Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2025 Quality Performance Category Quick Start Guide

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Purpose:

This resource focuses on the quality performance category, providing the high-level requirements and practical information about quality measure selection, data collection, and submission for the 2025 performance period for individual, group, virtual group, subgroup, and Alternative Payment Model (APM) Entity participation. This resource doesn't address quality requirements under the APM Performance Pathway (APP).

Already know what MIPS is?

Skip ahead by clicking the links in the Table of Contents.

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How to Use This Guide

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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.

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Overview

What Is The Merit-based Incentive Payment System?

If you're eligible for MIPS:

- You 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, extreme and uncontrollable circumstances, or hardship exception. Detailed information for each performance year will be available in the Traditional MIPS Scoring Guide, APP Scoring Guide, and MIPS Value Pathways Implementation Guide. These resources are updated annually and 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.

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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)

If you're eligible for MIPS (Continued):

- 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 final score **above** the performance threshold (**75 points** in 2022 – 2025 performance years).
  - **Neutral payment adjustment** for clinicians with a final score **equal to** the performance threshold (**75 points** in 2022 – 2025 performance years).
  - **Negative payment adjustment** for clinicians with a 2025 final score **below** the performance threshold (**75 points** in 2022 – 2025 performance years).

- Your MIPS payment adjustment is based on your performance during the performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1 of the payment year.
  - E.g., 2027 is the payment year for the 2025 performance year.

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.	• This reporting option offers 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 and any applicable administrative claims measures 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.

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

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality

30% | of MIPS Score

Cost

30% | of MIPS Score

Improvement Activities

15% | of MIPS Score

Promoting Interoperability

25% | of MIPS Score

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

APM Entity Participation

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality

55% | of MIPS Score

Cost

0% | of MIPS Score

Improvement Activities

15% | of MIPS Score

Promoting Interoperability

30% | of MIPS Score

Standard Weighting for Small Practices

(Promoting Interoperability Automatically Reweighted to 0%)

Traditional MIPS and MVP Performance Category Weights in 2025:

Quality

40% | of MIPS Score

Cost

30% | of MIPS Score

Improvement Activities

30% | of MIPS Score

Promoting Interoperability

0% | of MIPS Score

What's New with Quality in 2025?

Updates to Quality Measure Inventory

1	We added 6 new quality measures and removed 9 quality measures from traditional MIPS. Additionally, 1 quality measure was finalized for addition in the calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) Final Rule for the CY 2025 MIPS performance period.
2	There were 66 existing quality measures with substantive changes, 3 of which won't have a historical benchmark because the changes were so significant that it won't allow for a direct comparison of performance data from prior years to performance data submitted for the 2025 performance period.
3	The data completeness threshold will remain at 75%.

For more information on the new and removed quality measures, please review the Appendix.

This resource examines the quality performance category under traditional MIPS and MVPs.

- For more information about the quality performance category **under the APP**, please refer to the APP Quality Requirements webpage.

What's New with Quality in 2025 (Continued)

Updates to Quality Measures

1

We finalized a policy to apply **a flat benchmarking methodology** to a subset of topped-out measures that belong to specialty sets with limited measure choice and a high proportion of topped-out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

- We'll propose the measures to which this policy will apply during each year in rulemaking.
- For a list of quality measures subject to the new topped-out measure benchmarks for the 2025 performance period, please see Appendix E.

2

We finalized a **complex organization adjustment** to account for the organizational complexities facing **APM Entities (including Shared Savings Program ACOs) and virtual groups** when reporting eCQMs.

- **Add one measure achievement point for each submitted eCQM** for an APM Entity or virtual group that meets data completeness and case minimum requirements.
- The **adjustment may not exceed 10%** of the total available measure achievement points in the quality performance category.

What's New with Quality in 2025 (Continued)

Updates to Quality Measures (Continued)

3

We finalized that the **minimum criteria required for a valid submission** in the quality performance category must include numerator and denominator information for at least one quality measure from the list of MIPS quality measures to be considered a data submission and scored.

- Data submissions without any scorable data (e.g., practice ID, date, activity ID, measure ID, or CMS Electronic Health Record (EHR) Certification ID (CEHRT ID)) wouldn't satisfy the submission criteria.
- This policy is intended to mitigate the negative scoring impact on clinicians due to unintentional submissions without data that can be scored, which would override an approved reweighting application or a prior data submission and result in a zero score.

4

We've finalized a policy that aligns with our existing processing rules when we receive multiple quality submissions from the same organization or different organizations.

- For multiple quality submissions for an individual clinician, group, subgroup, or virtual group from **different organizations**, we'll calculate and score each submission received and assign the higher of the scores.
- For multiple quality submissions received for an individual clinician, group, subgroup, or virtual group from the **same organization**, we'll score the most recent submission. The new submission would override a previous submission.
- This policy wouldn't apply to different submission types from the same organization.

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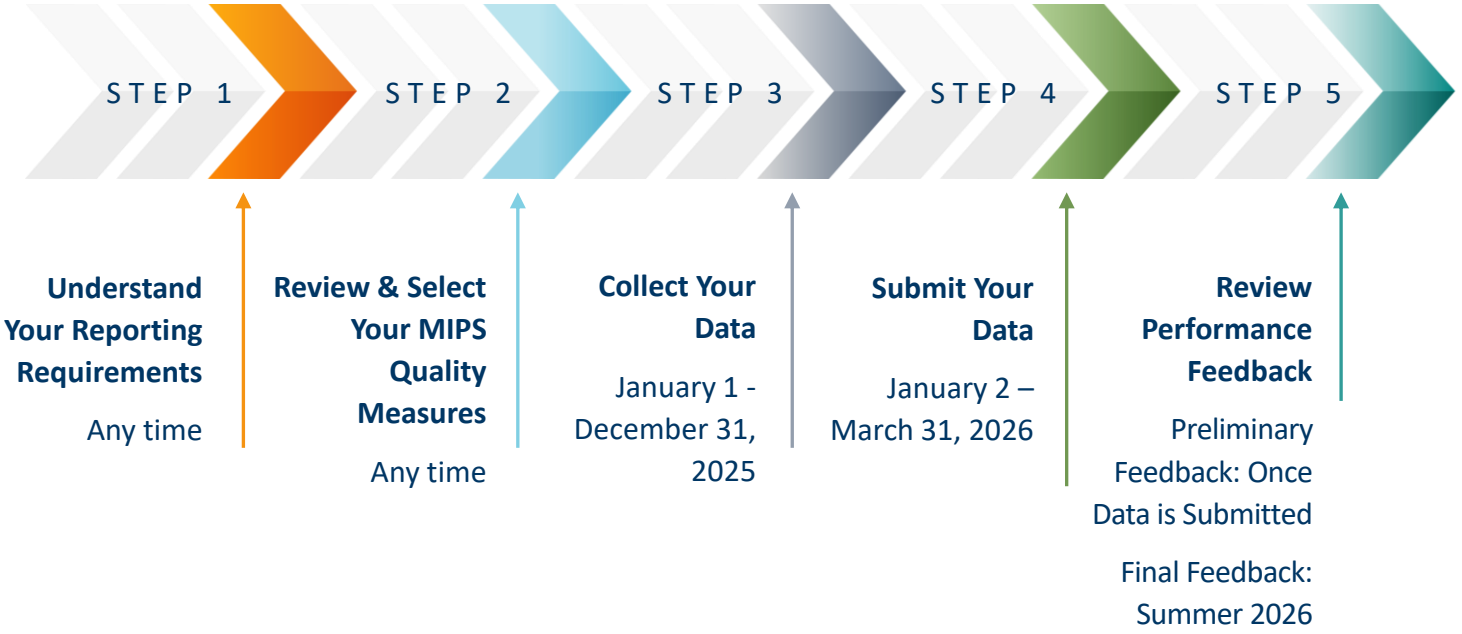
Get Started with Quality in 5 Steps

Overview


STEP 1
STEP 2
STEP 3
STEP 4
STEP 5
Understand Your Reporting Requirements
Any time
Review & Select Your MIPS Quality Measures
Any time
Collect Your Data
January 1 - December 31, 2025
Submit Your Data
January 2 – March 31, 2026
Review Performance Feedback
Preliminary Feedback: Once Data is Submitted
Final Feedback: Summer 2026

Step 1. Understand Your Reporting Requirements

The quality performance category has a **12-month performance period** (January 1 – December 31, 2025), which means you must collect data for each measure for the full calendar year. Your quality reporting requirements are determined by your MIPS reporting option.

Traditional MIPS	MVPs
Select a minimum of 6 quality measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. **OR** Report 1 **complete specialty measure set.** **Did you know?** • If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set.	**Select a minimum of 4 quality measures** (including 1 outcome or high priority measure) from your chosen MVP. **Did you know?** • For small practices reporting through Medicare Part B claims, if your selected MVP includes fewer than 4 Medicare Part B claims measures available, you don't need to report additional measures to meet quality reporting requirements.

Helpful Hints and Reminders:

- If you report more than the required number of quality measures, we'll pick the highest scored outcome measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.
- If you submit the same measure through multiple collection types (i.e., as a Medicare Part B claims measure and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points.

Did you know? Facility-based clinicians, groups, and virtual groups whose assigned facility has a Fiscal Year (FY) 2026 Hospital Value-Based Purchasing (VBP) Program score may have the option to use their Hospital VBP Program score for the traditional MIPS quality and cost performance categories. **However, we won't calculate a facility-based score at the subgroup level.** For more information on facility-based measurement, please refer to the 2025 Facility-Based Measurement Quick Start Guide (PDF, 1MB).

Step 2. Review & Select Your MIPS Quality Measures

Your quality measure options are determined by your MIPS reporting option.

Traditional MIPS	MVPs
There are 195 MIPS quality measures available (XLSX, 804KB) to report for the 2025 performance period, as well as 226 Qualified Clinical Data Registry (QCDR) measures approved outside the rulemaking process.	Each MVP includes a subset of quality measures that best align with a given specialty or medical condition. Review Explore MVPs for details about the quality measures available in each MVP.

Helpful Hints and Reminders:

- Review your patient population to ensure you'll be able to meet the case minimum requirement (20 cases) on the quality measures you choose to report. You'll earn 0 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark. Small practices will continue to earn 3 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark.
- There are no bonus points available for reporting additional outcome and high priority measures or measures that meet end-to-end electronic reporting criteria.
- You can report measures from multiple collection types to meet quality reporting requirements.
- You can report your quality measures through multiple submission formats (e.g., JSON and QRDA III files).

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Did you know?

- **Collection Type** refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. Follow the measure specifications that correspond with how you choose to collect your quality data.
  - For example: You're looking for a quality measure to report on the Use of High-Risk Medications in the Elderly. This measure is available as both a MIPS Clinical Quality Measure (CQM) and Electronic Clinical Quality Measure (eCQM) (distinct specifications). You would use the measure specification that corresponds with how you choose to collect your data.

Traditional MIPS	MVPs	What Do You Need to Know About This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2025 eCQM specifications 2025 eCQM flows eCQM Implementation and Preparation Checklists	You can report eCQMs if you use technology that meets the Certified Electronic Health Record Technology (CEHRT) certification from the Office of the National Coordinator for Health Information Technology (ONC) by the time eCQM data is generated for submission. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. Please refer to the Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) website to verify. If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2025	What Do You Need to Know About This Collection Type?
MIPS Clinical Quality Measures (MIPS CQMs)	2025 Clinical Quality Measure Specifications and Supporting Documents (ZIP, 68MB) 2025 Qualified Clinical Data Registries Qualified Posting (XLSX, 230KB) 2025 Qualified Registries Qualified Posting (XLSX, 202KB)	MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you choose this collection type, you may choose to work with a QCDR, Qualified Registry, or you can submit them yourself.
Qualified Clinical Data Registry (QCDR) Measures	2025 QCDR Measure Specifications (XLSX, 680KB) 2025 Qualified Clinical Data Registries Qualified Posting (XLSX, 230KB)	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures, which are approved along with the entity during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that feel relevant to their practice. You'll need to work with a QCDR to report these measures on your behalf.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2025	What Do You Need to Know About This Collection Type?
Medicare Part B Claims Measures	2025 Medicare Part B Claims Specifications and Supporting Documents (ZIP, 29MB) 2025 Part B Claims Reporting Quick Start Guide (PDF, 1MB)	Medicare Part B claims measures are reported with the clinician's individual (rendering) National Provider Identifier (NPI) when reporting as a group, virtual group, subgroup, or APM Entity. Medicare Part B claims measures are only available for small practices (15 or fewer clinicians).
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Measure	2025 CAHPS for MIPS Survey Overview Fact Sheet (available on the Quality Payment Program Resource Library in March 2025)	Groups, virtual groups, subgroups, and APM Entities can register between April 1, 2025, and June 30, 2025, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience of care within a group, virtual group, subgroup, or APM Entity. This survey measure must be administered by a CMS-approved survey vendor. The survey is administered during October 2025 – January 2026. Beginning in the 2026 performance year, survey vendors must submit the best estimate of the cost of their services to CMS. These vendor costs will be published to increase transparency on the cost of participation in the program and improve consistency across requirements.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2025	What Do You Need to Know About This Collection Type?
Administrative Claims Measures	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Eligible Clinician Groups (ZIP) Risk-Standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (ZIP) Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP) Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System (ZIP)	We calculate administrative claims measures automatically; no additional data submission required outside of routine billing. In traditional MIPS reporting, we evaluate you on every administrative claims measure in the MIPS inventory, and we score you on any measure for which you meet the criteria. In MVP reporting, we evaluate you on the population health measures and only score you on the measure for which you meet the criteria. You also have the option to select an outcomes-based administrative claims measure as 1 of your 4 required measures if available in your selected MVP.

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures)

You should start data collection on **January 1, 2025**, to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive **zero points** for the measure, unless you're a small practice, in which case you'll receive 3 points.

The **data completeness requirement will remain at a threshold of 75%** for the 2025 performance period. Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, numerator exclusions, or denominator exceptions) for at least 75% of the eligible population (excluding denominator exclusions).

Note: The data completeness threshold will remain at 75% through the 2028 performance period.

Selectively reporting data that misrepresents your performance in a disingenuous manner, commonly referred to as **"cherry-picking,"** results in data that aren't true, accurate, or complete and may subject you to an audit.
If you're working with a third party intermediary to collect and submit data, make sure you work with them throughout the year on data collection.

Aggregation of Data Using an EHR

If you transition from one EHR system to another EHR system during the performance period, you should aggregate the data from the previous EHR system and the new EHR system into one report for the full 12 months prior to submitting the data.

During the 2025 performance period, the EHR system(s) must use technology that meets the CEHRT certification from ONC by the time eCQM data is generated for submission.

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures) (Continued)

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
  - These errors include, but are not limited to:
    - Changes to the active status of codes.
    - The inadvertent omission of codes.
    - The inclusion of inactive or inaccurate codes.
- Updates to ICD-10 codes during the performance period.
  - We publish a list of measures requiring 9 consecutive months of data to be reported on the Quality Payment Program Resource Library by October 1st of the performance period (if technically feasible), but no later than the beginning of the data submission period (for example, January 2, 2026, for the 2025 performance period).
- Clinical guideline changes.
- Updates to measure specifications during the performance period.

For a quality measure impacted by one of the above items, the **quality measure will have a truncated performance period of 9 consecutive months if there are 9 consecutive months of accurate, available data.**

If there aren't 9 consecutive months of available data and revised clinical guidelines, measure specifications, or codes impact a clinician's ability to submit information on the measure, the **measure will be suppressed.**

Step 4. Submit Your Data

We'll assess your performance on the data you submit. If you plan to report an MVP, you're required to include your MVP ID (and subgroup ID if applicable) with your submission.

The data submission period will begin on **January 2, 2026**, and end on **March 31, 2026**. If reporting Medicare Part B claims measures, submission will be continuous throughout the performance period.

Who (Submitter Type)	What (Collective Type)	How (Submission Type)	When
You (Individual, Group, Virtual Group, Subgroup, or APM Entity Representative)	Medicare Part B Claims Measures (small practice only)	Through your routine Medicare Part B billing practices	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2026)
	eCQMs	Sign in to the QPP website and upload a QRDA III file	January 2 – March 31, 2026
	MIPS CQMs	Sign in to the QPP website and upload a QPP JSON file	January 2 – March 31, 2026
Third Party Intermediaries QCDRs or Qualified Registries	eCQMs MIPS CQMs QCDR Measures	Sign in to the QPP website and upload a QRDA III or QPP JSON file **OR** Use the QPP Submission Application Programming Interface (API)	January 2 – March 31, 2026
CMS-Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of the QPP website	In January 2026 - following data collection (standardized annual timeframe)

Step 4. Submit Your Data (Continued)

Did you know?

The level at which you participate in MIPS (individual, group, virtual group, subgroup, or APM Entity) generally applies to all performance categories. We won't combine data submitted at the individual, group, virtual group, subgroup, and/or APM Entity level into a single final score.

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all performance categories as a group.
- If data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all performance categories, but your MIPS payment adjustment will be based on the higher score.

Exception:

- When participating as an APM Entity, the Entity will submit quality measures (and improvement activities if reporting traditional MIPS or an MVP). MIPS eligible clinicians in the Entity may submit Promoting Interoperability data as individuals or as a group and we will 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 into a single final score or submit performance data for one category and count it for both traditional MIPS and MVP 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).

Note: We'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data for another category as a group (signaling their intent to participate as a group).

IMPORTANT: Each MVP submission must include the related MVP ID, signaling your intent to report the measure 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 through a subgroup, you'll also need to include the subgroup identifier given to you by CMS for your MVP submission.

For a list of MVP identifiers to add to your MVP submission, please review Appendix D.

Step 5. Review Your Performance Feedback

- Measure- and activity-level scores will be available starting on **January 2, 2026,** once data has been submitted.
- Your MIPS final score will be available in **early summer 2026**, and payment adjustment information will be available in **Summer 2026**. The Targeted Review period will open in **early summer 2026** when final scores are released and close 30 days after the release of your payment adjustment information in **late summer 2026**.
- You can review your performance feedback by signing in to QPP website.
- In addition to your final score and payment adjustment, MVP participants will receive "MVP Comparative Feedback." MVP comparative feedback will highlight how your performance compares at the category level to other clinicians reporting the same MVP.

Did you know?

- Small practices (15 or fewer clinicians, reporting individually, as a group, virtual group, subgroup, or APM Entity) that submit at least one quality measure will continue to earn 6 bonus points, which will be added to their quality performance category score.

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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
01/06/2025	Original Posting.

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Appendix

Appendix A: New Quality Measures Finalized for the 2025 Performance Period and Future Years

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
494*	eCQM	Intermediate Outcome	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)
506	MIPS CQM	Process	Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy
507	MIPS CQM	Process	Appropriate Germline Testing for Ovarian Cancer Patients
508	MIPS CQM	Process	Adult COVID-19 Vaccination Status
509	MIPS CQM	Process	Melanoma: Tracking and Evaluation of Recurrence
510	MIPS CQM	Process	First Year Standardized Waitlist Ratio (FYSWR)
511	MIPS CQM	Process	Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)

*MIPS Quality Measure #494 (eCQM collection type): Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level) was finalized as a new measure in the CY 2024 Medicare PFS final rule with a 1-year delay for implementation.

Appendix B: Quality Measures Finalized for Removal for the 2025 Performance Period and Future Years

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

*MIPS Quality Measure #436 (Medicare Part B Claims and MIPS CQM collection types): Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques was finalized for removal in the CY 2024 Medicare PFS final rule with a 1-year delay for implementation.

Appendix C: Measures with Substantive Changes Finalized for the 2025 Performance Period, Resulting in No Historical Benchmark for the 2025 Performance Period

MIP Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
340	eCQM MIPS CQM	Process	HIV Annual Retention in Care
344	MIPS CQM	Outcome	Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)
432	MIPS CQM	Outcome	Proportion of Patients Sustaining a Bladder or Bowel Injury at the time of any Pelvic Organ Prolapse Repair

Appendix D: MVP Identifiers

MIP Quality ID	Collection Type
G0057	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
M001	Advancing Cancer Care
G0055	Advancing Care for Heart Disease
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0058	Improving Care for Lower Extremity Joint Repair
M0002	Optimal Care for Kidney Health
G0059	Patient Safety and Support of Positive Experiences with Anesthesia
M0004	Quality Care for Patients with Neurological Conditions
M0005	Value in Primary Care

Appendix D: MVP Identifiers (Continued)

MIP Quality ID	Collection Type
M1366	Focusing on Women's Health
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1369	Quality Care in Mental Health and Substance Use Disorders
M1370	Rehabilitative Support for Musculoskeletal Care
M1420	Complete Ophthalmologic Care
M1421	Dermatological Care
M1422	Gastroenterology Care
M1423	Optimal Care for Patients with Urologic Conditions
M1424	Pulmonology Care
M1425	Surgical Care

Appendix E: Quality Measures Subject to the New Topped-Out Measure Benchmarks Policy

MIP Quality ID	Measure Type	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

Appendix E: Quality Measures Subject to the New Topped-Out Measure Benchmarks Policy (Continued)

MIP Quality ID	Measure Type	Collection Type
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