Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Reporting Traditional MIPS:

2025 Measures and Activities for Pathologists

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Overview

What is the Merit-based Incentive Payment System?

If you're eligible for MIPS in 2025:

- You must report measure and activity data for the quality (PDF, 261KB), improvement activities (PDF, 264KB), and Promoting Interoperability (PDF, 244KB) performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances (EUC) or hardship exception. Detailed information will be available in the forthcoming 2025 Traditional MIPS Scoring Guide, 2025 APP Scoring Guide and 2025 MIPS Value Pathways Implementation Guide. These will be posted to the QPP Resource Library.
- We collect and calculate data for the cost (PDF, 325KB) performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances and whether or not you meet the case minimum for any cost measures. Detailed information will be available in the forthcoming 2025 MIPS Cost User Guide, which will be posted on the QPP Resource Library.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - Positive payment adjustment for clinicians with a 2025 final score above 75.
  - Neutral payment adjustment for clinicians with a 2025 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2025 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2025 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2027.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

What is the Merit-based Incentive Payment System (Continued)

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Traditional MIPS Overview webpage to learn more.	• The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for clinicians who participate in a MIPS Alternative Payment Model (APM). • Visit the APM Performance Pathway webpage to learn more.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

MIPS Value Pathways (MVPs)

MVPs are the newest way that you can meet reporting requirements, offering a more meaningful way to participate in MIPS. Each MVP includes a subset of measures and activities related to a specialty or medical condition. While some MVPs are considered most applicable to certain specialties, you aren't limited to only those identified MVPs. Clinicians may select the MVP that aligns best with their scope of care and for which they're able to meet the reporting requirements. Please note that not all specialties may have an applicable MVP.

There are 21 MVPs finalized for the 2025 performance year. You can review each MVP in detail by clicking the links below.

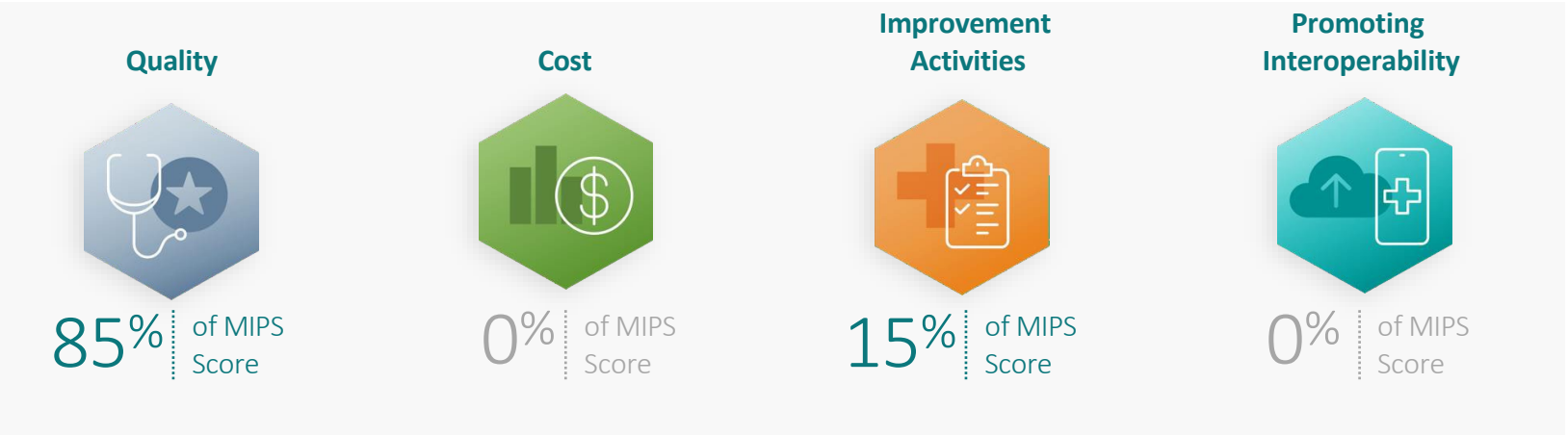
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP
- Advancing Cancer Care MVP
- Advancing Care for Heart Disease MVP
- Advancing Rheumatology Patient Care MVP
- Complete Ophthalmologic Care MVP
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP
- Dermatological Care MVP
- Focusing on Women's Health MVP
- Gastroenterology Care MVP
- Improving Care for Lower Extremity Joint Repair MVP
- Optimal Care for Kidney Health MVP
- Optimal Care for Patients with Urologic Conditions MVP
- Patient Safety and Support of Positive Experiences with Anesthesia MVP
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP
- Pulmonology Care MVP
- Quality Care for Patients with Neurological Conditions MVP
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP
- Quality Care in Mental Health and Substance Use Disorders MVP
- Rehabilitative Support for Musculoskeletal Care MVP
- Surgical Care MVP
- Value in Primary Care MVP

Through future rulemaking, CMS will continue to expand MVPs to include more specialties and subspecialties that participate in MIPS. Review the MVP Candidate Development & Submission webpage to learn more about the MVP development process and participate in the future of MIPS.

What is MIPS?

If you're participating in the Quality Payment Program through MIPS, you generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you.) Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.

This is the most common performance category weighting for pathologists in a practice with more than 15 clinicians (i.e., not a small practice). Skip ahead for information about pathologists in a small practice (15 or fewer clinicians).



Why is this the most common weighting?

- Under existing policy, non-patient-facing clinicians, such as pathologists, qualify for automatic reweighting of the Promoting Interoperability performance category.
- In practice, most pathologists don't meet the case minimum criteria for any of the currently available cost measures, which results in the cost performance category being reweighted. However, a pathologist who meets the case minimum criteria for even one cost measure will be scored on the performance category, which will be weighted at 30% (see next slide).

What is MIPS? (Continued)

If a pathologist who isn't in a small practice meets case minimum for at least one cost measure, the following performance category weights will apply:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
55% of MIPS Score	30% of MIPS Score	15% of MIPS Score	0% of MIPS Score

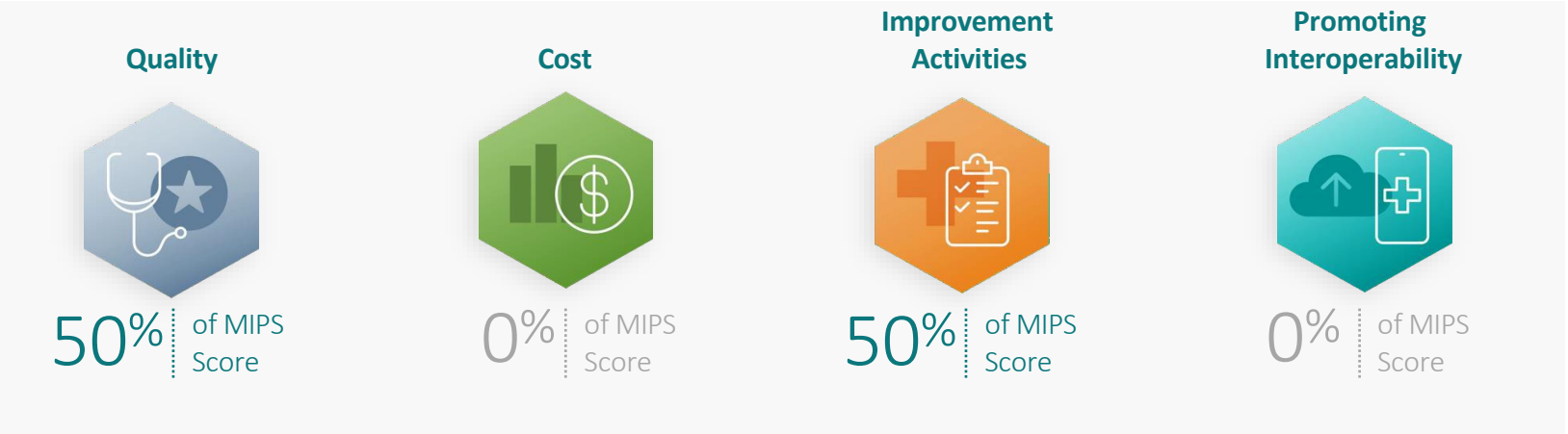
In the unlikely event that a pathologist can be scored on at least one cost measure and is able and chooses to report Promoting Interoperability measures, the standard MIPS performance category weights will apply:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

What is MIPS? (Continued)

Most Common Performance Category Weighting for Pathologists in a Small Practice.

Small practices qualify for different redistribution policies when one or more performance category is reweighted.



Why is this the most common weighting?

- Under existing policy, non-patient-facing clinicians, such as pathologists, and clinicians in small practices qualify for automatic reweighting of the Promoting Interoperability performance category.
- In practice, most pathologists don't meet the case minimum criteria for any of the currently available cost measures, which results in the cost performance category being reweighted. However, a pathologist who meets the case minimum criteria for even one cost measure will be scored on the performance category, which will be weighted at 30% (see next slide).

What is MIPS? (Continued)

If a pathologist in a small practice meets case minimum for at least one cost measure, the following performance category weights will apply:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

In the unlikely event that a pathologist can be scored on at least one cost measure and is able and chooses to report Promoting Interoperability measures, the standard MIPS performance category weights will apply:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Performance Categories

Quality Performance Category – Traditional MIPS

Getting Started with Quality

1. Understand Your Reporting Requirements
   - To meet the quality performance category requirements, you must report:

6 quality measures Including at least 1 outcome measure or high-priority measure in absence of an applicable outcome measure.	**OR**	**A defined specialty measure set or sub-specialty measure set** If the measure set has fewer than 6 measures, you need to submit all applicable measures within that set.

2. Choose Your Quality Measures
   - Use the 2025 Quality Measures List (XLSX, 804KB) to identify:
     - The available collection type(s) for each measure
     - Measure type (outcome, patient experience, etc.)
     - Specialty sets associated with each measure

Did you know?

- Collection Type refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specifications (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.
- For example: You're looking for a quality measure to report on the Use of High-Risk Medications in Older Adults (ID: 238). The measure is available as 2 distinct collections types with 2 distinct specifications: MIPS CQM (clinical quality measure) and eCQM (electronic clinical quality measure). You would use the measure specification that corresponds with how you choose to collect your data.
- You can report measures from multiple collection types to meet quality reporting requirements.

Quality Performance Category – Traditional MIPS (Continued)

3. Collect Your Data
    - **Start data collection on January 1, 2025**, to meet data completeness requirements for a 12-month performance period (January 1 to December 31, 2025).
    - The **data completeness requirement will remain at 75% for the 2025 performance period.**
        - You need to report performance data (met, not met, or exclusion/exceptions) for at least 75% of denominator-eligible encounters.
        - Measures that don't meet data completeness requirements will earn 0 points (3 points for small practices).
    - If you're working with a third party intermediary to collect and submit data, make sure you work with them throughout the year on data collection.

Did you know?

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

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all performance categories as a group.
- If a clinician has multiple final scores, CMS will use the following hierarchy to assign the final score and determine the payment adjustment:
    - Virtual group final score
    - Highest available final score from the group or individual participation

* Note: Subgroups are only available within MVP reporting. Refer to the MIPS Value Pathways (MVPs) webpage for additional information.

Quality Performance Category – Traditional MIPS (Continued)

The Pathology Specialty Measure Set contains quality measures relevant to the pathology specialty and includes the measures below.

- Barrett's Esophagus **(Identifier [ID]: 249)**
- Radical prostatectomy pathology reporting **(ID: 250)**
- Lung cancer reporting (biopsy/cytology specimens) **(ID: 395)**
- Lung cancer reporting (resection specimens) **(ID: 396)**
- Melanoma reporting **(ID: 397)**
- Skin cancer: biopsy reporting time – pathologist to clinician **(ID: 440)**
- Mismatch repair (MMR) or microsatellite instability (MSI) biomarker testing status **(ID: 491)**

30% of final score for most MIPS eligible clinicians, groups, and virtual groups.

Please refer to Help, Resources, and Version History for more information.

In addition, MIPS eligible clinicians, groups, and virtual groups may want to consider applicable pathology-specific Qualified Clinical Data Registry (QCDR) measures that are available via the QCDR collection type only. Review the 2025 QCDR measure specifications (XLSX, 680KB) on the QPP Resource Library.

Improvement Activities Performance Category – Traditional MIPS

Clinicians need to choose between 1 and 2 improvement activities to earn full credit in the improvement activities performance category.

Recommended Improvement Activities for Pathology	
• IA_AHE_8 – Create and implement an anti-racism plan • IA_CC_1 – Implementation of use of specialist reports back to referring clinician or group to close referral loop • IA_CC_2 – Implementation of improvements that contribute to more timely communication of test results • IA_CC_9 – Implementation of practices/processes for developing regular individual care plans	• IA_ERP_5 – Implementation of a Laboratory Preparedness Plan • IA_PSPA_1 – Participation in an AHRQ-listed patient safety organization • IA_PSPA_2 – Participation in MOC Part IV • IA_PSPA_13 – Participation in Joint Commission Evaluation Initiative • IA_PSPA_19 – Implementation of formal quality improvement methods, practice changes, or other practice improvement processes

15% of final score for most MIPS eligible clinicians, groups, and virtual groups.

Review the MIPS data validation criteria for detailed information and guidance on documentation requirements for each improvement activity. Download the resource here.

Note: Attestation to IA_PCMH: You'll receive full credit in this performance category if you attest to Patient Centered Medical Home accreditation (or comparable specialty practice) during the submission period.

Note: The following activities have been suspended for the 2025 performance period: IA_AHE_5, IA_AHE_8, IA_AHE_9, IA_AHE_11, IA_AHE_12, IA_PM_6, IA_ERP_3, and IA_PM_26. Please review the 2025 Improvement Activities Inventory for available activities. However, if any of the suspended improvement activities have already been completed or were in the process of being completed, clinicians will still be able to attest to completing them and receive credit. Please review the 2025 Improvement Activities Inventory for available improvement activities.

Cost Performance Category – Traditional MIPS

Helps create efficiencies in Medicare spending

- The 2025 performance period includes 2 population-based cost measures:
  - Medicare Spending Per Beneficiary Clinician measure, which assesses costs surrounding a hospital stay.
  - Revised Total Per Capita Cost measure, which assesses overall cost of care.
- It also includes 33 episode-based cost measures across a range of procedures, acute inpatient medical conditions requiring a hospital stay, settings (i.e., emergency medicine), and chronic conditions.
- A full list of the MIPS cost measures is available on the Quality Payment Program Cost Measures page.
- Data for cost measurement are collected from Medicare Parts A and B claims submitted by MIPS eligible clinicians, groups, and virtual groups. Certain measures also incorporate Part D costs. Clinicians, groups, and virtual groups don't have to submit any additional data.
- For a cost measure to be scored, a MIPS eligible clinician, group, or virtual group must have enough attributed cases to meet or exceed the case minimum for that measure.
- For most MIPS eligible clinicians, groups, and virtual groups who don't have a cost performance category score assigned, the majority of the cost weight goes to the quality performance category. This is true if only the cost performance category is reweighted.
- Benchmarks based on data from the performance period will be established for each cost measure. Since the benchmark isn't based on a historical baseline period, CMS can't publish the numerical benchmarks for the cost measures before the start of each performance period.
  - A MIPS eligible clinician, group, or virtual group can compare their costs for each measure with the benchmark information provided in their performance feedback to better understand their performance relative to their peers.

30% of final score for most MIPS eligible clinicians, groups, and virtual groups.

Cost Performance Category – Traditional MIPS (Continued)

CMS will automatically reweight the cost performance category for MIPS eligible clinicians, groups, and virtual groups located in a CMS-designated region that has been affected by extreme and uncontrollable circumstances.

- For MIPS eligible clinicians, groups, and virtual groups that are designated in the extreme and uncontrollable circumstances policy, they won't receive a score for the cost performance category, regardless of whether they have applicable cost measures.

Review the Cost Requirements page of the QPP website for information for the cost performance category.

Did you know?

If only 1 cost measure can be scored, that cost measure's score will serve as the performance category score. If 3 out of 25 cost measures are scored, the cost performance category score is the equally-weighted average of the 3 scored measures. If none of the 25 measures can be scored, the MIPS eligible clinician, group, or virtual group won't be scored on cost, and the weight of the cost performance category would be reweighted.

Help, Resources, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

Additional Resources

The following resources are available in the QPP Resource Library and other QPP and CMS webpages:

- MIPS Overview Quick Start Guide (PDF, 1MB)
- 2025 MIPS Quick Start Guide for Small Practices (PDF, 3MB)
- 2025 MIPS Data Validation Criteria (ZIP, 2MB)
- 2025 Quality Quick Start Guide (PDF, 2MB)
- 2025 MIPS Eligibility and Participation User Guide (PDF, 2MB)
- 2025 Part B Claims Reporting Quick Start Guide (PDF, 3MB)
- 2025 MIPS Quality Measures List (XLSX, 804KB)
- 2025 Clinical Quality Measure Specifications and Supporting Documents (ZIP, 68MB)
- 2025 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP, 29MB)
- 2025 eCQM Measure Specifications (Links)
- 2025 MIPS Promoting Interoperability Quick Start Guide (PDF, 849KB)
- 2025 MIPS Promoting Interoperability Measure Specifications (ZIP, 4MB)
- 2025 Improvement Activities Quick Start Guide (PDF, 1MB)
- 2025 Improvement Activities Inventory (ZIP, 831KB)
- 2025 MIPS Summary of Cost Measures (PDF, 340KB)
- 2025 Cost Measure Codes Lists (ZIP, 21KB)
- 2025 QPP Policies Final Rule Fact Sheet (PDF, 798 KB)

Version History

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

DATE	DESCRIPTION
06/13/2025	Original Posting.

Appendix

Quality Payment PROGRAM

Promoting Interoperability Performance Category – Traditional MIPS

Promote patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT) certified to ONC Certification Criteria for Health IT necessary to meet the CEHRT definition (88 FR 79307). To earn a score greater than zero for the Promoting Interoperability performance category, MIPS eligible clinicians, groups, and virtual groups must:

- ☑ Collect your data using technology certified to the Office of the National Coordinator for Health Information Technology (ONC) Certification Criteria for Health IT necessary to meet the CEHRT definition (certified by the last day of the performance period) for a minimum of any continuous 180-day period in 2025;
- ☑ Submit a "yes" to the Actions to Limit or Restrict Interoperability of CEHRT Attestation (formerly named Prevention of Information Blocking);
- ☑ Submit a "yes" to the SAFER Guides attestation measure;
- ☑ Submit a "yes" to the ONC Direct Review Attestation;
- ☑ Submit a "yes" that you have completed the Security Risk Analysis measure in 2025;
- ☑ Report the 6 to 7 required measures or claim their exclusion(s); and
  - For measures that require a numerator and denominator (as defined in the measure specifications), you must submit at least a '1' in the numerator;
- ☑ Submit your level of active engagement for the Public Health and Clinical Data Exchange measures you're reporting;
- ☑ Provide your EHR's CMS identification code from the Certified Health IT Product List (CHPL), available on HealthIT.gov.

25% of final score for most MIPS eligible clinicians, groups, and virtual groups.

*Measure exclusions may be applicable. Please review the individual measure specifications to see if you meet the exclusion criteria. You must claim an exclusion to have the measure points redistributed to another measure. The measure specifications are on the QPP Resource Library.

Clinicians must use CEHRT for the 2025 performance period. Functionality must be in place by the start of the performance period with certification obtained by the last day of the performance period. The 2025 Promoting Interoperability performance category scored objectives are:

- e-Prescribing*
- Health Information Exchange (HIE)*
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange*

Promoting Interoperability Performance Category – Traditional MIPS (Continued)

Qualifying hospital-based, Ambulatory Surgical Center (ASC)-based, small practice, and non-patient-facing MIPS eligible clinicians, groups, and virtual groups will automatically have their Promoting Interoperability performance category score reweighted to 0% of the final score. You can find additional information on the Special Statuses webpage.

- In the case of reweighting to 0%, CMS will assign the 25% from the Promoting Interoperability performance category to another performance category or categories.
- MIPS eligible clinicians, groups, and virtual groups that qualify for reweighting of the Promoting Interoperability performance category can still choose to report if they would like, and if data is submitted, CMS will score their performance and weight their Promoting Interoperability performance accordingly.
- Clinicians may request a Promoting Interoperability performance category hardship exception by submitting an application prior to the start of data submission. An approved application will result in reweighting and the 2 bullets above will apply.

See the 2025 Promoting Interoperability Quick Start Guide (PDF, 849KB) for more information on Promoting Interoperability performance category objectives and measures, reporting requirements, scoring, and reweighting. Comprehensive information about hardship exceptions for the 2025 Promoting Interoperability performance category will be available on the QPP Resource Library later in the year.