flat benchmarking methodology to a subset of topped out measures, with minor modifications: Those that belong to specialty sets with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

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

- The following 7 MIPS quality measures were added as new measures starting with the 2025 performance period/2027 MIPS payment year. These 2 proposed measures were not finalized: Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer and Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer.

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q494	High Priority Outcome	eCQM Specifications	Intermediate Outcome	Note: This measure was finalized in the 2024 PFS final rule with a 1-year delay in implementation to CY 2025. Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)
Q506	High Priority	MIPS CQM Specifications	Process	Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy
Q507	N/A	MIPS CQM Specifications	Process	Appropriate Germline Testing for Ovarian Cancer Patients
Q508	N/A	MIPS CQM Specifications	Process	Adult COVID-19 Vaccination Status
Q509	High Priority	MIPS CQM Specifications	Process	Melanoma: Tracking and Evaluation of Recurrence
Q510	N/A	MIPS CQM Specifications	Process	First Year Standardized Waitlist Ratio (FYSWR)

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q511	N/A	MIPS CQM Specifications	Process	Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)

- The following 10 MIPS quality measures were removed, of the 11 proposed for removal, starting with the 2025 performance period/2027 MIPS payment year. Measure Q144: Oncology: Medical and Radiation – Plan of Care for Pain was not finalized for removal to allow the measure steward time to evaluate respecifying measures Q144 and Q143: Oncology: Medical and Radiation – Pain Intensity Quantified into a single, combined measure.

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q104	N/A	MIPS CQM Specifications	Process	Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer
Q137	High Priority	MIPS CQM Specifications	Structure	Melanoma: Continuity of Care – Recall System
Q254	N/A	MIPS CQM Specifications	Process	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
Q260	High Priority	MIPS CQM Specifications	Outcome	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):
Q409	High Priority	MIPS CQM Specifications	Outcome	Clinical Outcome Post Endovascular Stroke Treatment

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q433	High Priority	MIPS CQM Specifications	Outcome	Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair
Q436	N/A	Medicare Part B Claims Measure Specifications, MIPS CQM Specifications	Process	Note: This measure was finalized in the 2024 PFS final rule with a 1-year delay in implementation to CY 2025. Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques
Q439	High Priority	MIPS CQM Specifications	Efficiency	Age Appropriate Screening Colonoscopy
Q452	High Priority	MIPS CQM Specifications	Process	Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies
Q472	High Priority	eCQM Specifications	Process	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

- One MIPS quality measure had specific collection types added starting with the 2025 performance period/2026 MIPS payment year:

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q340	High Priority	MIPS CQM Specifications	Process	HIV Annual Retention in Care

- Two MIPS quality measures had specific collection types removed starting with the 2025 performance period/2026 MIPS payment year:

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Quality Measure Title
Q019	High Priority	MIPS CQM Specifications	Process	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Q155	High Priority	Medicare Part B Claims Measure Specifications	Process	Falls: Plan of Care

- The 2 improvement activities below were added as new activities starting with the 2025 performance period/2027 MIPS payment year.
- Improvement activity weights have been removed starting in CY 2025.
- For MVP reporting, clinicians, groups, and subgroups (regardless of special status) must attest to 1 activity.
- For traditional MIPS reporting, clinicians, groups, and virtual groups with the small practice, rural, non-patient facing, or health professional shortage area special status must attest to 1 activity.
- All other clinicians, groups, and virtual groups must attest to 2 activities.
- IA_ERP_6: COVID-19 Vaccine Achievement for Practice Staff has been modified and renamed as IA_PM_26.

MIPS Improvement Activity ID	MIPS Improvement Activity Title
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

- Four improvement activities were removed starting with the 2025 performance period/2027 MIPS payment year. Four improvement activities were finalized for removal with a delay to CY 2026.

MIPS Improvement Activity ID	MIPS Improvement Activity Title
IA_EPA_1	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record

MIPS Improvement Activity ID	MIPS Improvement Activity Title
IA_PM_12	Population empanelment (removal delayed until CY 2026) Note: This activity was finalized in the 2025 PFS Final Rule with a one-year delay in implementation to CY 2026.
IA_CC_1	Implementation of use of specialist reports back to referring clinician or group to close referral loop (removal delayed until CY 2026) Note: This activity was finalized in the 2025 PFS Final Rule with a one-year delay in implementation to CY 2026.
IA_CC_2	Implementation of improvements that contribute to more timely communication of test results (removal delayed until CY 2026) Note: This activity was finalized in the 2025 PFS Final Rule with a one-year delay in implementation to CY 2026.
IA_ERP_4	Implementation of a Personal Protective Equipment (PPE) Plan
IA_ERP_5	Implementation of a Laboratory Preparedness Plan
IA_BMH_8	Electronic Health Record Enhancements for BH data capture (removal delayed until 2026) Note: This activity was finalized in the 2025 PFS Final Rule with a one-year delay in implementation to CY 2026.
IA_PSPA_27	Invasive Procedure or Surgery Anticoagulation Medication Management

- There were policy updates to the Promoting Interoperability performance category but no new or removed Promoting Interoperability measures for the 2025 performance period/2027 MIPS payment year (for policy updates on this category see 89 FR 98376 through 98378).
- There was also a Request for Information (RFI) on how the Centers for Medicare & Medicaid Services (CMS) can leverage the Public Health and Clinical Data Exchange requirements. See 89 FR 98427.

Program Impacts

- For further details on the items below, please consult the CY 2025 Medicare Physician Fee Schedule Final Rule.

Updates for 2025 Performance Period/2027 MIPS Payment Year

Calculating the Final Score (89 FR 98455 through 98459)

Reweighting Performance Category(ies) Policy When a Third-Party Intermediary Didn't Submit Data Due to Reasons Outside the MIPS Eligible Clinician's Control

- Beginning with the 2024 performance period/2026 MIPS payment year, CMS finalized that CMS may reweight 1 or more of the quality, improvement activities, and Promoting Interoperability performance categories where CMS determines, that data for a MIPS eligible clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the MIPS eligible clinician delegated submission of their data to a third party intermediary, evidenced by a written agreement between the MIPS eligible clinician and the third party intermediary, and the third party intermediary didn't submit the data for the performance category or categories on behalf of the MIPS eligible clinician in accordance with applicable deadlines.
- Under this finalized reweighting policy, the MIPS eligible clinician must submit reweighting requests beginning with the close of a relevant performance period's data submission period, only after it is confirmed that no data has been submitted in accordance with applicable deadlines. MIPS eligible clinicians will be able to submit reweighting requests on or before November 1 of the year preceding the associated MIPS payment year in order to allow time for CMS to re-calculate their final score and MIPS payment adjustment factor. Note: this submission process is different from the targeted review process.
- CMS will only approve reweighting requests with evidence of a written agreement between the MIPS eligible clinician and a third-party intermediary. Such written agreement must provide that the MIPS eligible clinician delegated submission of their data to the third-party intermediary, and that the third-party intermediary agreed to submit data on their behalf in accordance with applicable deadlines, for the performance category or categories in question.
- CMS will review requests and make determinations to reweight based on CMS' assessment that data were not submitted outside the control of the MIPS eligible clinician.
- CMS finalized that they'll determine whether to apply reweighting to the affected performance category or categories under this policy based on their consideration of the following criteria: whether the MIPS eligible clinician knew or had reason to know of the issue with its third party intermediary's submission of the clinician's data for the performance category or categories; whether the MIPS eligible clinician took reasonable efforts to correct the issue; and whether the issue

between the MIPS eligible clinician and their third-party intermediary caused no data to be submitted for the performance category or categories in accordance with applicable deadlines.

- Circumstances resulting in a clinician's data being inaccessible or unable to be submitted that will merit reweighting could include, but aren't limited to, a critical systems failure, the third-party intermediary going out of business, the third-party intermediary having collected data on a MIPS eligible clinicians behalf and refusing to hand it over for the MIPS eligible clinician to submit, or other circumstances CMS determines to be outside the control of the MIPS eligible clinician.
- This finalized reweighting policy is solely intended to mitigate the potentially adverse financial impact of no data being submitted during the MIPS data submission period for one or more performance categories on behalf of the MIPS eligible clinician due to the failure of a third-party intermediary to fulfill its contractual responsibilities.
- CMS' determination to grant a reweighting request under this finalized policy doesn't indicate, and shouldn't be interpreted to suggest, that the third party intermediary couldn't be held liable for the failure to perform the task as delegated, that is, to submit data on the performance category or categories on behalf of the MIPS eligible clinician. In these circumstances where CMS determines that a third-party intermediary failed to fulfill its agreement with the MIPS eligible clinician to submit their data, CMS believes it is appropriate to give the MIPS eligible clinician the opportunity to request reweighting of the affected performance category or categories , provided that all elements of the finalized policy are met.
- CMS finalized that this policy will be effective beginning with 2024 performance period/2026 MIPS payment year. This policy change will become effective prospectively, prior to the beginning of the data submission period for the 2024 performance period/2026 MIPS payment year, which will occur January 2, 2025, through March 31, 2025. CMS finalized this effective date to provide relief to MIPS eligible clinicians, whose circumstances meet all requirements set forth in this finalized reweighting policy, as soon as feasible.
- CMS finalized to codify this new reweighting policy at §414.1380(c)(2)(i)(A)(10) for the quality and improvement activities performance categories and at §414.1380(c)(2)(i)(C)(12) for the Promoting Interoperability performance category.

Requirements for CMS-Approved Survey Vendors (89 FR 98459 through 98460)

Requirement to Submit Cost of Services

- CMS finalized under the current application submission requirement at §414.1400(d)(2) that beginning with the 2026 performance period/2028 MIPS payment year, a survey vendor must include on its application the range of costs of its third-party intermediary services. Ranges of cost estimates will vary based on different levels of service (i.e., number of survey respondents, languages provided, etc.).
- With respect to a third-party intermediary that is solely a CMS-approved survey vendor, the publishable costs will be limited to the cost of services related to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.
- The CAHPS for MIPS Survey Vendor Participation Form submitted by vendors seeking CMS approval will be updated to include fields to report the cost information. The vendor-specific cost information will then be published in the list of CAHPS for MIPS Survey Approved Vendors which is also posted in the Resource Library.

MVPs Effective with the 2025 Performance Period/2027 MIPS Payment Year

- There are 21 MVPs available for voluntary reporting beginning with the 2025 performance period/2027 MIPS payment year.
- Complete Ophthalmologic Care, Dermatological Care, Gastroenterology Care, Optimal Care for Patients with Urologic Conditions, Pulmonology Care, and Surgical Care are the 6 new MVPs finalized for CY 2025.
- The previously finalized Optimal Care for Patients with Episodic Neurological Conditions and the Supportive Care for Neurodegenerative Conditions MVPs are combined into a single consolidated neurological MVP titled Quality Care for Patients with Neurological Conditions.
- MVPs that have QCDR measures are indicated below.
- See 89 FR 98974 through 99005 for the complete list of measures and activities for the MVPs finalized in 2025 rulemaking.
- See 89 FR 99006 through 99057 for the complete list of measures and activities for MVPs finalized in previous rulemaking that were updated in 2025 rulemaking using the MVP maintenance process.
- See 89 FR 98346 for more information on the RFI on Transforming the Quality Payment Program.

- In this final rule, the Rehabilitative Support for Musculoskeletal Care MVP added 4 QCDR measures starting in 2025.
- See the 2025 Finalized MIPS Value Pathways Guide (PDF, 2MB), for more information on MVP policies.

MVP Name	Includes QCDR Measures
Complete Ophthalmologic Care	Yes
Dermatological Care	Yes
Gastroenterology Care	Yes
Optimal Care for Patients with Urologic Conditions	Yes
Pulmonology Care	Yes
Surgical Care	No
Quality Care for Patients with Neurological Conditions	No
Value in Primary Care	No
Focusing on Women's Health	Yes
Quality Care for the Treatment of Ear, Nose, and Throat Disorders	Yes
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV	No
Quality Care in Mental Health and Substance Use Disorders	Yes
Rehabilitative Support for Musculoskeletal Care	Yes
Advancing Cancer Care	Yes
Optimal Care for Kidney Health	No
Advancing Care for Heart Disease	No
Advancing Rheumatology Patient Care	Yes
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine	Yes
Improving Care for Lower Extremity Joint Repair	No
Patient Safety and Support of Positive Experiences with Anesthesia	Yes
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes	No

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

- The Medicare CQMs for ACOs collection type is available for the 4 measures below to be used by ACOs participating in the Shared Savings Program reporting through the Alternative Payment Model (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, 112, 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, 112SSP, 134SSP, and 236SSP.
- The Medicare CQM collection type was added to measure Q112: Breast Cancer Screening (112SSP), starting in 2025.

MIPS Quality ID #	Medicare CQM Submission File Identifier	Collection Type	MPS Quality Measure Title
001	001SSP	Medicare CQM Specifications	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
112	112SSP	Medicare CQM Specifications	Breast Cancer Screening
134	134SSP	Medicare CQM Specifications	Preventive Care and Screening: Screening for Depression and Follow-up Plan
236	236SSP	Medicare CQM Specifications	Controlling High Blood Pressure