

2025 Quality Payment Program Final Rule Summary

On Friday, November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the 2024 Quality Payment Program (QPP) final rule that includes updates to the current program, the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP) framework, Alternative Payment Model (APM), and the APM Performance Pathway (APP).

The QPP encompasses the MIPS and the Alternative Payment Model (APM) programs, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It is important that radiation oncology practices understand key aspects of the QPP, which include a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

MIPS

MIPS Scoring Methodology

Since 2022, the performance category weights have been as follows:

- Quality – 30%
- Improvement Activities – 15%
- Promoting Interoperability – 25%
- Cost – 30%

The performance category weights will remain the same for the 2025 performance period, however, CMS finalized its recommendation to continue to set the performance threshold at 75 points for the CY2025 performance period/2027 payment year.

The payment adjustment for 2027 (based on 2025 performance) will range from -9% to +9%, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), excluding Part B drugs.

For the Quality, Improvement Activities, and Promoting Interoperability performance categories, CMS finalized its proposal that a data submission with only a date and practice ID will not be considered a data submission and will be assigned a null score. This is intended to mitigate the negative scoring impact on clinicians due to data submitted with only a practice ID, date, or measure ID included (no numerator or denominator) which results in a zero score.

Performance Category Reweighting

CMS finalized its proposal to allow clinicians to request reweighting for quality, improvement activities, and/or Promoting Interoperability performance category(ies) where data are inaccessible and unable to be submitted due to reasons outside of the clinician's control because

the clinician delegated submission of the data to their third party intermediary (evidenced by a written agreement) and the third party intermediary didn't submit the data on the clinician's behalf in accordance with applicable deadlines.

In determining whether to apply reweighting to the affected performance category(ies), CMS will consider the following:

- Whether the clinician knew or had reason to know of the issue with its third-party intermediary's submission of their data;
- Whether the clinician took reasonable efforts to correct the issue; and
- Whether the issue between the clinician and their third-party intermediary caused no data to be submitted.

As finalized, these requests would be submitted through the QPP Service Center and must be received on or before November 1 prior to the relevant MIPS payment year. These requests could be submitted beginning with the CY2024 performance period/2026 MIPS payment year.

Quality Performance Category

CMS finalized its proposal to retain the data completeness threshold of 75% for the 2027 and 2028 performance periods. Previously, the Agency finalized the 75% data completeness threshold through the 2026 performance period.

Data Submission Criteria for Quality Measures

CMS finalized its proposal that a submission for the quality performance category must include numerator and denominator information for at least one quality measure from the list of MIPS quality measures to be considered a data submission and scored.

Multiple Submissions

For multiple quality submissions for an individual clinician, group, subgroup, or virtual group from different organizations (for example by a qualified registry and the practice administrator), CMS finalized its proposal to calculate and score each submission received and assign the higher of the scores.

For multiple submissions received for an individual clinician, group, subgroup, or virtual group from the same organization (for example, by 2 practice administrators), the Agency finalized its proposal to score the most recent submission. The new submission would override a previous submission (of the same submission type) from the same organization. This would not apply to different submission types by the same organization. For example, a small practice can report some quality measures through Medicare Part B claims, and some through a file upload. The measures submitted via file upload would not override the measures submitted via Medicare Part B claims, as these are distinct submission types.

New Measures

CMS finalized the addition of 7 quality measures, including 2 patient-reported outcome measures. CMS also finalized the removal of 10 quality measures.

CMS did not finalize its proposal to remove Oncology: Medical and Radiation – Plan of Care for Pain [Quality #144] beginning with the 2025 performance period.

Quality Measure Scoring

CMS finalized its proposal to remove the 7-point topped out measure score cap for clinicians reporting measures included in certain specialty measures and to implement a benchmarking strategy for affected measures that would ensure clinicians with limited measure choice are not unfairly penalized.

Cost Performance Category

CMS finalized its proposal to add six new episode-based measures beginning with the 2025 performance period for implementation at the group (TIN) and clinician (TIN/NPI) level with a 20-episode case minimum: Respiratory Infection Hospitalization, Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis.

Prostate Cancer Cost Measure

CMS finalized its decision to establish a Prostate Cancer Cost measure beginning with the CY 2025 performance period/2027 MIPS payment year. The cost measure will assess MIPS eligible clinicians on the risk-adjusted and specialty-adjusted cost to Medicare for the management and treatment of prostate cancer.

The measure designates two radiation oncology imaging codes, CPT Code 77014 CT Image Guidance and G6001 Ultrasonic guidance for placement of radiation fields, as episode trigger codes. These codes in combination with an ICD-10 diagnosis code indicating prostate cancer trigger a process by which the costs associated with prostate cancer treatment would be attributed to the physician who bills at least 30% of related prostate cancer treatment services. The ratio of observed to expected costs associated with the episode is compared with national cost data and then used to determine the cost measure score. Additionally, this new cost measure aligns with quality measure Q462: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy or MUSIC4: Prostate Cancer: Active Surveillance/Watchful Waiting for Newly Diagnosed Low-Risk Prostate Cancer Patients.

ASTRO, along with several other stakeholder groups, expressed concern about the measure proposal and pointed to the heterogenous nature of prostate cancer, which results in significant variation in treatment costs, which cannot be addressed via claims data. There was also common concern regarding the lack of consensus among the clinician experts involved in measure

development and no additional testing after the measure was modified after an initial test. The Agency disagreed with these assertions.

CMS claims that the Prostate Cancer Cost measure accounts for severity using claims-based risk adjustment variables including ADT drugs, chemotherapy, immunotherapy, prostatectomy, PSA tests, and radiation. Furthermore, the Agency asserted that the measure stratifies patients based on whether they have a metastatic cancer diagnosis or metastatic cancer drug usage in the year prior to the episode.

ASTRO is supportive of high-value approaches to cancer treatment; however, we remain concerned that this measure adds to the complexity and burden of the MIPS payment system. Additionally, it may unfairly penalize radiation oncologists. ASTRO will monitor its implementation and continue to advocate for modifications.

Cost Measure Removal Criteria

CMS finalized the following criteria to serve as guidance when considering whether to remove a cost measure:

1. It is not feasible to implement the measure specifications.
2. A measure steward is no longer able to maintain the cost measure.
3. The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
4. The measure specifications do not reflect current clinical practice or guidelines.
5. The availability of a more applicable measure, including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic.

The Agency also finalized its proposal that it may retain a cost measure that meets one or more of these criteria if it is determined that the benefit of retaining the measure outweighs the benefit of removing it.

Cost Measure Exclusion

CMS finalized its proposal that if data used to calculate a score for a cost measure are impacted by significant changes or errors affecting the performance period, such that calculating the cost measure score would lead to misleading or inaccurate results, then the affected cost measure is excluded from the MIPS eligible clinician's or group's cost performance category score. This will go into effect with the 2025 performance period.

Cost Improvement Scoring

CMS finalized its proposal to revise the cost scoring benchmark methodology starting in the 2024 performance period/2026 MIPS payment year. If finalized, these changes would take effect

when 2024 final scores are released in the summer of 2025. The cost scoring methodology would use a new distribution for cost scoring in which the median cost for a measure would be set at a score derived from the performance threshold established for the MIPS payment year. For example, for the CY2024 performance period/2026 payment year, the median would be set at 7.5, the performance threshold equivalent. The cut-offs for benchmark point ranges would then be calculated based on standard deviations from the median. CMS believes that the finalized benchmark methodology would more appropriately incentivize or penalize clinicians with below or above national average spending.

Improvement Activities Performance Category

The Agency finalized its proposal to add the following new improvement activities:

- Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake
- Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk

The Agency finalized its proposal to remove the following improvement activities:

- Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
- Population Empanelment
- Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
- Implementation of Improvements that Contribute to More Timely Communication of Test Results
- Implementation of a Personal Protective Equipment (PPE) Plan
- Implementation of a Laboratory Preparedness Plan
- Electronic Health Record Enhancements for BH Data Capture
- Invasive Procedure or Surgery Anticoagulation Medication Management

Activity Weighting

CMS finalized its proposal to remove activity weightings to simplify scoring and complement the Agency's ongoing efforts to refine and improve the Inventory.

Required Activities

CMS finalized its proposal that MIPS eligible clinicians receive 20 points for each improvement activity, while non-patient-facing MIPS- eligible clinicians, small practices, and rural practices receive 40 points for each improvement activity. Therefore, to receive full credit (40 points), MIPS eligible clinicians must report 2 improvement activities, while non-patient facing MIPS eligible clinicians, small practices, and practices located in rural areas must report one improvement activity.

Minimum Submission Criteria

CMS finalized its proposal that a submission for the improvement activities performance category must include a “yes” response for at least one improvement activity to be considered a data submission and scored.

Multiple Submissions

For multiple improvement activity submissions for an individual clinician, group, subgroup, or virtual group from different organizations (for example, by a qualified registry and the practice administrator), the Agency finalized the existing process of calculating and scoring each submission received and assigning the higher of the scores.

For multiple data submissions received for an individual clinician, group, subgroup, or virtual group from the same organization (for example, by 2 practice administrators), the Agency finalized the existing process of scoring the most recent submission. The new submission would override a previous submission (of the same submission type) from the same organization. This will not apply to different submission types by the same organization.

Promoting Interoperability (PI) Performance Category

Minimum Submission Criteria

Beginning with the CY 2024 performance period/2026 payment year, CMS finalized that a data submission for the Promoting Interoperability performance category must include all of the following elements to be considered a qualified data submission and scored:

- Performance data, including any claim of an applicable exclusion, for the measures in each objective, as specified by CMS;
- Required attestation statements, as specified by CMS;
- CMS EHR Certification ID (CEHRT ID) from the Certified Health IT Product List (CHPL); and
- The start date and end date for the applicable performance period.

Multiple Data Submissions

Beginning with the CY 2024 performance period/2026 MIPS payment year, CMS finalized its proposal that, for multiple data submissions received, CMS would calculate a score for each data submission received and assign the highest of the scores. CMS believes that this policy may provide flexibility for individual MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities to fix errors in a prior data submission. Additionally, The Agency recognizes there may be instances when a practice switches EHR vendors during a performance period, potentially resulting in separate data submissions for the Promoting Interoperability performance category. This policy also aligns with the Agency’s intent to maintain consistency in data

submission requirements across all MIPS performance categories, to the extent possible, as it significantly reduces the complexity for MIPS eligible clinicians participating in MIPS.

Subgroup Reporting

CMS finalized its proposal to continue its policy that a subgroup is required to submit its affiliated group's data for the Promoting Interoperability performance category.

MIPS Value Pathways (MVPs)

In 2021, CMS introduced the Merit Based Incentive Program Value Pathways (MVPs). MVPs are a subset of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning in the 2023 performance year. CMS established the following guiding principles associated with MVPs in the 2022 MPFS Final Rule:

- MVP must include at least one outcome measure that is relevant to the MVP topic, so MVP Participants are measured on outcomes that are meaningful to the care they provide.
- Each MVP that is applicable to more than one clinician specialty should include at least one outcome measure that is relevant to each clinician specialty included.
- In instances when outcome measures are not available, each MVP must include at least one high priority measure that is relevant to the MVP topic, so MVP Participants are measured on high priority measures that are meaningful to the care they provide.
- Allow the inclusion of outcomes-based administrative claims measures within the quality component of an MVP.
- Each MVP must include at least one high priority measure that is relevant to each clinician specialty included.
- To be included in an MVP, a qualified clinical data registry (QCDR) measure must be fully tested.

CMS developed the framework to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, the MVP framework incorporates a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focuses on population health to reduce reporting burden.

MVPs have the following reporting criteria:

- **Quality Performance Category:** MVP Participants will select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome is not available or

applicable). This can include an outcome measure calculated by CMS through administrative claims, if available in the MVP.

- Improvement Activities Performance Category: MVP Participants will select two medium-weighted improvement activities OR one high-weighted improvement activity OR participation in a patient-centered medical home if it is already included in the MVP.
- Promoting Interoperability Performance Category: MVP Participants will report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualify for reweighting of the Promoting Interoperability performance category.
- Cost Performance Category: MVP Participants will be scored on the cost measures included in the MVP that they select and report.
- Foundational Layer (MVP-agnostic): Population Health Measures: MVP Participants will select one population health measure to be calculated on. The results will be added to the quality score.

The Agency finalized the inclusion of the following six new MVPs:

1. Complete Ophthalmologic Care
2. Dermatological Care
3. Gastroenterology Care
4. Pulmonology Care
5. Optimal Care for Patients with Urologic Conditions
6. Surgical Care

Cost performance category

For Cost performance category policy changes, please see the discussion of the Cost performance category for Traditional MIPS above.

Improvement Activities

CMS finalized efforts to align MVP scoring with traditional MIPS policies by removing references to high- and medium-weighted improvement activities in MVPs. Further, the Agency finalized its proposal to update MVP scoring to assign 40 points for each improvement activity to provide full credit for the improvement activities performance category for MVP Participants who report one improvement activity.

Population Health Measures (MVPs: Foundational Layer)

CMS finalized its proposal to calculate all available population health measures for an MVP participant and apply the highest scoring population health measure to their quality performance category score. MVP participants will no longer be required to select a population health

measure as part of their MVP registration, rather measures will be collected via claims data and scored as part of the quality performance category.

Promoting Interoperability

CMS is finalizing its proposal to require a subgroup to submit the affiliated group's data for the performance category, by removing references to specific performance periods/MIPS payment years, thereby permitting subgroups to report data for this category in this manner for the CY2025 performance year and beyond. CMS will continue to monitor the operational challenges with the EHR systems and reassess whether subgroups should be required to submit subgroup level performance data for the Promoting Interoperability performance category.

Advancing Cancer MVP

In the 2023 MPFS final rule, CMS established the Advancing Cancer Care MIPS Value Pathway (MVP) which specifically applies to medical, hematological, and gynecological oncologists.

In the 2025 MPFS final rule, CMS is adding five quality measures, two improvement activities, and one cost measure, while removing two quality measures and two improvement activities from the Advancing Cancer Care MVP.

Alternative Payment Models (APM)

Advanced APMs

Qualifying APM Participant

If an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) status, they are excluded from the MIPS reporting requirements. Eligible clinicians who achieve QP status in performance year 2024 will receive a 1.88% APM Incentive Payment in 2026. This is a decline from the 3.5% APM Incentive Payment set for 2025 based on the 2023 performance year. This is due to the expiration of the 5% Advanced APM Bonus which has been replaced with a 0.75 conversion factor increase.

In the 2025 MPFS final rule, CMS proposed but did not modify the “sixth criterion” under “attribution-eligible beneficiary,” which is used for QP determination. Therefore, the following criteria for calculating QP threshold scores attributed beneficiaries will remain as follows::

1. Is not enrolled in Medicare Advantage or a Medicare cost plan;
2. Does not have Medicare as a secondary payer;
3. Is enrolled in both Medicare Parts A and B;
4. Is at least 18 years of age;
5. Is a US resident; and
6. Has a minimum of one claim for E/M services furnished by an eligible clinician who is in an APM Entity.

Additional Resources:

CMS 2025 Quality Payment Program Proposed Rule [Resources](#)

2025 Quality Payment Program [final rule](#).

ASTRO [Quality Payment Program resources](#)