Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2025 MIPS Group Participation Guide: Traditional MIPS and MVPs

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Purpose: This resource examines Merit-based Incentive Payment System (MIPS) eligibility and participation for groups under traditional MIPS and MIPS Value Pathways reporting options. It provides high-level information and steps for interpreting eligibility and participation requirements, selecting measures and activities, and submitting data for the 2025 MIPS performance period. This resource doesn't cover virtual groups (traditional MIPS) or subgroups (MVPs).

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

How to Use This Guide

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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Hyperlinks

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

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Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:

If you're a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve QP status, you will be excluded from MIPS.

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.

The Merit-based Incentive Payment System (Continued)

If you're eligible for MIPS:

- 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 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.

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.

Group Participation Frequently Asked Questions

What does it mean to participate as a group?

When you participate as a group, you're choosing to submit aggregated data on behalf of all clinicians billing under the group's Taxpayer Identification Number (TIN), for each performance category requiring data submission: quality, improvement activities, and Promoting Interoperability.

- There are no data submission requirements for the cost performance category or administrative claims-based quality measures; we collect this data for you and calculate a score for the group.
- The group will earn a final score based on the aggregated data submitted (or collected for you) across all performance categories.

Each **MIPS eligible clinician** in the group will receive the same final score and payment adjustment unless the clinician receives a higher final score from individual or APM Entity participation under the same TIN/National Provider Identifier (NPI) combination.

Do we have to register to participate as a group?

You don't have to register if you're reporting traditional MIPS. You do have to register to report an MVP. Learn more about MVP registration on the QPP website.

Group Participation Frequently Asked Questions (Continued)

Who are the MIPS Eligible Clinicians in our group?

For group participation, a MIPS eligible clinician:

Is an eligible clinician type*	AND	Enrolled as a Medicare provider prior to the performance year	AND	Isn't identified as a Qualifying APM Participant (QP)

When participating as a group, it is the group, and not each individual MIPS eligible clinician, that must exceed the low-volume threshold at the group level.

*The 2025 MIPS eligible clinician types are physicians (MD, DO, DDS, DMD, DPM, OD), osteopathic practitioners, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, registered dietitians or nutrition professionals, clinical social workers, and certified nurse-midwives.

If we choose to report as a group, whose data do we need to include?

- All clinicians: For the quality, cost, and improvement activities* performance categories, performance is measured across all clinicians in your group including those that aren't MIPS eligible clinicians.
- MIPS eligible clinicians: For the Promoting Interoperability performance category, groups are required to submit the data collected in Certified Electronic Health Record Technology (CEHRT) on behalf of all MIPS eligible clinicians in the group.
  - You're not required to submit Promoting Interoperability data for clinicians that aren't MIPS eligible, but you may choose to include them.

*Refer to slide 46 for additional details about including QPs in your improvement activity data.

Group Participation Frequently Asked Questions (Continued)

Which clinicians in our practice are eligible for a payment adjustment based on our group submission?

The MIPS eligible clinicians (defined on the preceding page) who have reassigned billing rights to your TIN will receive a MIPS payment adjustment based on the group's submission.

MIPS eligible clinicians who didn't exceed the low-volume threshold at the individual level and those who start billing Medicare Part B claims under your TIN in the final 3 months of the MIPS performance year, between 10/1/2025 and 12/31/2025, are eligible for a MIPS payment adjustment based on the group's final score.

Your practice may choose to participate in MIPS as a group and the MIPS eligible clinicians within the practice may also choose to participate as individuals. If the MIPS eligible clinicians within your practice exceed the low-volume threshold at the individual level or elect to opt-in as individuals, they'll be evaluated for 2 final scores: one from their individual participation and one from the group participation. They'll receive the higher final score and associated MIPS payment adjustment when billing Medicare Part B claims under your practice's TIN in the 2027 payment year.

Group Participation Examples

Example 1: A practice has 4 physicians on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A enrolled in Medicare during the performance year (on or after January 1, 2025).
- Clinician B enrolled in Medicare prior to the performance year (before January 1, 2025) but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D each enrolled in Medicare prior to the performance year (before January 1, 2025) and exceed the low-volume threshold as individuals at this practice.

For the 2025 performance year, the practice:

- Participates in MIPS at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 physicians as appropriate to the measures selected. For improvement activities, at least 2 physicians would need to complete the same activity during the performance year for the group to attest.

The group earns a final score that corresponds to a +1.2% MIPS payment adjustment based on their 2025 performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by Clinicians B, C, and D in the 2027 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- Clinician A isn't eligible to receive a MIPS payment adjustment because the clinician was newly enrolled in Medicare.

Group Participation Examples (Continued)

Example 2: A practice has a clinical pharmacist (Clinician A) and 3 physicians (Clinicians B, C, and D) on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A is a clinical pharmacist which isn't a MIPS eligible clinician type.
- Clinician B is a MIPS eligible clinician type but didn't exceed the low-volume threshold as an individual at this practice.
- Clinicians C and D are MIPS eligible clinician types and exceed the low-volume threshold as individuals at this practice.

For the 2025 performance year, the practice:

- Participates at the group level;
- Exceeds the low-volume threshold as a group; and
- Submits aggregated data representing performance by all 4 clinicians as appropriate to the measures selected. For improvement activities, at least 2 clinicians were required to attest to completing the same activity during the performance year.

The group earns a final score that corresponds to a +0.5% MIPS payment adjustment based on their 2025 performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS) furnished by Clinicians B, C and D in the 2027 MIPS payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- The payment adjustment won't be applied to Clinician A because she isn't a MIPS eligible clinician type.

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Eligibility & Participation

MIPS Determination Period

TIP: One professional claim line with positive allowed charges is considered one covered professional service.

How is eligibility determined?

We look at your Medicare Part B claims from two 12-month segments, called the MIPS Determination Period, to evaluate the total volume of care your practice provides to Medicare patients.

Segment 1
October 1, 2023 – September 30, 2024

AND

Segment 2
October 1, 2024 – September 30, 2025

During each segment, we look to see if you and your practice exceed the low-volume threshold criteria:

Charges:
Bill more than $90,000 for Medicare Part B covered professional services under the Physician Fee Schedule (PFS)

AND

Patient Count:
See more than 200 Medicare Part B patients

AND

Covered Services:
Provide more than 200 covered professional services to Medicare Part B patients

To be eligible for MIPS, your practice must exceed all 3 of the **low-volume threshold** criteria during both 12-month segments of the MIPS Determination Period. Your practice may be eligible to opt-in to participate in MIPS as a group if you exceed some, but not all, of the low-volume threshold criteria.

Did you know? If your practice is newly formed or has otherwise established a new TIN between October 1, 2024, and September 30, 2025, we'll only evaluate your eligibility during segment two.

Checking Eligibility Status

How do we know if our practice can participate as a group?

You can find your practice's current **group-level eligibility status** on the QPP website. Final eligibility will be available in December 2025.

Sign in to the QPP website and navigate to "Eligibility & Reporting" on the left-hand navigation.

- Make sure to select "2025" as the Performance Year at the top of the page.
- Look for the indicator under your practice's name.
- You have the option to participate as a group and earn a MIPS payment adjustment if you see text indicating that you are MIPS eligible or opt-in eligible as a group.

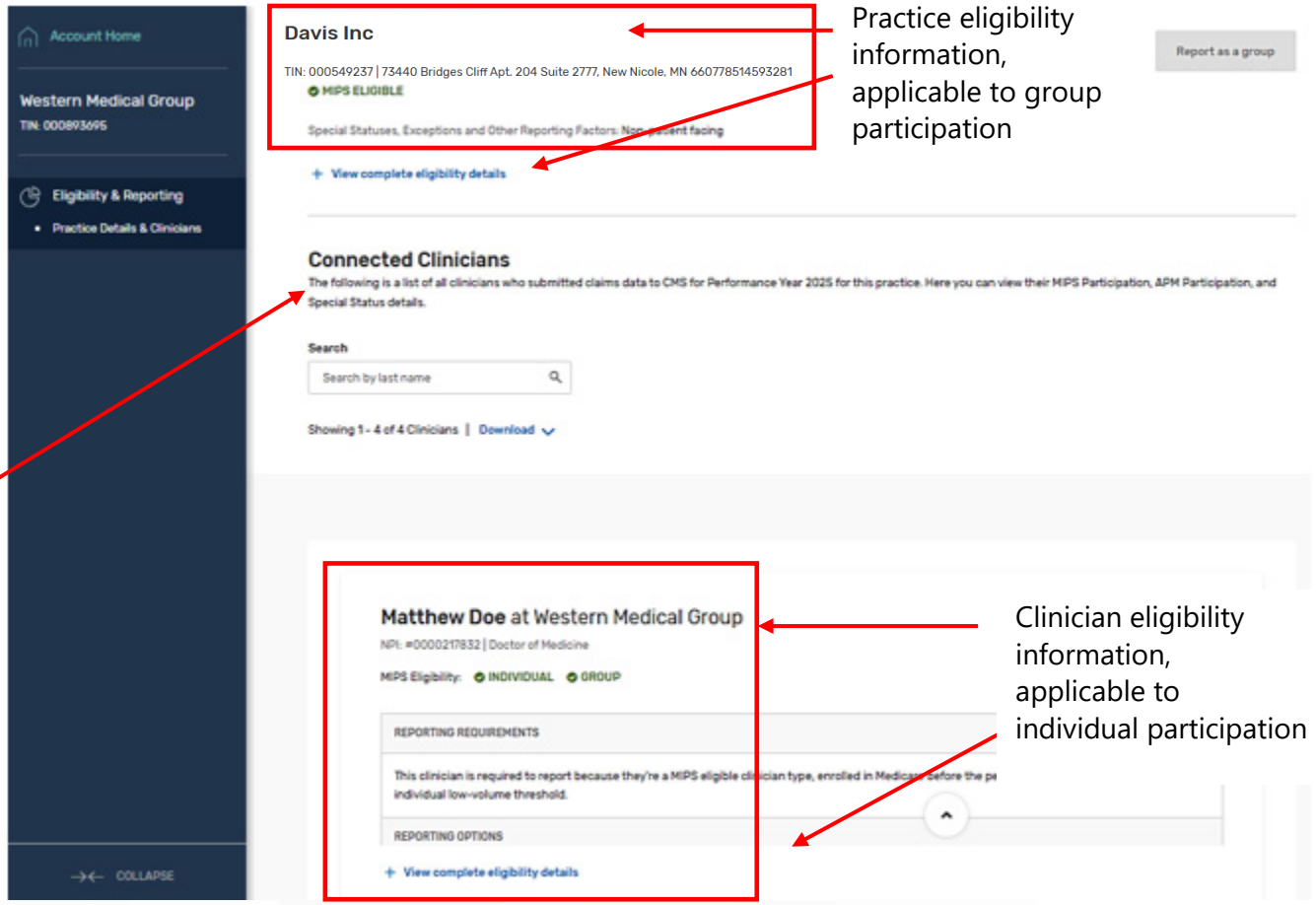
You See	This Means
MIPS ELIGIBLE	Your practice can choose to participate as a group, and all MIPS eligible clinicians who are eligible at the group level will receive a MIPS payment adjustment if you submit data as a group. (This includes clinicians who aren't individually eligible.)
MIPS EXEMPT Opt-in eligible	Your practice can choose to participate as a group and can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group's submission (i.e., choose to do nothing, opt-in, or voluntarily report). Learn more about opt-in eligible groups.
MIPS EXEMPT	Your practice can choose to voluntarily report, but your clinicians won't receive a MIPS payment adjustment.

Checking Eligibility Status (continued)

The **Practice Details & Clinicians** page provides the current eligibility status for your practice (for group participation) and the individual clinicians in the practice.

What's a Connected Clinician?

These are the clinicians associated with your TIN through Medicare Part B claims billing during the MIPS Determination Period.



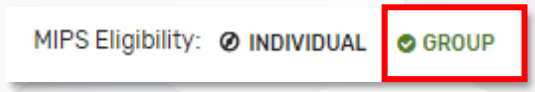
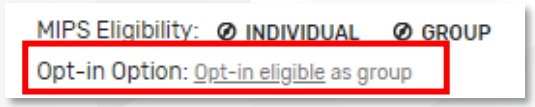
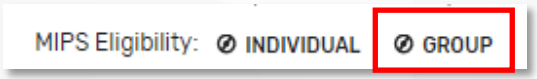
Practice eligibility information, applicable to group participation

Clinician eligibility information, applicable to individual participation

Checking Eligibility Status (Continued)

To view MIPS eligibility for the individuals associated with your practice, review your Connected Clinicians.

- A practice may see a mix of individual eligibility statuses under the Connected Clinicians.

You See	This Means
 	If your practice chooses to participate as a group, the MIPS eligible clinicians in the group will receive a MIPS payment adjustment based on the group's submission. (This includes clinicians who aren't individually eligible.) **If your practice chooses not to participate as a group, the MIPS eligible clinicians who are eligible as individuals will need to participate as individuals.**
	**If your practice chooses** to participate as a group, you can decide whether your MIPS eligible clinicians will receive a MIPS payment adjustment based on the group's submission (i.e., choose to do nothing, opt-in, or voluntarily report). Learn more about opt-in eligible groups.
	The clinician isn't eligible for a MIPS payment adjustment. Most commonly, you'll see this display when your practice isn't MIPS eligible, and none of the clinicians are eligible for a payment adjustment even if the practice voluntarily reports as a group. However, you may also see this when your practice is eligible, but an individual clinician in the practice isn't eligible for a MIPS payment adjustment (e.g., because they're a Qualifying APM Participant (QP).

Group Eligibility

If our practice is eligible as a group, are we required to participate as a group?

No. There is no requirement to participate as a group. If your practice is eligible at the group level, your practice has the option to participate as a group.

What does it mean if our group is "opt-in eligible"?

If your group is otherwise eligible for MIPS and exceeds 1 or 2, but not all 3 low-volume threshold criteria, you are **opt-in eligible.** This is applicable to traditional MIPS only; you can't opt-in or voluntarily report an MVP. If the group is opt-in eligible, you can:

Do nothing. Your group isn't required to participate in MIPS.

OR

Elect to opt-in. If your group decides to opt-in, the group will submit data at the group level, receive performance feedback, and the MIPS eligible clinicians within the group will receive a MIPS payment adjustment in 2027.

OR

Elect to voluntarily report. If your group wants to participate in MIPS but doesn't want its clinicians to receive a MIPS payment adjustment in 2027, the group can voluntarily report data and receive limited performance feedback.

The election to opt-in (or voluntarily report) to MIPS for the 2025 performance year is irreversible. If you are considering this option, be sure to explore program requirements to ensure that you're prepared to collect and report on data needed to demonstrate successful performance in 2025.

Group Eligibility (Continued)

Applicable to traditional MIPS only; you can't opt-in or voluntarily report an MVP.

How do we elect to opt-in or voluntarily report?

- Opt-in eligible groups that want to submit data must submit an election before data can be submitted. Groups can submit this election themselves by signing in to the QPP website during the submission period and choosing to opt-in or voluntarily report.
- Alternately, if you're working with a Qualified Registry or QCDR, the third party intermediary can submit this election on your behalf before submitting your data. (The 2024 MIPS Opt-In and Voluntary Reporting Election Guide (PDF 2MB) reviews what this process looked like for the 2024 performance year; at this time, there haven't been any significant changes to this process.)

Voluntary Reporting

- If your group chooses to voluntarily report, your group will receive performance feedback based on the measures and activities for which the group submitted data. This can help to inform the group's potential future MIPS participation. If you submit data, you'll receive performance feedback, but the group's clinicians won't receive a MIPS payment adjustment.
- You can voluntarily report if you're identified as either MIPS exempt or as opt-in eligible for the 2025 performance year. Groups identified as opt-in eligible will need to submit their election before data can be submitted; groups identified as MIPS exempt can simply submit their data.

Review how to tell what your practice's group participation options are in MIPS.

Group Eligibility (Continued)

MIPS Eligible Groups, Opt-in Eligible Groups, and Group Voluntary Reporting

Applicable to traditional MIPS only; you can't opt-in or voluntarily report an MVP.

	Group is Eligible AND chooses to submit data as a group	Group is Opt-in Eligible AND elects to opt-in	Group voluntarily reports
Is the group required to make an active election indicating the chosen participation option?	No	Yes	Yes, if you are opt-in eligible. No, if your group isn't MIPS eligible.
Will the group receive performance feedback?	Yes	Yes	Yes (but no feedback on cost measures, Medicare Part B Claims quality measures, or administrative claims measures).
Will the MIPS eligible clinicians in the group receive a positive, neutral, or negative payment adjustment?	Yes	Yes	No
Is the group's data eligible to be published in the Doctors & Clinicians section of Medicare Care Compare, formerly known as Physician Compare?	Yes	Yes	Yes (but, able to opt-out of public reporting during preview period).
Will the group's quality measure submissions be used to establish historical MIPS measure benchmarks for future program years?	Yes	Yes	No

Reminder: Clinicians who are MIPS eligible as individuals must report or be subjected to a negative payment adjustment. They may report individually, or as a group (if eligible), or both.

Checking Final Eligibility Status

MIPS Eligible Groups, Opt-in Eligible Groups, and Group Voluntary Reporting

Eligibility can change once we reconcile eligibility results from the 2 segments of the MIPS Determination Period. This information will be added to the QPP website in December 2025. If your group falls below all 3 elements of the low-volume threshold in either segment, your group will be ineligible to participate in MIPS as a group, except as voluntary reporters.

• Remain eligible; • Become opt-in eligible; or • Become ineligible (but can still voluntarily report).	• Remain opt-in eligible; or • Become ineligible (but can still voluntarily report).	• Your group will remain ineligible (but can still voluntarily report).

Helpful hint: When you sign in to check your group's eligibility status, you can also view individual eligibility for the clinicians in your practice.

When you sign in before eligibility is updated in December 2025:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2023, to Sept. 30, 2024, and received by CMS by October 30, 2024.

When you sign in after eligibility is updated in December 2025:

- Your clinician list displays the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2024, to Sept. 30, 2025, and received by CMS by October 30, 2025.
- If you have clinicians who participate in a MIPS APM, you may also see clinicians who didn't bill Medicare Part B claims but were identified as part of your practice on an APM participation list.

Did You Know?

It's possible for a practice to be opt-in eligible or ineligible as a group AND for a clinician in the practice to be individually eligible and required to participate in MIPS.

This can happen when a group falls below the low-volume threshold in the first segment and a new clinician joins in the second segment and exceeds the low-volume threshold.

Special Status Designations

What are special status designations?

We determine if a group qualifies for most special statuses by reviewing Medicare Part B claims data from the two 12-month segments of the MIPS Determination Period.

The following table outlines special status designations and their impact on group reporting requirements for the 2025 performance year.

If a group has a "special status", this will be indicated on the Special Statuses webpage of the QPP website.

Sign in to the QPP website and navigate to the "Eligibility & Reporting" webpage.

Or check the QPP Participation Status Tool.

(Click **Expand** next to the clinician's name and scroll down to 'Practice Level' in the Other Factors section.)

Special Status	Description	Impact to MIPS Reporting and Scoring
Ambulatory Surgical Center (ASC)-based	All MIPS eligible clinicians billing under your practice's TIN are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	**Traditional MIPS and MVPs:** Groups qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. If no qualifying Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Hospital-based	More than 75% of the clinicians billing under your practice's TIN are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	**Traditional MIPS and MVPs:** Groups qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. If no qualifying Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Non-patient Facing	More than 75% of the clinicians billing under your practice's TIN meet the definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	**Traditional MIPS:** You only need to perform and attest to one improvement activity. (MVP requirements were updated for all MVP participants in the 2025 performance year to require one activity.) **Traditional MIPS and MVPs:** Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no qualifying Promoting Interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.

Special Status Designations (Continued)

Special Status	Description	Impact to MIPS Reporting and Scoring
Facility-based	75% or more of the clinicians billing under your practice's TIN are facility-based as individuals. Groups are assigned to the facility at which the plurality of clinicians in the TIN were assigned as individuals. **Note:** We don't evaluate clinicians and groups for the facility-based status in the 2nd segment of the MIPS Determination Period. The facility-based status and assigned facility currently displayed on the QPP website will be updated if the assigned facility doesn't receive a Fiscal Year (FY) 2026 Hospital Value Based Purchasing (VBP) Program score. We won't know if a facility has a FY 2026 score until late 2025.	**Traditional MIPS:** Your group may qualify to receive scores for the quality and cost performance categories based on your assigned facility's FY 2026 Hospital VBP Program score. To receive facility-based scoring as a group, your group must submit group level data for the improvement activities and/or Promoting Interoperability performance category(ies) to signal your intent to participate as a group. **MVPs:** If your facility-based group is registered for and reports an MVP, we'll calculate a final score for traditional MIPS using facility-based measurement and a final score for your MVP reporting and assign the higher of the 2 scores.
Health Professional Shortage Area (HPSA)	More than 75% of the clinicians billing under your practice's TIN are in an area designated as an HPSA.	**Traditional MIPS:** You only need to perform and attest to one improvement activity. (MVP requirements were updated for all MVP participants in the 2025 performance year to require one activity.)

Special Status Designations (Continued)

Special Status	Description	Impact to MIPS Reporting and Scoring
Small Practice	There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.	**Traditional MIPS:** You only need to perform and attest to one improvement activity. (MVP requirements were updated for all MVP participants in the 2025 performance year to require one activity.) **Traditional MIPS and MVPs:** • You'll continue to receive 3 points (instead of zero) for quality measures that don't meet data completeness or case minimum requirements, or that can't be reliably scored against a benchmark. • Groups who submit at least 1 quality measure will also receive 6 bonus points for the quality performance category. • Your group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no qualifying Promoting Interoperability data is submitted, the performance category weight will be reallocated to another performance category or categories. • View Appendix D for additional information on the redistribution policies that apply to small practices.
Rural	More than 75% of the clinicians billing under the practice's TIN are in a ZIP code designated as rural using the most recent Federal Office of Rural Health Policy (FORHP) ZIP code file.	**Traditional MIPS:** You only need to perform and attest to one improvement activity.

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Quality Performance Category

Overview

The quality performance category assesses health care processes, outcomes, and patient experiences of their care. This category accounts for 30% of your final score, unless you qualify for reweighting in another performance category. Your quality reporting requirements are determined by your MIPS reporting option.

Reporting Requirements

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 or high priority measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.
- 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.

Reporting Requirements (Continued)

Does our group have to report quality data if we're a facility-based practice?

Traditional MIPS: Facility-based groups reporting traditional MIPS **AND** whose assigned facility has a FY 2026 Hospital VBP Program score don't need to report additional quality measures for MIPS.

However, **groups must submit data for the improvement activities and/or Promoting Interoperability performance categories** to qualify for facility-based scoring. This data submission alerts us of your group's intent to participate as a group.

- You can still submit quality measures. We'll calculate 2 final scores – 1 with facility-scoring and 1 without – and assign the higher final score to the group.

MVPs: Facility-based groups **reporting an MVP must report 4 quality measures in the MVP.** We won't calculate a quality score for an MVP using facility-based measurement. Facility-based groups reporting an MVP must report data for all required performance categories; if we can calculate a facility-based score in traditional MIPS, we'll create 2 final scores and assign the higher of the 2.

Please review the 2025 Facility-Based Measurement Quick Start Guide (PDF, 969KB) for more information.

Important: we won't know if your group's assigned facility has a FY 2026 Hospital VBP Program score until the end of the 2025 performance year – at this point, we'll remove the facility-based status from any clinician or group assigned to a facility without a FY 2026 score and you would need to report quality measures for MIPS.

Measure Selection

How do we select measures?

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

Traditional MIPS	MVPs
There are 195 MIPS quality measures available 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.

Learn more about available quality measures by reviewing Links to 2025 MIPS Performance Category Measure Specifications, Activity Inventory, and Supporting Documentation (PDF, 435KB).

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.
- 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).

Collection Types

What do we need to know about collection types?

A 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.

There are 5 collection types, or ways you can collect and submit your quality measures to CMS. They include:

1. Electronic Clinical Quality Measures (eCQMs)
2. MIPS Clinical Quality Measures (MIPS CQMs)
3. Qualified Clinical Data Registry (QCDR) Measures
4. Medicare Part B Claims Measures
5. CAHPS for MIPS Survey Measure

Additionally, there are some quality measures automatically calculated through administrative claims. There are up to 4 administrative claims measures automatically calculated in traditional MIPS reporting.

Beginning with the 2025 performance year, you won't be required to select a population health measure during MVP registration. We'll calculate both population health measures (if you meet the case minimum) but will only assign the higher of these measures to your quality score.

- If neither of the population health measures can be calculated, we'll exclude them from scoring.

Collection Types (Continued)

Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population and can choose from one or more collection types for a single quality performance category score.

Traditional MIPS Example

A group could:

Collect and report **2 eCQMs** without third party assistance	+	Work with a QCDR to collect and report **2 MIPS CQMs** and **2 QCDR measures** on their behalf.	=	All **6 of these measures** would contribute to a single quality performance category score for the group for traditional MIPS.

MVP Example

A small practice reporting the Advancing Cancer Care MVP could:

Report **2 Medicare Part B claims** measures throughout the performance period.	+	Collect and report **2 eCQMs** without third party assistance	=	All **4 of these measures** would contribute to a single quality performance category score for the group for this MVP.

Collection Types (Continued)

The table below walks through the different collection types, provides links to the 2025 measure specifications and provides helpful hints.

What do we need to know about collection types?

Collection Type	Quality Measures Available For 2025	What You Need to Know
eCQMs	2025 eCQM specifications eCQM Implementation and Preparation Checklist	• Groups can report eCQMs if they 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. - Review the Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) website. - If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted. • Groups can report their eCQMs themselves or work with a third party intermediary to report these measures on their behalf. • eCQMs can be reported in combination with Medicare Part B claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.

Collection Types (Continued)

The table below walks through the different collection types, provides links to the 2025 measure specifications and provides helpful hints.

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2025	What You Need to Know
Medicare Part B Claims Measures	2025 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP, 29MB) 2025 Part B Claims Reporting Quick Start Guide (PDF, 3MB)	• Only small practices (15 or fewer clinicians) can report Medicare Part B claims measures. • Claims measures must still be reported with the clinician's individual (rendering) NPI even when reporting as a group. **Don't report claims measures with the group's organizational NPI.** • We'll only calculate a quality score for groups based on individual claims data if group-level data is submitted for the improvement activities and/or Promoting Interoperability performance categories. • Claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.

Collection Types (Continued)

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2025	What You Need to Know
MIPS CQMs	2025 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 27MB)	• Groups can report their MIPS CQMs themselves or work with a third party intermediary to collect and report these measures on their behalf. • MIPS CQMs can be reported in combination with Medicare Part B claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
QCDR Measures	2025 Qualified Clinical Data Registry (QCDR) Measure Specifications (XLSX, 680KB)	• Groups will need to work with a CMS-approved QCDR to report these measures on their behalf. • QCDR measures can be a great option for groups that provide specialized care or who have trouble finding MIPS measures that feel relevant to their practice. • QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and the CAHPS for MIPS Survey measure.
CAHPS for MIPS Survey Measure	2025 CAHPS for MIPS Survey Overview Fact Sheet (PDF, 1MB)	• Groups (with 2 or more eligible clinicians) that wish to administer the CAHPS for MIPS Survey must register with a CMS-approved vendor between April 1, 2025, and June 30, 2025. The survey is administered during October 2025 – January 2026. • The CAHPS for MIPS Survey assesses patients' experiences of care within a group. This measure is most appropriate for groups that provide primary care services. • The CAHPS for MIPS Survey vendor is required to administer the survey, using the survey template provided by CMS. • This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures.

Collection Types (Continued)

What do we need to know about collection types? (Continued)

Collection Type	Quality Measures Available For 2025	What You Need to Know
Administrative Claims Measures	2025 All-Cause, Unplanned, Hospital-Wide Readmission Measure Specifications (ZIP, 854KB)* • This measure will have a case minimum of 200 cases and will only apply to groups with at least 16 clinicians. 2025 Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) Complications Measure Specifications (ZIP, 556KB) • This measure will have a case minimum of 25 cases and will apply to groups. • This measure will have a 3-year performance period (consecutive 36-month timeframe) that will start on October 1, 2022 (3 years prior to the performance year), and end on September 30, 2025 (current performance year) with complication outcomes assessed through December 2025. 2025 All-Cause Unplanned Admissions for Multiple Chronic Conditions Measure Specifications (ZIP, 5MB)* • This measure will have a case minimum of 18 cases and will only apply to groups with at least 16 clinicians. 2025 Acute Cardiovascular-Related Admission Rates for Patients with Heart Failure Measure Specifications (ZIP, 1MB) • This measure will have a case minimum of 21 cases and will only apply to groups with at least 1 cardiologist.	We calculate administrative claims measures automatically; no additional data submission required outside of routine billing. **Traditional MIPS:** We evaluate you on every administrative claims measure in the MIPS inventory, and we score you on any administrative claims measure for which you meet the criteria. **MVPs: We'll calculate both available population health measures (if you meet the case minimum) but will only assign the higher of these measures to your quality score.** You also have the option to select an outcomes-based administrative claims measure as 1 of your 4 required quality measures if available in your selected MVP.

*These administrative claims measures are available within each MVP as part of the foundational layer.

Data Collection & Submission

How much data do we need to collect?

There is a **12-month performance period** for the quality performance category, which means that your group must collect data for each quality measure from January 1 – December 31, 2025. To meet data completeness requirements, you should start data collection on January 1, 2025.

The data completeness threshold will remain at 75% for the 2025 performance period.

- 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.

Data completeness refers to the volume of performance data reported for the measure's eligible population.

- 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).
- **For Medicare Part B claims measures**, we identify the eligible denominator patient population based on your submitted Medicare Part B claims. Small practices choosing to report Medicare Part B claims measures submit data for their quality measures at the Medicare patient level.
- **For eCQMs, MIPS CQMs, and QCDR measures**, you (or your third party intermediary) identify the eligible population (include data from all payers) in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) specifications. Quality measure data (numerators, denominators, etc.) are aggregated for all the clinicians in the group, as applicable to the measure, not just the MIPS eligible clinicians in the practice.
    - Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking), wouldn't be considered true, accurate, or complete and may subject you to audit

Data Collection & Submission (Continued)

EHR-based Quality Reporting

- If you transition from one electronic health record (EHR) system to another during the performance period, you should aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month reporting period prior to submitting the data.
- If your practice uses multiple EHR systems for clinicians billing under the same TIN, you'll also need to aggregate data into a single report prior to submitting the data. For cases in which there are more than one EHR systems being used under a single TIN during the 2025 performance year and 12 months of data isn't available, you're required to submit as much data as possible.
- During the 2025 performance year, the EHR system(s) must use technology that meets the CEHRT certification from ONC by the time the eCQM data is generated for submission.

International Classification of Diseases 10th Revision (ICD-10) Updates

- Each year, the Value Set Authority Center (VSAC) releases updates to ICD-10 coding that take effect October 1st.
- We'll identify the measures that are significantly impacted by these updates in the 2025 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released by October 1 of the performance period if technically feasible, but no later than the beginning of the data submission period.
- Measures that are significantly impacted by ICD-10 updates will have a 9-month performance period, ending September 30, before the ICD-10 code changes take effect.
- Other measures may be impacted by these code changes, but not significantly enough to shorten the performance period. You should continue to report these measures according to the specification, reporting on encounters that use the codes identified in the measure's 2025 specification. You won't report on encounters that use updated codes not identified in the measure's 2025 specification.

Data Collection & Submission (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. (See previous slide)
- 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.**

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.

Data Collection & Submission (Continued)

How do we submit our data?

We'll assess your performance on the data you submit. If you're registered and reporting an MVP, you're required to include your MVP ID with your submission (see Appendix B: MVP Identifiers).

Data will generally be submitted during the 2025 submission period, January 2 – March 31, 2026.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Practice/Group, representative)	Medicare Part B Claims Measures (Only for Small Practices)	Through your routine Medicare Part B claims billing practices.	Throughout the performance period (must be processed by your Medicare Administrative Contractor (MAC) and received by CMS by March 1, 2026.)
	eCQMs	Sign in to the QPP website and upload a QRDA III file or a QPP JSON 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 and Qualified Registries)	eCQMs MIPS CQMs QCDR Measures	Sign in to QPP website and upload a QRDA III or QPP JSON file. **OR** Use the QPP Submissions 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.	Early 2026, following data collection (standardized annual timeframe).

Quality Payment
PROGRAM

Cost Performance Category

Overview

The cost performance category measures Medicare payments made for care provided to patients and accounts for 30% of your group's final score, unless you qualify for reweighting in another performance category.

Reporting Requirements

Traditional MIPS – Your group won't choose measures for the cost performance category in traditional MIPS. Groups will be scored on each cost measure for which they meet or exceed the established case minimum.

- You can find the measure descriptions, specifications ("Cost Measure Information Forms"), and code lists on the Explore Measures & Activities Tool on the QPP website.

MVPs – You don't select cost measures during MVP registration. We use Medicare claims data to calculate your cost measure performance. Each MVP includes cost measures that are relevant and applicable to the MVP clinical specialty or medical condition. You can find measure descriptions and specifications for your chosen MVP on Explore MIPS Value Pathways.

Helpful Reminder: 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.

Measure Review

For the 2025 performance year, there are 35 cost measures:

- The Total Per Capita Cost (TPCC) measure;
- The Medicare Spending Per Beneficiary Clinician (MSPB Clinician) measure;
- 15 Procedural Episode-based measures;
- 7 Acute Inpatient Medical Condition Episode-based measures;
- 10 Chronic Condition Episode-based measures; and
- 1 measure focusing on care provided in the emergency department setting.

For more information about this performance category, refer to the 2025 Cost Performance Category Quick Start Guide, available in the summer on the QPP Resource Library.

Data Collection & Submission

There are no data submission requirements for the cost performance category. We use Medicare administrative claims data to calculate your group's performance on cost measures. We'll calculate cost measure performance on behalf of all clinicians in your group including those who aren't eligible to participate in MIPS.

Scoring

How are cost measures scored?

Each cost measure that can be scored is assigned between 1 and 10 achievement points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

A cost improvement score is available to groups demonstrating improvement in their cost performance category. Cost improvement scoring is calculated by comparing the cost performance category score from the previous (2024) performance period to the one earned for the current (2025) performance period. There's a maximum of 1 percentage point (out of 100) available for cost improvement.

Traditional MIPS

- You'll only be scored for the cost measures for which your group meets or exceeds the case minimum.
- If your group doesn't meet the case minimum for any of the available cost measures, we'll reweight the cost performance category to 0%. It's 30% weight will be redistributed to other performance categories*.
- Learn more about cost scoring in the 2025 Traditional MIPS Scoring Guide.

MVPs

- We'll calculate performance exclusively on the cost measures that are included in the selected MVP for which you meet or exceed the established case minimum, even if additional cost measures (outside your selected MVP) are available for scoring. If you can't be scored on any cost measures in your selected MVP, we'll reweight the cost performance category to 0%. It's 30% weight will be redistributed to other performance categories*.
- Learn more about cost scoring in the 2025 MVPs Implementation Guide (PDF, 2MB)

*Appendix C provides additional information on the redistribution of performance category weights (**small practices** should review Appendix D).

Quality Payment
PROGRAM

Improvement Activities Performance Category

Overview

The improvement activities performance category measures participation in activities that improve clinical practice and generally accounts for 15% of your group's final score.

View Appendix D for more information on performance category weighting for small practices.

Reporting Requirements

Implement and attest to 1 or 2 improvement activities to receive the **maximum score of 40 points** in this performance category.

Clinicians, groups, virtual groups, and APM Entities with **certain special statuses (small practice, rural, health professional shortage area (HPSA), non-patient facing)** select (from **over 100 activities**) and perform: • **1 improvement activity** (40 points)	**N/A - there are no reduced reporting requirements for special status designations**
All other MIPS eligible clinicians select (from over 100 activities) and perform: • **2 improvement activities** (20 points each)	**All MVP participants** select (from the activities available within the MVP): 1 improvement activity (40 points)

Helpful Reminder: 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.

Activity Selection

Resources to help you find improvement activities relevant to your group or within your selected MVP:

Traditional MIPS

- 2025 Improvement Activities Inventory (ZIP, 2.7MB) in the Quality Payment Program Resource Library and Explore Measures & Activities Tool, which list the names, sub-categories, and descriptions of all available activities.
- 2025 Specialty Guides (ZIP) in the Quality Payment Program Resource Library (**TIP:** select "Specialty Guides" filter under "Resource Type"), suggest improvement activities that may be relevant to a given specialty practice (available in the first quarter of 2025).

MVPs

- Learn about the MVP reporting option and MVP Registration on the QPP website.
- Explore MVPs and the 2025 Proposed and Modified MVPs Guide (PDF, 3MB), which list all finalized MVPs, including the improvement activities in each MVP.
- 2025 Improvement Activities Inventory (ZIP, 499KB) in the Quality Payment Program Resource Library, which lists the names, sub-categories, and descriptions of all available activities.

Did You know? A certified or recognized patient-centered medical home or comparable specialty practice will receive full credit in this category if the following requirements are met:

At least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.

AND

The group must attest (IA_PCMH) to their status as a certified or recognized patient-centered medical home or comparable specialty practice during the 2025 submission period.

Data Collection & Submission

What are the requirements for a group to attest to having completed an improvement activity?

You can attest to an activity when at least 50% of the clinicians in the group (traditional MIPS or MVP) perform the activity. Clinicians must perform the activity for a continuous 90-day period during the 2025 calendar year unless a different performance period is specified in the activity description. However, clinicians in the group don't have to perform the activity concurrently and don't have to be eligible for MIPS to be included in the 50% threshold.

Did you know? You can attest to improvement activities already performed during the prior performance period again unless otherwise indicated in the activity description.

A note about QPs - If your group includes some clinicians who participate in an Advanced APM and have QP status, they don't count toward the requirement that 50% of clinicians in the group perform the activity. However, you can include them in the 50% if they choose to perform the activity.

Example. Practice A has 4 clinicians and is reporting as a group. Clinician 1 and Clinician 2 are QPs, Clinician 3 and Clinician 4 aren't.

- If Clinicians 1 and 2 (the QPs) don't perform the activity, the group will meet the 50% threshold and can attest to the activity as long as **either** Clinician 3 or Clinician 4 perform the activity.
- If Clinicians 1 and 2 (the QPs) perform the activity, the group will meet the 50% threshold and can attest to the activity even if **neither** Clinician 3 nor Clinician 4 perform the activity.

Data Collection & Submission (Continued)

TIP: We suggest reviewing this validation document during the performance period to ensure you document your work appropriately.

How do we document our work?
While implementing the activities you select, compile documentation demonstrating your work.

- **Once available, review the 2025 MIPS Data Validation Criteria document for examples of individual improvement activity documentation requirements.**
  - Ensure that each activity selected and attested to is completed and documented accurately and in accordance with the guidance provided in the MIPS Data Validation document.
  - Maintain documentation for each activity you attested to for a period of 6 years as evidence of completion in the event of a CMS audit.
    - **Note:** Submission platforms may allow you to attest to more than 40 points-worth of activities, but you can't earn more than 40 points in this performance category. You're responsible for compiling and maintaining documentation for all activities to which you attest.

- **Common examples of documentation may include, but are not limited to:**
  - Screenshot or digital capture of relevant information supporting the attestation.
  - Improvement plans and/or outlines supporting the interventional strategies/processes implemented to meet the intent of the improvement activity.
  - Electronic Health Record Report: Retain a copy of documentation relevant to the chosen improvement activity as evidence of attestation.

Note: QCDRs and Qualified Registries generally must support all performance categories to be approved by CMS. However, if you're working with a QCDR or Qualified Registry, you should verify that they can support and submit your selected improvement activities.

Data Collection & Submission (Continued)

How do we submit our data?
You can attest to your improvement activities yourself or use a third party intermediary to submit improvement activity data on your behalf during the 2025 submission period, January 2 – March 31, 2026.

There are 3 ways to attest to the completion of your improvement activities:

You	Sign in to the QPP website and attest to (manually select) the activities you've performed.
You or a third party	Sign in to the QPP website and upload a file with your activity attestations.
Third party	Perform a direct submission on your behalf, using our submissions API.

Reminder: 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, the group would need to submit (or attest to) their improvement activities for traditional MIPS and then separately submit (or attest to) their activities for their selected MVP. This is required even if you're submitting the same activities for both traditional MIPS and MVP reporting.

IMPORTANT: Each MVP submission must include the related MVP ID signaling your intent to report the activity 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 to your MVP submission. See Appendix B for a list of MVP Identifiers.

Quality Payment
PROGRAM

Promoting Interoperability Performance Category

Overview

The Promoting Interoperability performance category promotes patient engagement and the electronic exchange of health information using CEHRT. This performance category accounts for 25% of your group's final score.

Reporting Requirements

Traditional MIPS and MVPs have the same reporting requirements.

Your group is required to report the complete measure set unless you qualify for an exception or reweighting of this performance category.

- **Helpful Reminder:** 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.

Groups are only required to submit data from their MIPS eligible clinicians for this performance category.

Measure Review

The 2025 Promoting Interoperability performance category focuses on the following objectives: 1) e-Prescribing, 2) Health Information Exchange (HIE), 3) Provider to Patient Exchange, 4) 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.

- You must collect data for all required measures (unless you can claim an exclusion(s)) for the same **minimum continuous 180-day period in calendar year (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.

Reweighting & Hardship Exceptions

How does reweighting of the Promoting Interoperability performance category apply to groups?

A group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when:

- The group is identified on the QPP Participation Status Lookup Tool as **hospital-based**, **ASC-based**, **non-patient facing**, or a **small practice** at the practice level; **OR**
- The group's MIPS eligible clinicians qualify individually for reweighting based on special status or approved significant hardship exception. If any MIPS eligible clinician within the group doesn't qualify for reweighting, the group **must submit** Promoting Interoperability data.

Important: If the group qualifies for reweighting but submits qualifying data in this performance category, the group will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the final score. **A qualifying data submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period.**

Reminder: A group is considered hospital-based and eligible for reweighting when **more than 75%** of the clinicians billing under the practice's TIN meet the definition of hospital-based.

The hospital-based status is different than the facility-based status which has implications for quality reporting. Learn more about facility-based reporting.

Reweighting & Hardship Exceptions (Continued)

What if clinicians in the group are facing a significant hardship? There may be circumstances, out of your control, that make it difficult for you to meet the MIPS requirements.

Groups can submit a **Promoting Interoperability Hardship Exception** application when all MIPS eligible clinicians in their entire practice:

- Have decertified EHR technology (decertified under the Assistant Secretary for Technology Policy/Office of the National Coordinator (ASTP/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 the availability of CEHRT.

Note: Simply lacking the required certification criteria for CEHRT doesn't qualify the MIPS eligible clinician or group for re-weighting.

If **each** of the MIPS eligible clinicians in a group faces a significant hardship and **qualifies as an individual** for reweighting the Promoting Interoperability performance category, the group may submit an application to have their Promoting Interoperability performance category score be reweighted to 0%. If approved, the group will have their Promoting Interoperability performance category score reweighted to 0% and the category weight will be reallocated to the quality or improvement activities performance categories.

If **any** MIPS eligible clinician within the group **doesn't qualify** for a significant hardship exception (or doesn't otherwise qualify for reweighting), the group can't apply to have their Promoting Interoperability performance category reweighted to 0% and will need to submit data for this performance category, submitting all available measure data in their CEHRT.

Learn more about the 2025 Promoting Interoperability Performance Category Hardship Exception. The application deadline for 2025 is 8 p.m. ET on December 31, 2025; applications must be approved by CMS to qualify for reweighting.

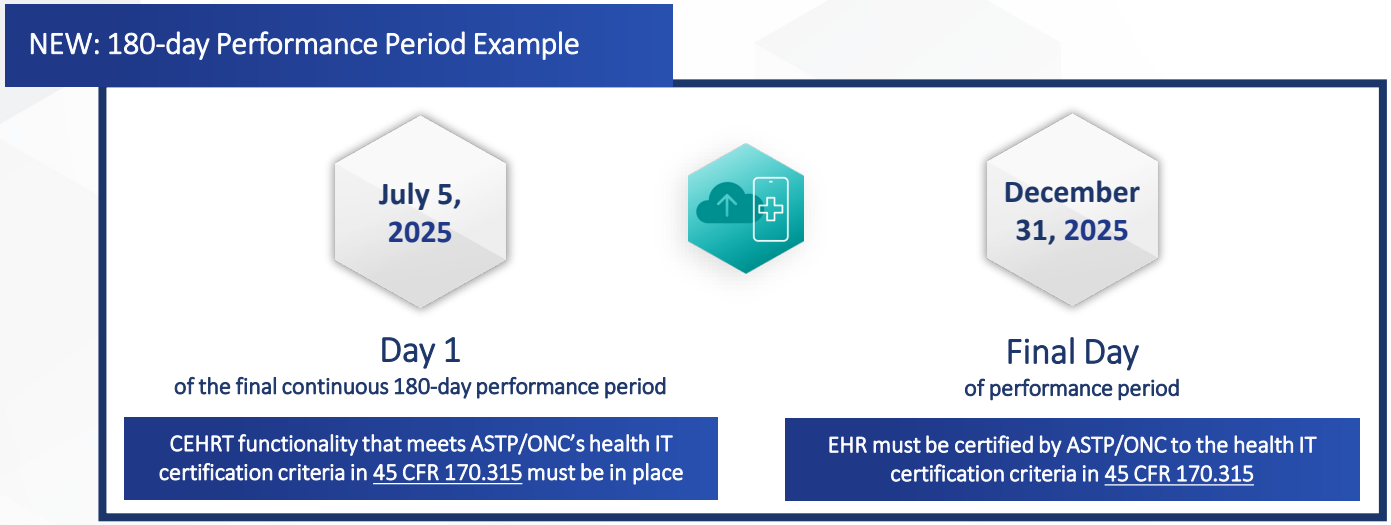
NOTE: Groups that have been approved for a hardship exception but submit qualifying data in this performance category, will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the group's final score.

Data Collection & Submission

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

- Have CEHRT **functionality** that meets ASTP/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 ASTP/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.



Data Collection & Submission (Continued)

How much data do we need to collect?

- If your practice has several EHRs and not all are certified to ASTP/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:
  - You'll aggregate the measure numerators and denominators for all MIPS eligible clinicians with data in your **CEHRT that meets ASTP/ONC's health IT certification criteria in 45 CFR 170.315** under your TIN.
    - Report all eligible encounters.
  - 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**. See Appendix B for MVP Identifiers)
- If participating as a subgroup, you'll also need to include the subgroup identifier given to you by CMS for your MVP submission.

Did you know?

- 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.

Data Collection & Submission (Continued)

When reporting as a group, do we need to include data from MIPS eligible clinicians who individually qualify for reweighting?

Yes. When submitting data as a group for the Promoting Interoperability performance category, the group should combine data for all MIPS eligible clinicians within the TIN. This includes the data of **MIPS eligible clinicians who may qualify for a reweighting** of the Promoting Interoperability performance category when submitting data individually.

If these MIPS eligible clinicians are part of the group and have data in the group's CEHRT, their data should be included in the group's data submission, and they'll be scored on the Promoting Interoperability performance category like the other MIPS eligible clinicians in the group.

Did you know?
The level at which you participate in MIPS (e.g., 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.**

For example:
- A clinician reports quality as an individual but doesn't report improvement activity or Promoting Interoperability data.
- The practice submits improvement activity and Promoting Interoperability data as a group but doesn't submit any quality measures.

We won't combine the individual's quality data with the group's improvement activity and Promoting Interoperability data into a single final score.
- The individual would receive a score of 0 in the improvement activity and Promoting Interoperability performance categories.
- The group would receive a score of 0 in the quality category unless they could be scored on an administrative claims measure.

Data Collection & Submission (Continued)

What data do we have to submit?

In order to receive a score greater than zero for the Promoting Interoperability performance category, your group must:

✓	Collect your data in CEHRT with the functionality that meets ASTP/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.

Data Collection & Submission (Continued)

How do we submit our data?

You can submit your group's Promoting Interoperability data yourself or use a third party intermediary to submit data on your behalf during the 2025 submission period, January 2 – March 31, 2026. There are 3 ways to submit your Promoting Interoperability performance category data:

Who	How
You	Sign in to the QPP website and attest to (manually enter) your information.
You or a third party	Sign in to the QPP website and upload a file with your data.
Third party	Perform a direct submission on your behalf, using our submissions API.

IMPORTANT!: 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 the scores.

TIP: QCDRs and Qualified Registries generally must support all performance categories to be approved by CMS, though some are exempt from supporting the Promoting Interoperability performance category based on the types of clinicians they support. If you're working with a QCDR or Qualified Registry, verify whether they can support and submit your Promoting Interoperability measures.

Did you know?

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. See the 2025 MIPS Data Validation Criteria for more information.

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Scoring & Payment Adjustments

Overview

How is our group's data scored?

For practices that choose to participate at the group level, group performance is assessed and scored at the practice (TIN) level across all 4 MIPS performance categories for the 2025 performance year.

Each category is scored based on the aggregated (group-level) data submitted or collected on your group's behalf.

How are payment adjustments applied?

Each MIPS eligible clinician participating in MIPS at the group level will receive a payment adjustment in the 2027 payment year based on the group's performance in 2025. MIPS payment adjustments will be applied on a claim-by-claim basis to covered professional services furnished by MIPS eligible clinicians under the Physician Fee Schedule.

MIPS eligible clinicians who submit data as a part of a group **AND** individually will be evaluated as an individual and as a group for all performance categories. We'll take the higher of the 2 final scores and apply the MIPS payment adjustment associated with it.

When the practice (TIN) participates as a group,

- Any individual (NPI) included in the TIN who is excluded from MIPS because they aren't a MIPS eligible clinician type or are identified as a new Medicare-enrolled clinician, a QP, or Partial QP **won't** receive a MIPS payment adjustment, regardless of their MIPS participation.
- Clinicians who are below the low-volume threshold as individuals, but otherwise eligible for MIPS, **will** receive a MIPS payment adjustment when reporting as a group provided no other exclusions apply to them.

Overview (Continued)

What happens if a clinician joins our group after September 30 of the performance year?

Clinicians who start billing Medicare Part B claims at a practice (TIN) between October 1 and December 31 of the performance year:

- When the practice participates as a group, these clinicians will receive the group's final score and associated payment adjustment unless they are otherwise excluded (see the answer to the previous question).
- These clinicians will receive a neutral payment adjustment if the practice doesn't report as a group.

What happens if a clinician leaves our group during the performance year?

When submitting data as a group, your practice will report aggregated data from the clinicians billing under your TIN as appropriate to the measures and activities you select. This may include data from clinicians who left your practice prior to the end of the 2025 performance year.

Even if a MIPS eligible clinician left your practice, the clinician will still receive a final score and payment adjustment based on your practice's performance which may follow the clinician to any new practice (TIN) they join for the 2027 payment year.

Final Score Calculation

What is the final score hierarchy for MIPS eligible clinicians who report data using more than one reporting and or participation option?

A MIPS eligible clinician (defined by a unique TIN/NPI combination) will receive the highest final score that can be attributed to that TIN/NPI combination from any reporting option (traditional MIPS, APP, or MVPs) and participation option (as an individual, group, subgroup, or APM Entity) with the exception of virtual groups. **Clinicians that participate as a virtual group will always receive the virtual group's final score.** Refer to the Scoring section for more details. An example of the final score hierarchy is provided below:

Participation Type	Reporting Option	Final Score
Group (ABCD)	MVP (Optimizing Chronic Disease Management)	90
Subgroup #1 (AB)	MVP (Coordinating Care to Promote Prevention and Cultivate Positive Outcomes)	80
Subgroup #2 (CD)	MVP (Advancing Care for Heart Disease)	97
Individual Reporter (A)	Traditional MIPS	98
Individual Reporter (C)	Traditional MIPS	60

TIN/ NPI	Group Final Score	Subgroup Final Score	Individual Final Score	Final Score Attributed to TIN/NPI	Reason for Final Score Attributed to TIN/NPI
A	90	80	98	98	Individual score is higher than both group and subgroup scores
B	90	80	N/A	90	Group score is higher than subgroup score
C	90	97	60	97	Subgroup score is higher than both group and individual scores
D	90	97	N/A	97	Subgroup score is higher than group 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

Version History

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

DATE	DESCRIPTION
xx/xx/2025	Original Posting.

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Appendices

Appendix A: Group Participation Timeline

Participation and data submission deadlines for the 2025 performance year are included in the chart below. You can also visit the performance year 2025 timeline on the QPP website.

Below are some key dates for MIPS group participation in traditional MIPS and MVPs:

Dec. 2024	Jan. 1, 2025	Apr. 1, 2025	Spring 2025	June 30, 2025	July 5, 2025	July 2025
Initial 2025 performance year eligibility available. **DO NOW:** Check preliminary eligibility on the QPP website.	2025 MIPS performance year begins. **DO NOW:** Review collection types and available quality measures so you can start collecting quality data.	Registration period begins for the CAHPS for MIPS Survey. Registration opens for MVPs **DO NOW:** Create a QPP account (ZIP, 4MB) and request the Security Official role for your practice if you don't have QPP credentials and your group wants to register.	MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exception application window opens. **DO NOW:** Review information about exception applications on the QPP website.	Registration deadline for CAHPS for MIPS Survey. **DO NOW:** Complete your registration before 8 p.m. ET.	Last day to start a 180-day performance period for Promoting Interoperability. **DO NOW:** Start performing your measures if you haven't already.	QP determinations & MIPS APM participation information are available. **DO NOW:** Check Quality Payment Program Participation Status Tool.

Appendix A: Group Participation Timeline (Continued)

Below are some key dates for MIPS group participation in traditional MIPS and MVPs:

Oct. 3, 2025	Dec. 1, 2025	Dec. 2025	Dec. 31, 2025	Jan. 2 – Mar. 31, 2026	Early Summer 2026	Summer 2026	Jan. 1, 2027
Last day to start a 90-day performance period for improvement activities. **DO NOW:** Start implementing activities if you haven't already.	PY 2025 MVP Registration Ends **DO NOW:** Complete your registration before 8 p.m. ET.	2025 performance year eligibility finalized. **DO NOW:** Check final eligibility on the QPP Participation Status Tool.	2025 MIPS performance year ends. MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exceptions application window closes. **DO NOW:** Complete and submit your application by 8 p.m. ET (if applying).	MIPS data submission period for the 2025 performance year. **DO NOW:** Create a QPP account and request a role for your practice so you can submit data or review data submitted on your behalf.	We will provide you with final scores based on the data you submitted for PY 2025. Targeted Review opens once your MIPS Final Scores are available. **DO NOW:** Sign in to the QPP website to view your MIPS Final Score.	Payment adjustment information available based on the data you submitted for PY 2025. Targeted review closes 30 days after the release of your payment adjustment information. **DO NOW:** Sign in to the QPP website to view the associated payment adjustment for your clinicians.	MIPS payment adjustments for the 2025 performance year go into effect. **DO NOW:** Review the MIPS payment adjustment applied to covered professional services furnished by your MIPS eligible clinicians on your remittance advance.

Appendix B: List of MVP Identifiers for MVP Reporting

This table contains a list of identifiers for each MVP. When reporting an MVP, 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. To learn more about MVPs, see Explore MIPS Value Pathways (MVPs).

MVP ID	MVP Title
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 B: List of MVP Identifiers for MVP Reporting (Continued)

This table contains a list of identifiers for each MVP. When reporting an MVP, 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. To learn more about MVPs, see Explore MIPS Value Pathways (MVPs).

MIPS Quality ID	MVP Title
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 C: 2025 Performance Year Redistribution Policies

Attention: If you are a small practice, please review Appendix D for the redistribution policies that apply to you.

Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Reweighting Needed				
General weighting for all 4 performance categories	**30%**	**30%**	**15%**	**25%**
Reweight 1 Performance Category				
No Cost	55%	0%	15%	30%
No Promoting Interoperability	55%	30%	15%	0%
No Quality	0%	30%	15%	55%
No Improvement Activities	45%	30%	0%	25%
Reweight 2 Performance Categories				
No Cost **and** No Promoting Interoperability	85%	0%	15%	0%
No Cost **and** No Quality	0%	0%	15%	85%
No Cost **and** No Improvement Activities	70%	0%	0%	30%
No Promoting Interoperability **and** No Quality	0%	50%	50%	0%
No Promoting Interoperability **and** No Improvement Activities	70%	30%	0%	0%
No Quality **and** No Improvement Activities	0%	30%	0%	70%

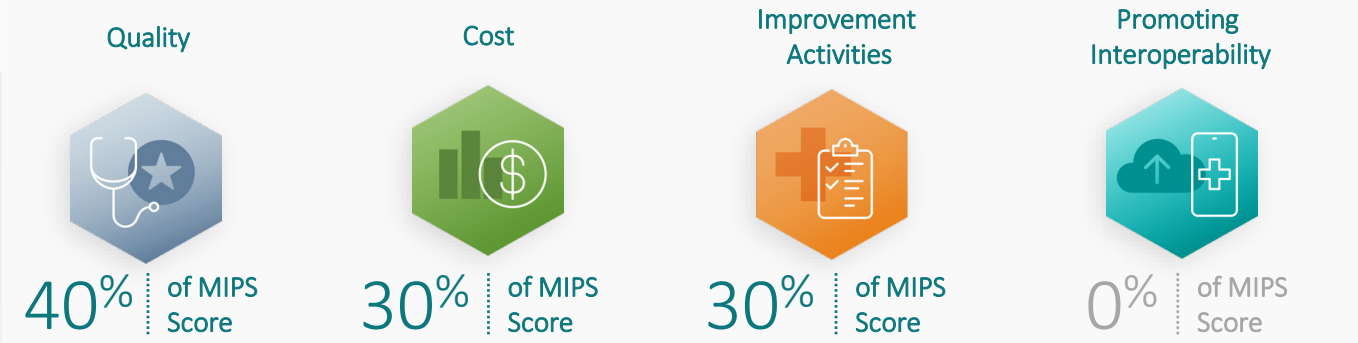
NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix D: Final Score Calculation

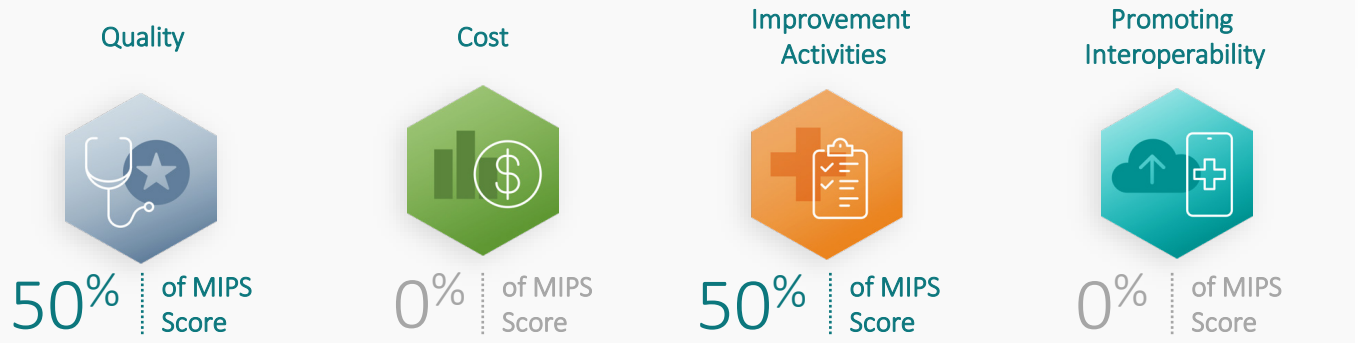
2025 Performance Year Redistribution Policies for Small Practices

We're continuing the performance category redistribution policies for small practices only **to more heavily weight the improvement activities performance category** when other performance categories are reweighted.

Standard weighting for small practices **(Promoting Interoperability automatically reweighted)**



When both the **cost** and the **Promoting Interoperability** performance categories are reweighted:

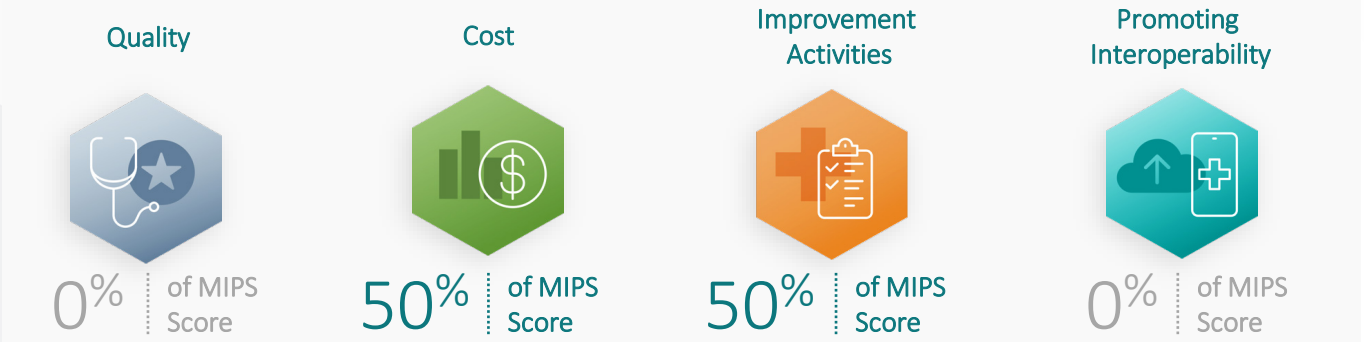


Appendix D: Final Score Calculation (Continued)

2025 Performance Year Redistribution Policies for Small Practices

NOTE: The following scenarios apply to all participating in MIPS, not just small practices.

When both the **quality** and the **Promoting Interoperability** performance categories are reweighted:



When **no** performance categories are reweighted (this means you submitted Promoting Interoperability data):