Quality Payment
PROGRAM

Alternative Payment Models (APMs)

Alternative Payment Model (APM) Performance Pathway (APP) Scoring Guide for the 2025 Performance Period

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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.

Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) advances a forward-looking and coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks.

In MIPS, you may earn performance-based payment adjustments for the services you provide to Medicare patients.

An Alternative Payment Model (APM) is a payment approach that rewards health care providers for delivering high-quality and cost-efficient care. APMs can focus on specific health conditions, care episodes, provider types, or communities. An Advanced APM is an APM that meets certain additional criteria

- Note: If you are a MIPS eligible clinician and participate in an Advanced APM but don't achieve Qualifying APM Participant (QP) status because you did not meet the required payment amount or patient count threshold, you are required to report to MIPS.

What is the Alternative Payment Model (APM) Performance Pathway (APP)?

The APP is an optional MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs, with the exception of Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). The APP is required for all Shared Savings Program ACOs. To view the list of MIPS APMs, please go to the 2024 and 2025 Comprehensive List of APMs. Please note that all Shared Savings Program ACOs are required to report their quality data on the APP Plus quality measure set via the APP to meet their quality reporting requirement for the Shared Savings Program.

The APP is optional for MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the 4 snapshot dates (March 31, June 30, August 31, and December 31) during a performance period.

The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. Performance is measured across 3 performance categories and accounts for the following percentages of the MIPS final score for MIPS APM participants reporting the APP: quality (50%), improvement activities (20%), and Promoting Interoperability (30%).

- All MIPS APM participants, including those in Shared Savings Program ACOs, who report the APP in 2025 will automatically receive full credit for the improvement activities performance category score.
- In addition, under the APP, the cost performance category is weighted to 0% of the MIPS final score, because all MIPS APM participants are already responsible for costs through their APMs.

Please note: The Shared Savings Program uses “performance year” instead “performance period.” Since the APP Toolkit is used by both Shared Savings Program ACOs and non-Shared Savings Program entities, the term “performance period” is used throughout.

Who Can Report the APP?

The APP can be reported by MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM. Virtual groups aren't eligible to report the APP. To check your eligibility, Enter your 10-digit National Provider Identifier (NPI) number to view your QPP participation status by performance year (PY) in the QPP Participation Status Tool. If you wish to check eligibility for all clinicians in a practice at once you can View practice eligibility in the signed in experience.

ACOs participating in the Shared Savings Program are required to report quality data on the APP Plus quality measure set to meet the quality reporting requirement for the Shared Savings Program.

- When an ACO reports the APP, ACO participants who are MIPS eligible clinicians don't have to report quality measures separately. However, MIPS eligible clinicians in the ACO still need to report Promoting Interoperability data and receive full credit for the improvement activities performance category and do not get evaluated on the cost performance category.
- Note-Though APM Entities can choose to submit their Promoting Interoperability data at the APM Entity level. APM Entities also have the option to report Promoting Interoperability data at the individual or group level; individual and group data will be aggregated and averaged into a single score for the APM Entity.

Your MIPS final score determines whether you will receive a positive, neutral, or negative MIPS payment adjustment. The Centers for Medicare & Medicaid Services (CMS) will award the highest available score. For example, if your APM Entity reports the APP and your group reports under traditional MIPS, you'll receive whichever of the 2 scores is greater for purposes of calculating your MIPS payment adjustment.

Getting Started: Reviewing MIPS Terms

Collection Type*

- Collection Type refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data. The following collection types apply to APP reporting:
  - Electronic clinical quality measures (eCQMs).
  - MIPS clinical quality measures (MIPS CQMs).
  - Medicare Part B Claims measures (available only to individuals, groups, and APM Entities with the small practice designation (15 or fewer clinicians) for the purpose of assessing quality performance for the Shared Savings Program).
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (required for groups and APM Entities with 2 or more MIPS eligible clinicians reporting the APP).
  - Medicare CQMs for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) (available only to Shared Savings Program ACOs reporting the APP Plus quality measure set).
- Appendix C explains each of these collection types in further detail.

Did you know? If you're submitting quality measures using the eCQM collection type with data sourced from multiple EHR systems, the submitting EHR system must be certified to align with the Office of the National Coordinator for Health IT (ONC)'s regulations at 45 CFR 170.315 for the 2025 performance period.

* The term "Collection Type" is unique to the quality performance category and doesn't apply to the other performance categories.

Getting Started: Reviewing MIPS Terms (Continued)

Submitter Type*

- Submitter type refers to the MIPS eligible clinician, group, APM Entity, or third party intermediary (acting on behalf of a MIPS eligible clinician, group, or APM Entity) that submits data on measures for the quality and Promoting Interoperability performance categories for APP reporting.

Submission Type

- Submission type is the mechanism by which the submitter type submits data to CMS:
  - Direct (transmitting data through a computer-to-computer interaction, such as an Application Programming Interface, or API).
  - Sign in and upload (attaching a file).
  - Sign in and attest (manually entering data).
  - Medicare Part B claims (available to individuals, groups, and APM entities with the small practice designation only; not available to Shared Savings Program ACOs).

* While Virtual Groups meet the definition of Submitter type per 42 CFR 414.1305, Virtual Groups are not eligible to report the APP.

APP: Quality Performance Category

What Are the Quality Performance Category Data Submission Requirements Under the APP?

Beginning with the CY 2025 performance period, there are 2 quality measure sets available under the APP: the existing APP quality measure set and the new APP Plus quality measure set.

Eligible individuals, groups, APM Entities (all models/programs excluding Shared Savings Program ACOs) can report the existing APP quality measure set.

Shared Savings Program ACOs are required to report the new APP Plus quality measure set beginning in the CY 2025 performance period. Consequently, the APP quality measure set will no longer be available for reporting by Shared Savings Program ACOs as a way to meet the quality reporting requirement for the Shared Savings Program beginning in the 2025 performance period. Only submissions using the APP Plus quality measure set will meet the quality reporting requirements for the Shared Savings Program.

What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

OPTION 1: APP Quality Measure Set

Optional quality measure set for MIPS eligible clinicians, groups, and APM Entities (all models/programs)

***No longer an option for Shared Savings Program ACOs to meet the quality reporting requirement for the Shared Saving Program*

Quality ID: 001

Diabetes: Glycemic Status Assessment Greater Than 9%

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 134

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 236

Controlling High Blood Pressure

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 321

CAHPS for MIPS

COLLECTION TYPE
- CAHPS for MIPS Survey

SUBMITTER TYPE
- Third Party Intermediary

Quality ID: 479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE
- N/A

Quality ID: 484

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE
- N/A

* Beginning in the CY 2025 performance period, APM Entities (including Shared Savings Program ACOs) and virtual groups are eligible to receive the complex organization adjustment when reporting eCQMs. One measure achievement point is added for each submitted eCQM for an APM Entity or virtual group that meets MIPS data completeness and case minimum requirements.

**Medicare Part B Claims measures can only be reported by individuals, groups, and APM Entities with the small practice designation and are limited to Medicare patients.

What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

Shared Savings Program ACOs are required to report the new APP Plus quality measure set beginning in the 2025 performance period to meet the quality reporting requirement for the Shared Savings Program. Eligible individuals, groups, and APM Entities can either report the APP Plus quality measure set or the existing APP quality measure set.

Shared Savings Program ACOs will have the option to report quality data on the APP Plus quality measure set via the eCQM, MIPS CQM, or Medicare CQM collection types, or a combination of these 3 collection types.

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What Are the Quality Performance Category Data Submission Requirements Under the APP? (Continued)

OPTION 2: APP Plus Quality Measure Set (*NEW for 2025)

Required for Shared Savings Program ACOs to meet the quality reporting requirement for the Shared Savings Program

Optional quality measure set for MIPS eligible clinicians, groups, and APM Entities

Quality ID: 001

Diabetes: Glycemic Status Assessment Greater Than 9%

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**
- Medicare CQM

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 112

Breast Cancer Screening

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**
- Medicare CQM

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 134

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**
- Medicare CQM

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 236

Controlling High Blood Pressure

COLLECTION TYPE
- eCQM*
- MIPS CQM
- Medicare Part B Claims**
- Medicare CQM

SUBMITTER TYPE
- MIPS Eligible Clinician
- Practice Representative
- APM Entity Representative
- Third Party Intermediary

Quality ID: 321

CAHPS for MIPS Survey

COLLECTION TYPE
- CAHPS for MIPS Survey

SUBMITTER TYPE
- Third Party Intermediary

Quality ID: 479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE
- N/A

* In the CY 2025 performance period, APM Entities and virtual groups can receive the complex organization adjustment when reporting eCQMs.

** Only individuals, groups, and APM Entities with the small practice designation can report Medicare Part B claims measures. Shared Saving Program ACOs cannot report Medicare Part B Claims measures as part of the APP Plus quality measure set in order to meet the quality reporting requirement for the Shared Savings Program.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs

Quality Measure Performance Period

- Quality measures have a 12-month performance period (January 1, 2025 – December 31, 2025).

What Does "Data Completeness" Mean?

- "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 entire eligible population as outlined in the measure's specification.
- **To meet data completeness criteria, you must identify the entire eligible population in your submission and report performance data for at least 75% of the eligible population.**

To illustrate:

$$\text{Data Completeness} = \frac{\text{Number of patients for which performance data is submitted } \textit{(met, not met, or denominator exception)}^{2}}{\text{Total number of patients in eligible population}}$$

Did you know?

- You can use multiple collection types when reporting Quality IDs 001, 112, 134, and 236. For example, you could report Quality ID 001 as an eCQM and Quality IDs 134 and 236 as MIPS CQMs.

For more information, view the 2024 MIPS Data Completeness Quick Start Guide.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Data Completeness and Eligible Population

- For Medicare Part B Claims measures, we identify the eligible population (denominator) for you based on the claims you submit.
- When reporting eCQMs and MIPS CQMs, your denominator eligible **encounters include your entire patient population**, not just your Medicare patient population.
- **Starting in performance period 2024**, for Shared Savings Program ACOs reporting a Medicare CQM, we provide a list of beneficiaries eligible for Medicare CQM reporting through quarterly reports based on your Medicare FFS patients. You have the option to use this list along with other data sources to determine the eligible population (denominator) for each measure and validate your quality measure data.
- For eCQMs and MIPS CQMs, you (or your vendor) identify the eligible population as outlined in the measure's specification in your submission according to the Quality Reporting Document Architecture (QRDA) III or QPP JavaScript Object Notation (JSON) templates. For Medicare CQMs, use the QPP JSON templates. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician, group, or APM Entity's performance (submitting only favorable performance data, commonly referred to as "cherry-picking"), wouldn't be considered true, accurate, or complete and may subject you to audit.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

How is "Data Completeness" Determined for Shared Savings Program ACOs?

To meet **data completeness** requirements, ACOs must also identify their entire eligible population across all participants, and report performance data for at least 75% of their eligible population.

- For eCQMs and MIPS CQMs, the denominator eligible population will reflect 100% of the eligible and matched, deduplicated all payer/all patient population across all participant Tax Identification Numbers (TINs) and CMS Certification Numbers (CCNs) in the ACO.
- When reporting Medicare CQMs, your denominator eligible population includes all the ACO's Medicare FFS beneficiaries that meet the definition at 42 CFR 425. 20, across TINs and CCNs, instead of the all payer/all patient population.
- Data completeness is calculated based on the data you submit.
- Since eCQMs are specified to be calculated using all-payer data and submitted electronically without any manual manipulation, ACOs that submit an eCQM via Certified Electronic Health Record Technology (CEHRT) would generally achieve 100 percent data completeness.
- Each eCQM contains data regarding 100 percent of the eligible clinicians' eligible and matched patient population. In the case of an ACO using multiple CEHRT, eCQM reporting requires the aggregation of data across all CEHRT used across the ACO into a single submission to ensure the ACO meets the measure specification by accounting for its complete eligible and matched patient population.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

How is "Data Completeness" Determined for Shared Savings Program ACOs? (Continued)

- MIPS CQM and Medicare CQM specifications allow for the use of multiple sources of data (e.g., EHRs, paper records, registries, claims data) to compile a measure's numerator and denominator, so an ACO must undertake additional effort to ensure it meets the data completeness standard.
- An ACO submitting via the MIPS CQM or Medicare CQM collection types must report performance data ("Performance Met," or "Performance Not Met," or denominator exceptions) for at least 75% of their eligible and matched population denominator.
- For additional information regarding the reporting of eCQMs, MIPS CQMs and Medicare CQMs, the below resources are available:
  - 2024 Data Aggregation Resource
  - 2024 MIPS Quality Data Completeness Quick Guide
  - Medicare Shared Savings Program 2024 Reporting eCQMs, MIPS CQMs and Medicare CQMs in the Alternative Payment Model (APM) Performance Pathway (APP)
  - Overview of the Quarterly List of Beneficiaries Eligible for Medicare CQMs Data Dictionary and Template: https://acoms.cms.gov/knowledge-management/view/8282.
    - **Note:** to access the above resource, you need ACO-MS access.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Quality Benchmarks

Your performance on each quality measure is assessed against a benchmark to determine how many points you earn for the measure.

- Benchmarks differ by collection type.
- Different benchmarks will be used for scoring based on whether you report these measures as eCQMs, MIPS CQMs, Medicare CQMs, or Medicare Part B Claims measures.

Whenever possible, we use historical data to establish benchmarks.

- Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years before the applicable performance period.
- The historical benchmarks for the 2025 MIPS performance period were established from quality data submitted for the 2023 MIPS performance period.

Note: For more information about the 2025 quality benchmarks, please review the 2025 Quality Benchmarks on the Benchmarks page of the QPP website.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

What If a Measure Doesn't Have a Historical Benchmark?

If a quality measure's collection type doesn't have a historical benchmark, we'll attempt to calculate a benchmark based on data submitted for the 2025 performance period. These performance period benchmarks will be available in the 2026 calendar year.

We can establish performance period benchmarks when at least 20 instances of the measure are reported through the same collection type and meet data completeness and case minimum requirements and have a performance rate greater than 0% (or less than 100% for inverse measures).

- We'll attempt to calculate a performance period benchmark for the new Medicare CQM collection type, which isn't eligible for historical benchmarking for the 2025 performance period. For performance period 2026 and beyond, CMS will score Medicare CQMs using historical benchmarks when baseline period data are available.

Under the APP, measures without a historical or performance period benchmark are excluded from scoring as long as data completeness is met.

Note: For more information about the 2025 quality benchmarks, please review the 2025 Quality Benchmarks on the Benchmarks page of the QPP website.

***** Most measures have a case minimum requirement of ≥20 cases. However, some measures have a different case minimum requirement. The case minimum requirements for each measure can be found in their respective measure specifications in the QPP Resource Library.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

How are Measures Scored?

If a measure can be reliably scored against a benchmark, it means:

- A benchmark is available.
- The volume of cases that you've submitted is sufficient (≥20 cases for most measures, 200 cases for the Hospital-Wide, 30-Day, All Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups, and 18 cases for the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions).
- You've met data completeness requirements (identified all denominator eligible encounters and submitted performance data for at least 75% of the denominator eligible encounters).
- For the CY 2025 performance period, the following measures of the Medicare CQM collection type will be scored using flat benchmarks: measures 001, 112, 134, and 236.

The 2025 Quality Benchmarks reflect these flat benchmarks.

* In flat percentage benchmarks, any performance rate at or above 90% would be in the top decile, any performance rate between 80% and 89.99% would be in the second highest decile, and so on. (For inverse measures, this would be reversed – any performance rate at or below 10% would be in the top decile, any performance rate between 10.01% and 20% would be in the second highest decile, and so on.)

Did you know? In 2020, we established an alternate (flat) benchmarking methodology for scoring the following quality measures when we determine that their historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient:

- Quality ID 001, Diabetes: Glycemic Status Assessment Greater Than 9%; and
- Quality ID 236, Controlling High Blood Pressure.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Measure achievement points are based on your performance for a measure in comparison to a benchmark, exclusive of bonus points.

Measure Achievement Points When Reporting the APP Quality Measure Set or the APP Plus Quality Measure Set

1-10 points	3 points (small practices only)	0 (0 out of 10 points)	0 (0 out of 10 points)	N/A (0 out of 0 points)
You'll receive between 1 and 10 achievement points for quality measures that meet case minimum and data completeness requirements and that can be scored against a benchmark.	Small practices receive 3 points for measures that don't meet data completeness requirements.	You'll receive 0 points for measures that don't meet data completeness requirements. This doesn't apply to small practices.	You'll receive 0 points for measures that are required but unreported. (You must report performance data for the measure to be considered reported.)	Measures that don't have a benchmark or meet the case minimum requirement are excluded from the total measure achievement points and total available measure achievement points as long as you meet data completeness requirements. Suppressed measures will also be excluded from scoring when submitted if data completeness is met.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Example: Assigning Measure Achievement Points

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 1. Find the benchmark based on collection type for the measure.

- Achievement points are determined by mapping the performance rate to the benchmark for the measure, specific to collection type.
- Remember that Quality ID 236 is scored according to the flat benchmark methodology for Medicare CQM.
- Quality ID 236 will be scored against a performance period benchmark if one can be calculated and for historic benchmarks as reflected in the 2025 Quality Benchmarks.

The following extract from the 2025 Quality Benchmarks shows the range of performance rates associated with each decile for each collection type for Quality ID 236.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Example: Assigning Measure Achievement Points (Continued)

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 2. Identify which decile performance rate falls in.

- Determine the decile that the performance rate falls in
- In this case, the measure performance rate is 66.74, which corresponds to Decile 7 (eligible for 7.0 – 7.9 points)

Measure Name	Controlling High Blood Pressure
Quality ID#	236
Collection Type	MIPS CQM
Measure Type	Intermediate Outcome
Benchmark	Y
Decile 1	1.00 – 9.99
Decile 2	10.00 – 19.99
Decile 3	20.00 – 29.99
Decile 4	30.00 – 39.99
Decile 5	40.00 – 49.99
Decile 6	50.00 – 59.99
Decile 7	60.00 – 69.99
Decile 8	70.00 – 79.99
Decile 9	80.00 – 89.99
Decile 10	≥90.00

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Example: Assigning Measure Achievement Points (Continued)

You submit Quality ID 236 (Controlling High Blood Pressure) as a MIPS CQM with a 66.74% performance rate.

Step 3. Use this formula and the decile to calculate achievement points.

$$\text{decile \# } X + \left[\frac{q \text{ performance rate} - a \text{ bottom of decile range}}{b \text{ bottom of next decile range} - a \text{ bottom of decile range}}\right] = \text{Achievement Points}$$

NOTE: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

$$\text{decile \# } 7 + \left[\frac{66.74 - 60.00}{70.00 - 60.00}\right] = 0.674\ldots = 7.7$$

…which is rounded to 0.7

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

Data Aggregation and Multiple Submissions

If you submit the same quality measure multiple times through the same collection type, we'll use the most recently reported data you submitted for that specific measure. We won't aggregate measure-level performance data when the same measure is reported multiple times.

Let's look at an example:

- You uploaded a file with the 3 or 4* eCQMs in January. In February, your electronic health record (EHR) vendor contacts you about a measure calculation issue that they just fixed so you upload a new file with the 3 or 4* eCQMs.
- The eCQMs you uploaded in February overwrote the ones you submitted in January.

*Depending on whether the APP quality measure set or the APP Plus quality measure set is reported

If you submit the same measure through multiple collection types, we'll select the higher scoring collection type of the measure based on achievement points. Under no circumstances will you earn achievement points for 2 collection types for the same measure. It is important to note, that when reporting the same measures through multiple collection types, the measure should be completely reported through each collection type; CMS will not aggregate data from multiple collection types to calculate a single measure score.

Let's look at an example:

- You're working with a qualified registry to report the 4 measures in the APP Plus quality measure set as MIPS CQMs because your certified EHR technology is only coded for Quality ID 001. Your registry uploads a file of all 4 measures submitted as MIPS CQMs, and you upload a file with Quality ID 001 submitted as an eCQM.
- When scoring Quality ID 001, we'll use either the MIPS CQM or eCQM collection type — whichever results in more achievement points based on comparison to its benchmark.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

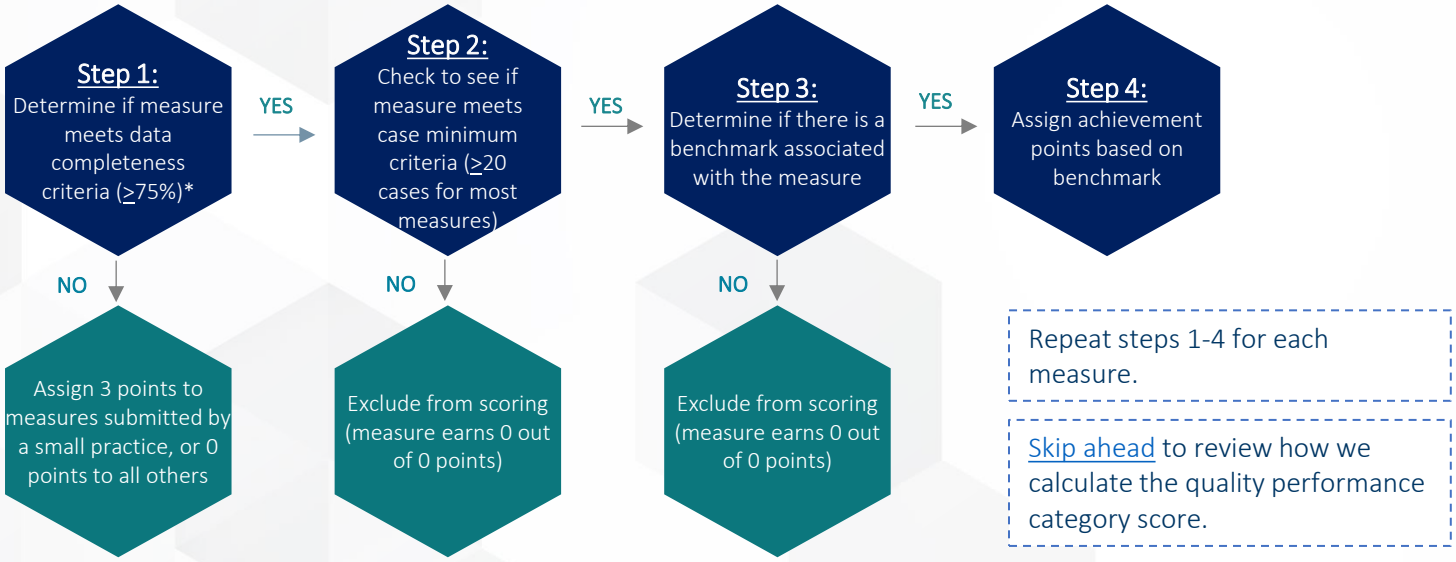
Factors Impacting Numerator Points and Available Denominator Points

Under certain circumstances, your numerator points for a measure may be set to 0, and your denominator (10 x the number of measures you're required to report) may be lower than the maximum points available.

Maximum Points by Reporting Label	
There's no historical benchmark for one of the required APP quality measures and we can't calculate one based on data submitted for the performance period…	…the measure will receive 0 out of 0 points.
You don't meet the case minimum for one or more quality measures…	…the measure will receive 0 out of 0 points.
Your group or APM Entity doesn't meet the minimum beneficiary sampling requirements for the CAHPS for MIPS Survey…	…we'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS survey measure.
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available. **NOTE:** To the extent feasible, we will identify suppressed measures by the beginning of the submission period.	…we'll lower the denominator by 10 points for each impacted measure. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification, or so that you aren't held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we will truncate the performance period instead of suppressing the measure and reducing the denominator.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

What Are the Steps for Scoring Medicare Part B Claims Measures, eCQMs, MIPS CQMs, and/or Medicare CQMs?



Repeat steps 1-4 for each measure.

Skip ahead to review how we calculate the quality performance category score.

*For Shared Savings Program ACOs, the denominator eligible population will reflect 100% of the eligible and matched, deduplicated population across all participant TINs and CCNs in the ACO. The numerator must reflect at least 75% met/not met to meet data completeness criteria.

CAHPS for MIPS Survey Measure

What Are the Steps for Scoring the CAHPS for MIPS Survey Measure?

Groups and APM Entities reporting the APP must register to administer the CAHPS for MIPS Survey. After registering, an approved CAHPS for MIPS Survey vendor must be selected to administer the survey. Shared Savings Program ACOs are required to report quality data on the APP Plus quality measure set. They are automatically registered but must still select a vendor to administer the survey.

NOTE: Beginning in the 2024 performance period, registered groups and APM Entities (including Shared Savings Program ACOs) are required to contract with a CAHPS for MIPS Survey vendor to administer the Spanish translation of the survey to Spanish-preferring patients.

CAHPS for MIPS Survey Measure Scoring and Benchmarks

We established a benchmark for individual summary survey measures (SSMs) in the CAHPS for MIPS Survey measure. These benchmarks were calculated using historical data from the 2023 performance period. Each SSM is awarded 1 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey measure score is calculated by the average number of points across all scored SSMs that meet case minimum requirements (20 cases). Please review the 2025 historical CAHPS for MIPS benchmarks in the 2025 Quality Benchmarks webpage.

NOTE: APM Entities and groups (including Shared Savings Program ACOs) will receive instructions from CMS on how to authorize a CMS-approved vendor after August 1st. CMS will produce your patient sample and send it to the vendor you authorize. Once you authorize a survey vendor, we'll proceed with data collection, and you'll be accountable for the costs associated with administering the survey.

The CAHPS for MIPS Survey isn't available to clinicians reporting the APP as an individual.

https://qpp.cms.gov/mips/how-to-register-for-CAHPS?py=2025

NOTE: If your group or APM Entity registers for the CAHPS for MIPS Survey, but doesn't meet the minimum beneficiary sampling requirements, we'll exclude the measure from scoring.

Administrative Claims Measures

Two of the MIPS quality measures required by the APP will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

- Hospital-wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure.
  - This measure has a case minimum of 200 cases and will apply to groups and APM Entities with at least 16 clinicians.
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
  - This measure has a case minimum of 18 cases and will apply to groups and APM Entities with at least 16 clinicians. Please note APM participants that achieve QP status are not included in the calculation of the MCC measure, under the APP quality measure set.
  - The MCC measure is not included in the APP Plus quality measure set for the 2025 performance period.

Administrative Claims Scoring and Benchmarks

For the HWR Rate for MIPS Eligible Clinician Groups measure and Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure, we intend to calculate performance period benchmarks for the 2025 performance period.

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, and APM Entities

We use the following formula to calculate a quality performance category score for individuals, groups, and APM Entities that aren't a small practice:

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points / Total Available Measure Achievement Points*) + Improvement Score

We use the following formula to calculate a quality performance category score for individuals, groups, and APM Entities with the small practice designation:

Quality Performance Category Score (Not to exceed 100%) = (Total Measure Achievement Points + Small Practice Bonus (6 points)[6] / Total Available Measure Achievement Points*) + Improvement Score

A total of 6 bonus points will be added to the numerator of the quality performance category score for MIPS eligible clinicians in small practices who submit data on at least one quality measure. (These bonus points are only available to individuals, groups and APM Entities with the small practice designation.)

Your quality performance category score is then multiplied by the 50% quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

*Total Available Measure Achievement Points = the number of required measures x 10

**No Shared Savings Program ACOs met the criteria for small practice at the APM Entity level in PY 2025.

Calculating the Quality Performance Category Score (Continued)

What is Improvement Scoring?

We use the following formula to calculate a quality score for individuals, groups, and APM Entities that aren't a small practice:

MIPS eligible clinicians can earn up to 10 additional percentage points in the quality performance category based on the rate of their improvement in the quality performance category from the previous year. The improvement score — calculated at the category level and representing improvement in achievement from one year to the next — may not total more than 10 percentage points. If CMS can't compare data between 2 performance periods, or if there is no improvement, the improvement score will be 0%. The improvement score can't be negative.

CMS determines eligibility for these additional percentage points when MIPS eligible clinicians meet the following criteria:

1. Full participation in the quality category for the current performance period:
    - Submits a complete set of measures in the APP quality measure set or the APP Plus quality measure set.
    - All submitted quality measures must meet data completeness requirements.
2. Data sufficiency standard is met — that is, data is available and can be compared:
    - There is a quality performance category achievement score (the score earned by measures based on performance, excluding bonus points) for the previous performance period (2024 performance period) and the current performance period (2025 performance period).
    - Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did You Know?

Improvement scoring isn't available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately before the current MIPS performance period.

Submitting Measures in the APP Quality Measure Set or the APP Plus Quality Measure Set as Medicare Part B Claims Measures, eCQMs, MIPS CQMs and/or Medicare CQMs (Continued)

How Many Measure Points Can I Earn in the Quality Performance Category?

Maximum Points by Reporting Label	
Individuals	• 30 POINTS – For the 3 required quality measures: o The CAHPS for MIPS Survey can't be administered for individual clinicians. o The Hospital-wide, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure doesn't apply to individual clinicians. o Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure doesn't apply to individual clinicians.
Groups and APM Entities	• 60 POINTS – For the 3 required quality measures + CAHPS for MIPS measure + HWR measure + MCC measure.
Shared Savings Program ACOs Reporting eCQMs/MIPS CQMs/Medicare CQMs	• 60 POINTS – For the 4 required quality measures + CAHPS for MIPS measure + HWR measure.

Did you know?

- The maximum number of measure points available is different from the quality performance category weight.
- The category weight identifies the number of points that the quality performance category can contribute to your MIPS final score.
- The total number of points for the quality performance category will be calculated as a percentage (for example, 55 out of 60 points would be 91.6%) and then multiplied by the category weight of 50% to determine the category's contribution to the final score.
- If you don't submit at least one required measure in the APP quality measure set or the APP Plus quality measure set, you will receive zero points in this performance category unless you qualify for the performance category to be reweighted.
- The total measure available achievement points may be less than the maximum points described on this slide when the individual, group, or APM Entity does not meet case minimum requirement or minimum beneficiary sampling requirement.

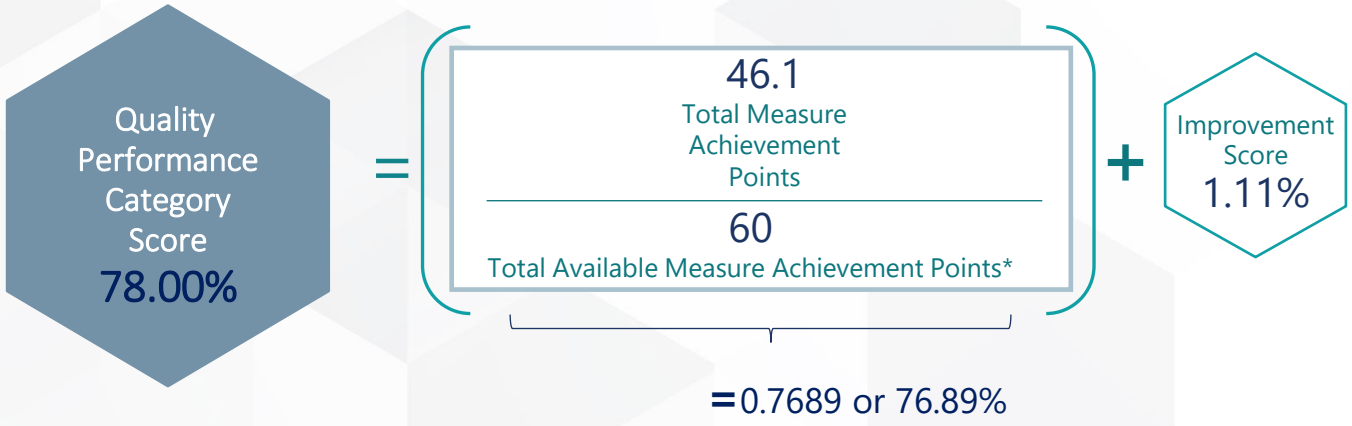
Calculating the Quality Performance Category Score (Continued)

Scoring Example #1

An APM Entity participating in ACO Realizing Equity Access and Community Health (ACO REACH) earns 46.1 achievement points out of 60 possible points for the 2025 performance period.

They also qualify for improvement scoring because their achievement score showed improvement from last year.

- Their 2025 achievement score = 46.1/60 = 76.89%.
- Their 2024 achievement score = 69.02%.
- The increase in their achievement score = 76.89% - 69.2% = 7.69%.
- Their improvement score = (7.69% ÷ 69.2%) ÷ 10 = 1.11%.



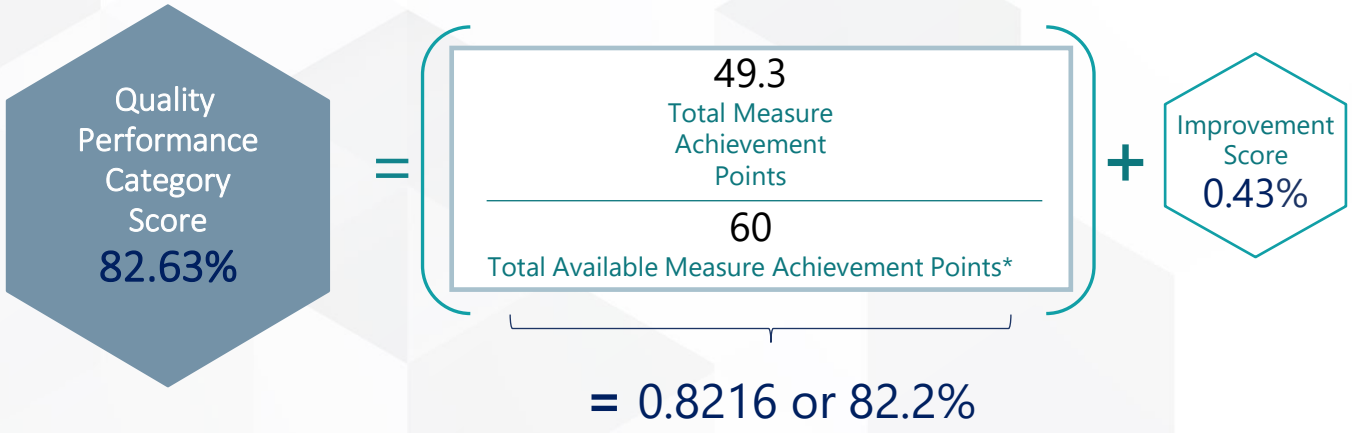
Calculating the Quality Performance Category Score (Continued)

Scoring Example #2

A Shared Saving Program ACO reported a full set of quality measures through a combination of MIPS CQMs and eCQMs for 2024 and 2025. They earn 49.3 achievement points out of 60 possible points for the 2025 performance period.

They also qualify for improvement scoring because their achievement score showed improvement from last year.

- Their 2025 achievement score = 49.3/60 = 82.2%.
- Their 2024 achievement score = 78.8%.
- The increase in their achievement score = 82.2% - 78.8% = 3.4%.
- Their improvement score = (3.4% ÷ 78.8%) ÷ 10 = 0.43%.



How is My Quality Performance Category Score Calculated?

To determine how many points the quality performance category contributes to your final score, we multiply your quality performance category score by the quality performance category weight. When reporting the APP, we multiply your quality performance category score by 50% (the quality performance category weight under the APP).*

Can the Quality Performance Category Be Reweighted?

There are a few scenarios that would allow the quality performance category to be reweighted.

- If you qualify for our extreme and uncontrollable circumstances (EUC) policy, you may request performance category reweighting through the EUC application. Please check the Exceptions Application webpage for more information.

Please see Appendix A for more information on the reweighting of the quality performance category, including the EUC policy.

For more information, visit the Quality: APP Requirements webpage.

* For Shared Savings Program ACOs, note that only the quality performance score is used by the Shared Savings Program to calculate shared savings and losses, including any relevant adjustments by the Shared Savings Program. The MIPS final score is not utilized by the Shared Savings Program.

APP: Improvement Activities Performance Category

What are the Data Submission Requirements for the Improvement Activities Performance Category?

MIPS APM participants, including those in Shared Savings Program ACOs, reporting the APP don't need to submit any data for the improvement activities performance category for the 2025 performance period. Each year, we'll assign a score for the improvement activities performance category for each MIPS APM. All MIPS APM participants who report the APP in 2025 will automatically receive full credit for the improvement activities performance category score (20 out of 20 points towards your MIPS final score).

Shared Savings Program ACOs are required to report the APP Plus quality measure set to receive full credit for the improvement activities performance category.

Improvement Activities

20% of MIPS Score

APP: Promoting Interoperability Performance Category

What are the Data Submission Requirements for the Promoting Interoperability Performance Category?

Objectives	Measures		Requirements
e-Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Query of Prescription Drug Monitoring Program (PDMP)		Required unless an exclusion is claimed
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 is reported
		Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 is reported
	Option 2	HIE Bi-Directional Exchange	Required (no exclusion available), unless option 1 or option 3 is reported
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (no exclusion available), unless option 1 or option 2 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required unless an exclusion(s) is claimed
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting		Optional measures (no exclusions available)

Promoting Interoperability

30% of MIPS Score

Did You Know?

If you claim an exclusion for the e-Prescribing measure, you can't report the Query of PDMP measure; an exclusion will be automatically applied.

You must submit collected data for the required measures in each objective (unless an applicable exclusion is claimed) for the same 180 continuous days (or more) during the calendar year.

What are the Data Submission Requirements for the Promoting Interoperability Performance Category? (Continued)

In addition to reporting the previously listed measures, you must:

- Use certified electronic health record (EHR) technology (CEHRT) functionality that meets the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology's (ASTP/ONC) certification criteria in 45 CFR 170.315 to collect your data (certified by the last day of the performance period) and report the measures on the previous slide.
- Submit a "Yes" to the Actions to Limit or Restrict the Interoperability of CEHRT attestation (previously named the Prevention of Information Blocking attestation).
- Submit a "Yes" or "No" to the ONC Direct Review attestation.
- Submit your level of active engagement for the required Public Health and Clinical Data Exchange measures you're reporting.
- Submit a "Yes" that you have completed the Security Risk Analysis measure during 2025.
- Submit the CMS EHR Certification identification code for your EHR product(s) (You can find this information here).
- Submit a "Yes" to completing the High Priority Practices Guide of the SAFER Guides measure during 2025.

You must meet all requirements to receive a Promoting Interoperability performance category score; if any of these requirements are **not met**, you'll get 0 points in the Promoting Interoperability performance category if you're participating as an individual MIPS eligible clinician, group, or virtual group. If you're participating as an APM Entity (including Shared Savings Program ACOs), then any clinician or group that fails to meet these criteria would contribute 0 points toward the APM Entity-level score.

Data Submission

A single submission (file upload, application programming interface (API), or attestation; by you or a third party intermediary) is recommended to report Promoting Interoperability data.

When multiple data submissions are received, CMS will calculate a score for each qualifying data submission received and assign the highest of the scores.

Any conflicting data submitted for a single measure or required attestation will result in a **score of 0** for the Promoting Interoperability performance category, or a contribution of 0 points to the APM Entity-level score if reporting Promoting Interoperability at the individual, group, or virtual group level.

NOTE: Shared Savings Program ACOs can submit data at the individual, group, virtual group, or APM Entity level (i.e., ACO reports on behalf of its clinicians). If submitting at the APM Entity level, Shared Savings Program ACOs are responsible for reporting on behalf of their ACO participants, which can be completed by the ACO or a third party intermediary. We encourage ACOs to evaluate reporting the MIPS Promoting Interoperability performance category at the APM Entity level for purposes of satisfying the Shared Savings Program Promoting Interoperability category reporting requirements.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2025?

For the 2025 performance period, each required measure will be scored based on the performance data you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Query of PDMP measure, Public Health and Clinical Data Exchange objective measures (required and optional/bonus), the optional HIE Bi-Directional Exchange and TEFCA measures, and the Security Risk Analysis and High Priority Practices Guide of the SAFER Guides attestation measure which require a "Yes" or "No" submission. Each measure will contribute to your total Promoting Interoperability performance category score.

NOTE: If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

NOTE: Beginning with the 2025 performance period, APM Entities, including Shared Savings Program ACOs, can choose to submit their Promoting Interoperability data at the APM Entity level. If no APM Entity level data is reported, we'll calculate a Promoting Interoperability score for the APM Entity based on the individual, group, or virtual group data submitted.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2025? (Continued)

New Shared Savings Program ACOs Requirement to Report Objectives and Measures for the MIPS Promoting Interoperability Performance Category:

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

- Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS at the individual, group, virtual group, or APM Entity level (i.e., ACO reports on behalf of its clinicians); and
- Earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level. This requirement applies regardless of the Shared Savings Program track in which the ACO participant, ACO provider/supplier, or ACO professional participates.

What are the Exclusions Shared Savings Programs ACOs for the Promoting Interoperability Performance Category for 2025? (Continued)

An ACO participant, ACO provider/supplier, or ACO professional is excluded from the Shared Savings Program's requirement to report the MIPS Promoting Interoperability performance category if they meet applicable requirements for an eligible clinician to be excluded or exempt from reporting the MIPS Promoting Interoperability performance category as set forth in the regulations at 42 CFR part 414, subpart O. Applicable exclusions include:

- Not exceeding the low volume threshold as set forth in 42 CFR 414.1310(b)(1)(iii).
- An eligible clinician (as defined in 42 CFR 414.1305) who is not a MIPS eligible clinician as set forth in 42 CFR 414.1310(b)(2).
- Reweighting of the MIPS Promoting Interoperability performance category in accordance with 42 CFR 414.1380(c)(2)(i)(C) granted by CMS based on a significant hardship or other type of exception for a specific performance year. Bases for reweighting include being, as defined in 42 CFR 414.1305:
  - A non-patient facing clinician;
  - A hospital-based clinician;
  - An Ambulatory Surgery Center (ASC)-based clinician; or
  - In a small practice.

An ACO participant, ACO provider/supplier, or ACO professional cannot be excluded from the Shared Savings Program's requirement to report the MIPS Promoting Interoperability performance category solely on the basis of being a QP or Partial QP. If a QP or Partial QP meets an exclusion noted above, or is not an eligible clinician, the QP or Partial QP would not be required to report.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2025? (Continued)

Additionally, for performance year 2025 and subsequent performance years, Shared Savings Program ACOs must publicly report the total number of ACO participants, ACO providers/suppliers, and ACO professionals that are MIPS eligible clinicians, QPs, or Partial QPs that earn a MIPS performance category score for the MIPS Promoting Interoperability performance category (and are not excluded as described above) for the applicable performance year, including:

- The number of ACO participants, ACO providers/suppliers, and ACO professionals that meet the requirements of 42 C.F.R. § 425.507(a) and are not excluded under § 425.507(b) for the applicable performance year; and
- The number of ACO participants, ACO providers/suppliers, and ACO professionals that are excluded under § 425.507(b) that voluntarily reported and received a MIPS Promoting Interoperability performance category score for the applicable performance year.

An ACO's performance on the MIPS Promoting Interoperability performance category does not impact the calculation of the ACO's shared savings or shared losses. For more information, please refer to the Frequently Asked Questions on the Shared Savings Program Requirement to Report Objectives and Measures for the MIPS Promoting Interoperability Performance Category.

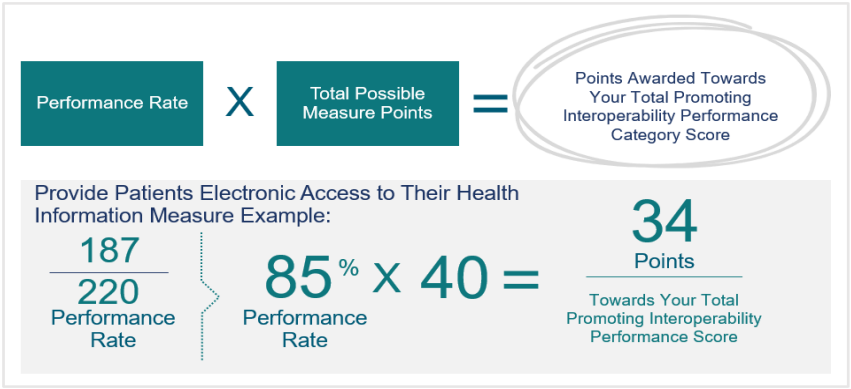
How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2025? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
e-Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES/NO
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required (unless option 2 or 3 is reported)	1 – 15 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 15 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange	Required (unless option 1 or 3 is reported)	30 points	YES/NO
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (unless option 1 or 2 is reported)	30 points	YES/NO
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required	1 – 25 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures • Immunization Registry Reporting • Electronic Case Reporting		Required	25 points for the entire objective	YES/NO
	Bonus (Optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		Optional	5 bonus points	YES/NO

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for 2025? (Continued)

For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure and then multiplying that performance rate by the maximum points available for the measure. Note: If a provider has an exclusion at the measure level, then the weighted average will take that provider out of the denominator.

Below is an example featuring the Patients Electronic Access to their Health Information measure, which is worth up to 10 points.



Important to Note:

You can earn a maximum of 5 bonus points for submitting 1 (or more) of the optional measures in the Public Health and Clinical Data Exchange objective (you'll earn a maximum of 5 bonus points even if you submit more than 1 measure).

When we calculate the performance rates, measure and objective scores, and the Promoting Interoperability performance category score, we generally round to the nearest whole number.

- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 if the numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category.)

Scoring Promoting Interoperability Measures Submitted with a Yes/No

For the Query of PDMP measure, you'll receive 10 points for this measure when:

- You submit a "Yes" for the required measure.

* Note: If you submit an exclusion, the points will be redistributed to another measure or objective.

For the Public Health and Clinical Data Exchange objective, you'll receive 25 points for this objective when:

- You submit a "Yes" for the Immunization Registry Reporting measure **AND** you submit a "Yes" for the Electronic Case Reporting measure.*

  OR

- You submit a "Yes" for one required measure **AND** you submit an exclusion for the other required measure.

* Note: If you submit an exclusion for both required measures, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

For Option 2 or 3 in the HIE objective, you'll receive 25 points for this objective when:

- You submit a "Yes" to participating in bi-directional exchange **OR** you submit a "Yes" to enabling exchange under participating in a TEFCA.

Promoting Interoperability Performance Category Scoring E-Prescribing Measure: Example

A Shared Savings Program ACO has 10 participants, but only 4 are MIPS eligible clinicians or QP/Partial QPs. The following example shows individual-level reporting for the e-Prescribing measure.

	Numerator- number of prescriptions generated and transmitted electronically using CEHRT.	**Denominator-** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.
MIPS Eligible Clinician 1	287	287
MIPS Eligible Clinician 2	872	872
MIPS Eligible Clinician 3	0 – did not have CEHRT and did not quality for reweighting/hardship	1459
MIPS Eligible Clinician 4	22 – qualified for reweighting/hardship-writes less than 100 scripts permissible prescriptions during the reporting period	22

Note: When reporting this measure as an APM Entity, submit 1,159 for the numerator and 2,618 for the denominator.

E-prescribing Measure Score = $\frac{287 + 872 + 0}{287 + 872 + 1459}$ = 44% x 10 ↓ 4.4 points

Did you know?

If you claim an exclusion for the e-Prescribing measure, you will need to claim one of the Query of PDMP exclusions that is most applicable to you. If an exclusion is claimed for the e-Prescribing measure, the 10 points for the e-Prescribing measure will be redistributed equally among the measures associated with the Health Information Exchange objective.

Promoting Interoperability Performance Category Scoring for Query of Prescription Drug Monitoring Program (PDMP)

For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using certified electronic health record technology (CEHRT) during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history.

If an exclusion is claimed, then 10 points are redistributed to the e-Prescribing measure.

The MIPS eligible clinician must attest "YES" to conducting a query of a PDMP for at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT. If this is completed, then the e-Prescribing measure score is 10 points.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

= 10 points

Did you know?

Any MIPS eligible clinician meeting one or more of the following criteria may be excluded from the PDMP measure if the MIPS eligible clinician:
1) Is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period.
2) Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period.

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

Promoting Interoperability Performance Category Scoring for Health Information Exchange (HIE) Objective - Option 1 Support Electronic Referral Loops by Sending Health Information Measure: Example

A Shared Savings Program ACO has 10 participants, but only 4 are MIPS eligible clinicians or QP/Partial QPs. The following example shows individual-level reporting for the Health Information Exchange objective, Option 1.

	Numerator- The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.	Denominator- Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.
MIPS Eligible Clinician 1	287	287
MIPS Eligible Clinician 2	872	872
MIPS Eligible Clinician 3	0 – did not have CEHRT and did not quality for reweighting/hardship	1459
MIPS Eligible Clinician 4	22 – qualified for reweighting/hardship-Refers a patient fewer than 100 times during the performance period	22

Note: When reporting this measure as an APM Entity, submit 1,159 for the numerator and 2,618 for the denominator.

Health Information Exchange Measure Score = $\frac{287 + 872 + 0}{287 + 872 + 1459}$ = 44% x 15 → 6.6 points

Did you know?

Any MIPS eligible clinician qualifies for an exclusion who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. If an exclusion is claimed for this measure, the 15 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

Promoting Interoperability Performance Category Scoring for HIE Objective - Option 1 Support Electronic Referral Loops by Receiving and Reconciling Health Information Measure: Example

A Shared Savings Program ACO has 10 participants, but only 4 are MIPS eligible clinicians or QP/Partial QPs. The following example shows individual-level reporting for the Health Information Exchange objective, Option 1.

	Numerator- The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using certified electronic health record technology (CEHRT) for the following three clinical information sets: (1) Medication; (2) Medication allergy; and (3) Current Problem List.	**Denominator-** Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.
MIPS Eligible Clinician 1	287	287
MIPS Eligible Clinician 2	872	872
MIPS Eligible Clinician 3	0 – did not have CEHRT and did not quality for reweighting/hardship	1459
MIPS Eligible Clinician 4	22 – qualified for reweighting/hardship	22

Note: When reporting this measure as an APM Entity, submit 1,159 for the numerator and 2,618 for the denominator.

Health Information Exchange Measure Score = $\frac{287 + 872 + 0}{287 + 872 + 1459}$ = 44% x 15 ↓ 6.6 points

Did you know?

Any MIPS eligible clinician qualifies for an exclusion who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period. If an exclusion is claimed for this measure, the 15 points will be redistributed to the other measure within this objective, the Support Electronic Referral Loops by Sending Health Information measure.

Promoting Interoperability Performance Category Scoring for HIE Objective - Option 2 Bi-Directional Exchange Measure

The MIPS eligible clinician or group must attest that they engage in bi-directional exchange with an HIE to support transitions of care. If this is completed, then the HIE objective score is 30 points.

The MIPS eligible clinician must attest "Yes" to the following:

- I participate in an HIE in order to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the electronic health record (EHR) during the performance period in accordance with applicable law and policy.
- The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and does not engage in exclusionary behavior when determining exchange partners.
- I use the functions of certified electronic health record technology (CEHRT) to support bi-directional exchange with an HIE.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

= 30 points

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

Did you know?

Reporting this measure satisfies the HIE Objective reporting requirement and is submitted as an alternative to the other measure options:
1) Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Reconciling measures.
2) The Enabling Exchange Under TEFCA measure.

Promoting Interoperability Performance Category Scoring for HIE Objective - Option 3 Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) Measure

The MIPS eligible clinician or group must attest that they enable exchange under the Trusted Exchange Framework and Common Agreement (TEFCA). If this is completed, then the HIE objective score is 30 points.

The MIPS eligible clinician must attest "Yes" to the following:

- I participate as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website) in good standing (that is, not suspended) and enable secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy.
- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

HIE Measure Score = 30 points

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

Did you know?

Reporting this measure satisfies the HIE Objective reporting requirement and is submitted as an alternative to the other measure options:
1) Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Reconciling measures.
2) The HIE Bi-Directional Exchange measure

Promoting Interoperability Performance Category Scoring for Provide Patients Electronic Access to Their Health Information Measure: Example

A Shared Savings Program ACO has 10 participants, but only 4 are MIPS eligible clinicians or QP/Partial QPs. The following example shows individual-level reporting for the Provider to Patient Exchange objective.

	Numerator- The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.	**Denominator-** The number of unique patients seen by the MIPS eligible clinician during the performance period.
MIPS Eligible Clinician 1	**287**	**287**
MIPS Eligible Clinician 2	**872**	**872**
MIPS Eligible Clinician 3	**0 – did not have CEHRT and did not quality for reweighting/hardship**	**1459**
MIPS Eligible Clinician 4	**22 – qualified for reweighting/hardship**	**22**

Note: When reporting this measure as an APM Entity, submit 1,159 for the numerator and 2,618 for the denominator.

Provider to Patient Exchange Measure Score = $\frac{287 + 872 + 0}{287 + 872 + 1459}$ = 44% x 25 ↓ 11 points

Did you know?

MIPS eligible clinicians may qualify for reweighting through an approved Promoting Interoperability hardship exception, hospital or ASC-based status, or in a specialty which is not required to report data to the Promoting Interoperability performance category.

Promoting Interoperability Performance Category Scoring for Public Health and Clinical Data Exchange-Immunization Registry Reporting (Required Measure)

The MIPS eligible clinician is in active engagement with a public health agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). If this is completed, then the Public Health and Clinical Data Exchange measure score is 25 points.

The MIPS eligible clinician must attest "Yes" to being in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

In addition to submitting a response, MIPS eligible clinicians must submit their level of active engagement, either OPTION 1 (Pre-production and Validation) or OPTION 2 (Validated Data Production) for each measure they report.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

Public Health and Clinical Data Exchange Measure Score = 25 points

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

Did you know?

The MIPS eligible clinician will receive the full 25 points for reporting two "yes" responses for the two required measures, or for submitting a "yes" for one measure and claiming an exclusion for another. If there are no "yes" responses and two exclusions are claimed, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

Promoting Interoperability Performance Category Scoring for Public Health and Clinical Data Exchange-Electronic Case Reporting (Required Measure)

The MIPS eligible clinician is in active engagement with a public health agency (PHA) to electronically submit case reporting of reportable conditions. If this is completed, then the Public Health and Clinical Data Exchange measure score is 25 points.

The MIPS eligible clinician must attest "Yes" to being in active engagement with a PHA to electronically submit case reporting of reportable conditions.

In addition to submitting a response, MIPS eligible clinicians must submit their level of active engagement, either Pre-production and Validation or Validated Data Production for each measure they report.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

= 25 points

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

Did you know?

The MIPS eligible clinician will receive the full 25 points for reporting two "yes" responses for the two required measures, or for submitting a "yes" for one measure and claiming an exclusion for another. If there are no "yes" responses and two exclusions are claimed, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

Promoting Interoperability Performance Category Scoring for Public Health and Clinical Data Exchange-Syndromic Surveillance Reporting – Optional Measures

Did you know?

Reporting on more than one of the three optional measures for the Public Health and Data Exchange objective will not result in more than 5 bonus points.

Three optional reporting measures exist for Public Health and Data Exchange:

1. Public Health Registry Reporting
2. Clinical Data Registry Reporting
3. Syndromic Surveillance Reporting

The MIPS eligible clinician is in active engagement with a public health agency (PHA) to submit data to public health registries, or to submit data to a clinical data registry, or to submit syndromic surveillance data from an urgent care setting. If any of these are completed, then the Public Health and Clinical Data Exchange measure score receives 5 bonus points.

The MIPS eligible clinician must attest "Yes" to being in active engagement with a PHA to submit data to public health registries, or to submit data to a clinical data registry, or to submit syndromic surveillance data from an urgent care setting.

In addition to submitting a response, MIPS eligible clinicians must submit their level of active engagement, either Pre-production and Validation or Validated Data Production for each measure they report.

Note: When reporting this measure as an APM Entity, attest "Yes" only if all eligible clinicians have complied with the requirement.

Public Health and Clinical Data Exchange Bonus = 5 points

To meet the requirements for the Promoting Interoperability performance category, review the 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB).

How Many Points can I Earn in the Promoting Interoperability Performance Category?

While there are 105 total points available, individuals, groups, virtual groups, and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

Can the Denominator (Maximum Number of Points) be Lower Than 100?

No; you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

- When reporting the APP as an individual or group, we'll add the scores for each of the individual measures (or objectives) and then divide the sum by the maximum possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

REMINDER: You'll receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).

Promoting Interoperability Performance Category Score = Total Points Earned for Completed Measures / Total Possible Measure Points

How is the Promoting Interoperability Performance Category Scored for APM Entities/ Shared Savings Program ACOs?

Quality Payment PROGRAM

APM Entity Participation

When reporting the APP as an APM Entity or APP Plus as a Shared Savings Program ACO, Promoting Interoperability data can be reported at the individual, group, or APM Entity level.

Promoting Interoperability Reported at the APM Entity Level

Since the 2023 performance period, APM Entities have been able to submit aggregated Promoting Interoperability data at the APM Entity level on behalf of all MIPS eligible clinicians in the APM Entity. The score is calculated the same way as for individuals and groups.

Promoting Interoperability Reported at the Individual or Group Level in a Shared Savings Program ACO

The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.

Individual clinicians in an APM Entity/Shared Savings Program ACO who do not have CEHRT and are not exempt will earn a score of zero. To meet Shared Savings Program requirements without CEHRT, they can only be included in group or APM Entity level reporting.

The APM Entity can also earn the bonus points if at least one individual or group in the APM Entity reports any of the optional measures in the Public Health and Clinical Data Exchange objective (5 bonus points), but the Promoting Interoperability performance category score can't exceed 100%.

Promoting Interoperability Performance Category Score = Total Points Earned for Completed Measures / Total Possible Measure Points

REMINDER: APM Entities that fail to do all of the following during reporting will contribute 0 points toward their Promoting Interoperability performance category score:

- submit a required attestation,
- report (submit at least 1 in the numerator) on a required measure or
- claim an exclusion for a required measure (where applicable).

APM Entity's Promoting Interoperability Score = Sum of Points Earned by QP/Partial QP/MIPS Eligible Clinicians for Required Measures / (Total QP/Partial QP and MIPS Eligible Clinicians in APM Entity − Excluded/Hardship Clinicians in APM Entity) + 5 Bonus Points (if at least one clinician reported an optional measure)

How Is the Promoting Interoperability Performance Category Scored?

Promoting Interoperability Performance Category Score = (Total Points Earned for Completed Measures) / (Total Possible Measure Points)

APM Entity's Promoting Interoperability Score = (Sum of Points Earned by All MIPS Eligible Clinicians for Required Measures) / (Total MIPS Eligible Clinicians in APM Entity − MIPS Eligible Clinicians Who Receive Performance Category Reweighting) + 5 Bonus Points (if at least one clinician reported an optional measure)

REMINDER: APM Entities that fail to do the following during reporting will contribute 0 points toward their Promoting Interoperability performance category score: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).

NOTE: Those who submit externally have to add in the bonus points manually.

Promoting Interoperability Performance Category Scoring for APM Entities

APM Entities that submit Promoting Interoperability data at the APM Entity level must engage in a data aggregation process prior to submission. This scoring calculation at the APM Entity level will:

- Be inclusive of all Taxpayer Identification Numbers/National Provider Identifiers (TINs/NPIs).
  - Clinicians/participants excluded by policy or have an approved hardship exemption should not be included.
  - Clinicians/participants without EHRs that should have them but are not otherwise excluded, would contribute zeros to the numerator and denominators.
- If the data includes multiple TINs and multiple CEHRT, APM Entities should generate a special ID in the CHPL database indicating all instances of CEHRT that were included.
- "Higher of" scenarios with TIN/NPI reporting refer to situations where performance scores are calculated at both the individual (NPI) and group (TIN) levels, with the higher score being used for final assessment.

	NPI score reported by clinician	TIN score reported
MIPS Eligible Clinician 1 TIN XXXX	**77**	75
MIPS Eligible Clinician 2 TIN XXXX	**84**	75
MIPS Eligible Clinician 3 TIN XXXX	70	**75**
MIPS Eligible Clinician 4 TIN YYYY	**72**	N/A
QP/Partial QP Clinician 5 TIN ZZZZ	**80**	N/A

Promoting Interoperability Performance Category Score = $\frac{77 + 84 + 75 + 72 + 80}{\text{Total of MIPS Eligible Clinicians } 5}$ = 77.6% (vs 75.4 otherwise)

Promoting Interoperability Performance Category Scoring for Shared Savings Program ACOs – Reporting Example

A Shared Savings Program ACO has 75 participants, but only 10 are MIPS eligible clinicians or QP/Partial QPs. The points assigned are earned through either individual or group reporting. This scenarios show individual reporting.

	Points for Required Measures (Excluding Bonus Points)
MIPS Eligible Clinician 1	87
MIPS Eligible Clinician 2	87
MIPS Eligible Clinician 3	77
MIPS Eligible Clinician 4	N/A – qualified for re-weighting; non-patient facing clinician
QP/Partial QP Clinician 5	92- Not MIPS Eligible, but Required for SSP reporting
MIPS Eligible Clinician 6	85
MIPS Eligible Clinician 7	0 – did not have CEHRT and did not quality for reweighting/hardship
MIPS Eligible Clinician 8	N/A – qualified for reweighting/hardship
MIPS Eligible Clinician 9	49
MIPS Eligible Clinician 10	82

Did you know?

For SSP reporting, MIPS eligible clinicains and QPs/Partial QPs **are required** when calculating the weighted average for the Promoting Interoperability score.

Promoting Interoperability Performance Category Score

$$= \frac{87 + 87 + 77 + 92 + 85 + 0 + 49 + 82}{10 - 2} + 5 = 74.9\%$$

Points from Required Measures

Total MIPS Eligible Clinicians in APM Entity

MIPS Eligible Clinicians Who Receive Reweighting

Bonus Points from Optional Public Health and Clinical Data Exchange measures

Can the Promoting Interoperability Performance Category be Reweighted?

Yes. There are several ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

Note that submitting Promoting Interoperability data will override any automatic or approved reweighting.

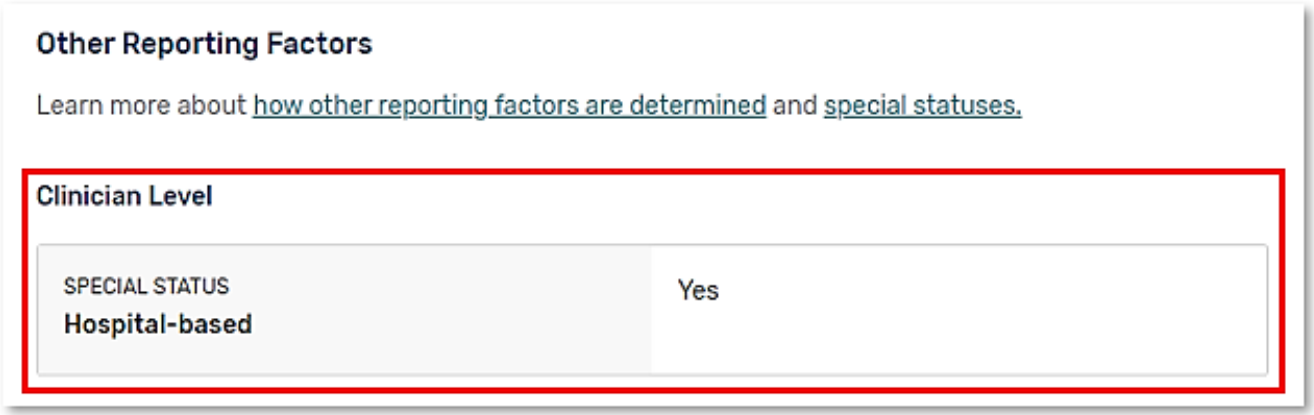
1. The MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application is available for submitting requests to reweight performance categories. Please check the Exception Applications webpage for more information.
2. An individual, group, or virtual group can submit a Promoting Interoperability Hardship Exception application citing one of the following specified reasons for review and approval:
    - Insufficient internet connectivity
    - Extreme and uncontrollable circumstances
    - Lack of control over the availability of CEHRT
    - Decertified EHR technology (decertified under the ASTP/ONC Health IT Certification Program)
3. Some MIPS eligible clinicians qualify for automatic reweighting based on special status (see the QPP Participation Status Tool):

NOTE: For the 2025 performance period, Promoting Interoperability Hardship Exception applications are due by December 31, 2025.

If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you later submit data for this performance category. Learn more about hardship exceptions.

Can the Promoting Interoperability Performance Category be Reweighted? (Continued)

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.



NOTE: If you have an approved exception or qualify for automatic reweighting, **we'll reweight the Promoting Interoperability performance category to 0% and redistribute the entire weight of the performance category (25% total) to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total)** so you can earn up to 100 points in your MIPS final score. However, you can still report Promoting Interoperability data if you want to. If you submit data on any of the measures for the Promoting Interoperability performance category as either an individual or a group, then we'll score your performance just like any other MIPS eligible clinician and weight your Promoting Interoperability performance category at 30% of the final score.

How Does Reweighting Work if We're Participating as a Group?

A **group's** Promoting Interoperability performance category score will be reweighted when:

- The group has an approved hardship exception or qualifies for automatic reweighting; OR
- All of the MIPS eligible clinicians in the group individually qualify for reweighting (for any reason).

Just as with individual participation, groups that qualify for reweighting but submit data for this performance category will be scored just like any other MIPS eligible clinician, and their Promoting Interoperability performance category will be weighted at 30% of the final score.

The image below is from the Other Reporting Factors section on the QPP Participation Status Tool.

NOTE: Groups are identified as non-patient facing or hospital-based when more than 75% of the MIPS eligible clinicians in the group have that status as individuals. These groups qualify for automatic reweighting.

How Does Reweighting Work if We're Participating as an APM Entity?

Individual MIPS eligible clinicians and groups participating as an APM Entity that qualify for automatic reweighting or have an approved Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category. They'll be excluded from the calculation when we determine the APM Entity's score but will still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire APM Entity for the 2025 performance period. This could occur when all of the MIPS eligible clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

As with individuals and groups who report the APP, APM Entities that qualify for reweighting will have the category reweighted to 0%, and CMS will redistribute the performance category weight (25% total) to the quality performance category (75% total) and 5% to the improvement activities performance category (25% total).

APP: MIPS Final Score

Quality Payment PROGRAM

How My MIPS Final Score is Calculated

To determine your MIPS final score, we multiply each performance category score by the performance category's weight and then multiply that figure by 100. We then add any complex patient bonus points you may have received to calculate your final score.

APP Performance Category Weights in 2025:

Quality

Up to **50** points toward your MIPS final score

+

Cost

Up to **0** points toward your MIPS final score

+

Improvement Activities

Up to **20** points toward your MIPS final score

+

Promoting Interoperability

Up to **30** points toward your MIPS final score

+

Up to **10** points toward your MIPS final score

=

Up to **100** points toward your MIPS final score

EXAMPLE: APP Performance Category Weights in 2025:

Quality

91.6% X 50% X 100 =

toward your MIPS final score

+

Cost

N/A

toward your MIPS final score

+

Improvement Activities

100% X 20% X 100 =

toward your MIPS final score

+

Promoting Interoperability

94% X 30% X 100 =

toward your MIPS final score

+

Complex Patient Bonus

toward your MIPS final score

=

97.20 points

NOTE: The cost performance category is weighted at 0% of the MIPS final score for the APP, because all MIPS APM participants are already responsible for costs under their APMs.

The MIPS final score can't exceed 100 points

What is the Complex Patient Bonus?

The complex patient bonus awards **up to 10 bonus points** based on the medical complexity and social risk of your patients. These bonus points are added to the MIPS final score for qualifying MIPS eligible clinicians, groups, and APM Entities.

The complex patient bonus is composed of 2 distinct calculations which are added together:

- The first calculation looks at medical complexity as determined by the average Hierarchical Condition Categories (HCC) risk score of your Medicare patient population.
- The second calculation looks at social risk as determined by the proportion of your Medicare patient population that's dually eligible for both Medicare and Medicaid.

We'll calculate the HCC risk scores and dual eligibility ratio for the unique Medicare patients treated during the second 12-month segment of the MIPS determination period.

The **complex patient bonus** is limited to MIPS eligible clinicians, groups, and APM Entities with at least one risk indicator (either average HCC risk score or dual eligibility ratio) at or above the median risk indicator calculated for all MIPS eligible clinicians, groups, virtual groups and APM Entities from performance period 2024.

We'll evaluate each MIPS eligible clinician, group, or APM Entity for their eligibility to receive the complex patient bonus.

Eligibility for the Complex Patient Bonus

Step 1

- We'll identify the **median HCC risk score** and **median dual eligibility ratio** based on the complex patient bonus included in the final score attributed to MIPS eligible clinicians (whether participating as an individual, group, or APM Entity) in performance period 2024.

Step 2

- We'll calculate the average HCC risk score and dual eligibility ratio for each MIPS eligible clinician, group, and APM Entity for performance period 2025.
  - **Average HCC risk score** = sum of HCC risk scores for the unique Medicare patients treated*/number of unique Medicare patients treated*
  - **Dual eligibility ratio =** unique Medicare patients treated* who were dually eligible for Medicare and full- or partial-Medicaid benefits/unique Medicare patients treated*

*Medicare patients must have been treated between October 1, 2024 and September 30, 2025 to be included in these calculations.

Step 3

- We'll compare your average HCC risk score and dual eligibility ratio (calculated in Step 2) to the median values identified in Step 1.
  - **If either (or both) of your risk indicators is at or above the median identified in step 1, you're eligible to receive the complex patient bonus.**

Did you know?

A patient's HCC risk score is based on:

- Age and gender.
- Diagnoses from the previous year.
- Whether they're eligible for Medicaid, first qualified for Medicare on the basis of disability, or live in an institution (usually a nursing home).

Calculating the Complex Patient Bonus

Step 1

- We'll identify the **mean HCC risk score and mean dual eligibility ratio** based on the complex patient bonus included in the final score attributed to MIPS eligible clinicians (whether participating as an individual, group, or APM Entity) in the 2024 performance period. (This is different than the median calculated to determine eligibility.)

Step 2

- We'll calculate **a standardized** score for the medical complexity component.
  - **Medical component standardized score =** (your 2024 average HCC risk score MINUS the 2023 mean HCC risk score from step 1)/ standard deviation for the 2023 mean HCC risk score from step 1.

Step 3

- We'll calculate **a standardized** score for the social risk component.
  - **Social component standardized score =** (your 2024 dual eligibility ratio MINUS the 2023 mean dual eligibility ratio from step 1)/ standard deviation for the 2023 mean dual eligibility ratio from step 1

Step 4

- We'll calculate the medical complexity component contribution to your complex patient bonus.
  - **Medical complexity complex patient bonus points =** 1.5 + 4*(standardized score from step 2)

Step 5

- We'll calculate the social risk component contribution to your complex patient bonus.
  - **Social risk complex patient bonus points =** 1.5 + 4*(standardized score from step 3)

Step 6

- We'll calculate your total complex patient bonus
  - **Complex patient bonus =** Medical complexity points (step 4) + Social risk points (step 5)

If only 1 of the 2 risk indicators – medical complexity or social risk – was at or above the median when we determined your eligibility for the complex patient bonus, then the other will contribute 0 points toward your complex patient bonus

APP: MIPS Payment Adjustment

How Does my MIPS Final Score Determine my Payment Adjustment? (Continued)

MIPS Payment Adjustment

- Clinicians with a final score above the performance threshold of 75 points will earn a positive payment adjustment (subject to a scaling factor).
- Clinicians with a final score at the performance threshold of 75 points will earn a neutral payment adjustment.
- Clinicians with a final score below the performance threshold of 75 points will receive a negative payment adjustment. The maximum negative adjustment is -9%.

MIPS payment adjustments are calculated to ensure budget neutrality. The final MIPS payment adjustments for a year will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold.

- More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease (lower positive payment adjustments) because more MIPS eligible clinicians receive a positive MIPS payment adjustment.
- More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase (higher positive payment adjustments) because more MIPS eligible clinicians would have negative MIPS payment adjustments, and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

REMINDER: The 2022 performance period/2024 payment year was the last year for the exceptional performance adjustment.

How Does my MIPS Final Score Determine my Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be.

Why? MIPS is required by law to be a budget-neutral program. Generally, this means that the amount of the payment adjustment will depend on the overall participation and performance of clinicians in MIPS for a certain year. The table below illustrates how 2025 MIPS final scores will correlate to 2027 MIPS payment adjustments for MIPS eligible clinicians.

Final Score	Payment Adjustment
75.01 – 100.00 points	Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)
75.00 points (Performance threshold=75.00 points)	Neutral MIPS payment adjustment (0%)
18.76 – 74.99 points	Negative MIPS payment adjustment (between -9% and 0%)
0.00 – 18.75 points	Negative MIPS payment adjustment of -9%

REMINDER: The 2022 performance period/2024 payment year was the last year for the exceptional performance adjustment.

FAQs

What Might a Clinician or Group Choose to Report Separately From Their APM Entity?

An individual or group of MIPS eligible clinicians may choose to report the APP or traditional MIPS separately from their APM Entity if they believe they are likely to receive a more favorable MIPS final score from individual or group participation. As noted, CMS will apply the higher MIPS final score to individuals and to groups who report to MIPS at different levels.

Why Might an Individual or Group Choose to Report the APP Separate from their APM Entity?

An individual or group of MIPS eligible clinicians might choose to report the APP separately if:

1. They believe they'll receive a higher score by reporting at the individual or group level than at the APM Entity level;
2. They want to streamline their data collection and reporting; or
3. Their APM Entity has indicated that it won't report to MIPS on their behalf.

We encourage individuals and groups who participate in MIPS APMs to reach out to their APM Entity during each performance period to confirm that the APM Entity will report data on their behalf.

Do we Need to Tell CMS That We're Reporting the APP, Traditional MIPS, or an MVP in Advance of the Submission Period?

No. MIPS APM participants aren't required to state their intention to report the APP or traditional MIPS before the data submission period. You'll identify your reporting option (APP or traditional MIPS) when you sign in to qpp.cms.gov to submit your data.

What Happens if Your ACO Doesn't Report Quality Measures?

If you're a MIPS eligible clinician participating in a Shared Savings Program ACO (or any MIPS APM) and your APM Entity doesn't report quality measures to MIPS on your behalf, you would receive a MIPS quality performance category score of 0 points and a final score below the performance threshold of 75 points, resulting in a negative payment adjustment, unless you report as an individual or group via the APP or traditional MIPS. We encourage individuals and groups that participate in the Shared Savings Program to reach out to their ACO during the performance period to determine whether the ACO will report data on their behalf. But regardless of the APM Entity's decision to report on behalf of its participants, individuals or groups of MIPS eligible clinicians who participate in MIPS APMs may choose to report the APP or traditional MIPS.

As a reminder, Shared Savings Program ACOs must report quality data on the APP Plus quality measure set at the APM Entity level to meet the quality reporting requirement for the Shared Savings Program.

Where Can Clinicians go for Additional Support?

Additional resources are available on the QPP website and the QPP Resource Library.

We will continue to provide support to clinicians who need assistance. While our support offerings reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance to help them successfully participate.

We encourage clinicians to contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time or by email at QPP@cms.hhs.gov. To help ACOs navigate the Shared Savings Program, please reach out to your ACO Coordinator as your first line of contact. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History

Version History

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

Date	Description
04/11/2025	Original Posting.

Appendices

Appendix A: Reweighting the Performance Categories

APP Performance Category Weight Redistribution: Individual, Group, and APM Entity Participation

The table below outlines the performance category weights under the APP for individuals, groups, and APM Entities when performance categories are reweighted to 0% based on any circumstances described throughout this guide.

Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
Standard Weighting				
General weighting for all performance categories	**50%**	**0%**	**20%**	**30%**
Reweighting 1 Performance Category				
No Promoting Interoperability: *PI → Quality and IA*	75%	0%	25%	0%
No Quality: *Quality → IA and PI*	0%	0%	25%	75%

NOTE: If multiple performance categories have been reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a MIPS final score equal to the performance threshold regardless of whether any data is submitted.

Appendix B: Reallocation of Points for Promoting Interoperability Measure(s)

When an Exclusion is Claimed

The table below outlines where points are redistributed when an exclusion is claimed.

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed…
e-Prescribing	e-Prescribing		Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure OR …the 10 points are redistributed to the HIE Bi-Directional Exchange measure OR …the 10 points are redistributed to the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	Query of Prescription Drug Monitoring Program (PDMP)		Yes	…the 10 points are redistributed to the e-Prescribing measure
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	…the 15 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	…the 15 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	No	N/A
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	No	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		No	N/A
Public Health and Clinical Data Exchange	**Report on the 2 required measures:** • Immunization Registry Reporting • Electronic Case Reporting		Yes	…the 25 points are still available in this objective if you claim an exclusion for one of the required measures and submit a "yes" attestation for the other required measure in the objective. … the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim two exclusions.
	Bonus: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting		N/A	N/A

NOTE: Even if you claim 1 or 2 exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures, you can still earn a total of 5 bonus points by reporting 1, 2 or 3 of the optional Public Health and Clinical Data Exchange measures (Public Health Registry Reporting, Clinical Data Registry Reporting, or Syndromic Surveillance Reporting).

Appendix C: Quality Measure Collection Types

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
eCQMs	PY 2025 APP Quality Requirements (All Participants, Excluding SSP ACOs) (ZIP, 3MB) PY 2025 APP Quality Requirements (SSP ACOs Only) (ZIP, 6MB) Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)	You can submit eCQMs if you use technology that is certified to align with ONC's regulations at 45 CFR 170.315. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication. Beginning in the CY 2025 performance period, APM Entities (including Shared Savings Program ACOs) and virtual groups are eligible to receive the complex organization adjustment when reporting electronic clinical quality measures (eCQMs). One measure achievement point is added for each submitted eCQM for an APM Entity or virtual group that meets data completeness and case minimum requirements.	• Individuals • Groups • APM Entities

Appendix C: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
MIPS CQMs	PY 2025 APP Quality Requirements (All Participants, Excluding SSP ACOs) (ZIP, 3MB) PY 2025 APP Quality Requirements (SSP ACOs Only) (ZIP, 6MB) Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (PDF, 865KB)	MIPS CQMs may be collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may choose to work with a Qualified Registry, QCDR, or Health IT vendor to support your data collection and submission. To see the lists of CMS approved Qualified Registries and QCDRs, visit the QPP Resource Library. For Shared Savings Program ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.	• Individuals • Groups • APM Entities

Appendix C: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
Medicare Part B Claims	2025 Medicare Part B Claims Measure Specifications and Supporting Documents 2025 Part B Claims Reporting Quick Start Guide	Medicare Part B Claims measures are always reported with the clinician's individual (rendering) National Provider Identifier (NPI), even when participating as a group, virtual group, or APM Entity.	• Individuals [Clinicians in small practices (15 or fewer clinicians) only] • Groups [small practices (15 or fewer clinicians) only] • APM Entities (15 or fewer clinicians in the APM Entity) • No Shared Savings Program ACOs met the criteria for small practice designation at the APM Entity level in PY 2025.
Medicare CQM	2025 Medicare CQMs Specifications and Supporting Documents for Accountable Care Organizations Participating in the Medicare Shared Savings Program Medicare Shared Savings Program: Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Pathway 2025 Medicare CQMs for Shared Savings Program Accountable Care Organizations Checklist	Data is reported on the ACO's Medicare FFS beneficiaries that meet the definition of a beneficiary eligible for Medicare CQMs at 42 CFR 425.20, instead of reporting on their all payer/all patient population. Performance data must be reported for at least 75% of the eligible population. You can collect and submit these measures yourself or with the help of a third-party intermediary such as a Qualified Registry.	• APM Entities (Shared Savings Program ACOs only)

Appendix C: Quality Measure Collection Types (Continued)

Collection Type	Quality Measure Specifications and Resources	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type?
CAHPS for MIPS Survey	2025 CAHPS for MIPS Overview Fact Sheet (PDF, 1MB)	Groups and APM Entities must register between April 1, 2025 and July 1, 2025 to administer the CAHPS for MIPS Survey, a survey measuring patient experience and care within a group or APM Entity. This survey must be administered by a CMS Approved Survey Vendor. Shared Savings Program ACOs don't have to register to administer CAHPS for MIPS Survey. They're automatically registered. **NEW:** Beginning with the 2024 performance period, registered groups and APM Entities (including Shared Savings Program ACOs) are required to contract with a CAHPS for MIPS Survey vendor to administer the Spanish translation of the survey to Spanish-preferring patients.	• Groups (registered groups with 2 or more clinicians) • APM Entities (registered APM Entities with 25 or more clinicians)