2025 MIPS Requirements for Rheumatologists

The Merit-based Incentive Payment System (MIPS) is one of two tracks under the Medicare Quality Payment Program (QPP), which was launched in 2017 by the Centers for Medicare and Medicaid Services (CMS) as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). With MIPS moving into its ninth performance year, it is important that rheumatologists are aware of important program policies and changes that might impact participation and performance in 2025.

2025 MIPS Eligibility

For 2025, MIPS reporting requirements and payment adjustments generally apply to several types of clinicians who receive payment under the Medicare Physician Fee Schedule, including but not limited to physicians, physician assistants, nurse practitioners, and more (click here for a full list of eligible clinician types). However, certain categories of clinicians are excluded from MIPS, including:

- Clinicians determined to be Qualifying Participants (QPs) in Advanced Alternative Payment Models (APMs), which means they meet participation thresholds based on their levels of Medicare payments or patients seen through risk-based APMs. QPs are not required to participate in MIPS and instead qualify for a separate APM incentive payment. Click here for more information about QP determinations, as well as financial incentives available to QPs.
  ** Note that both the QP financial incentives and thresholds are changing under current law starting in 2025. Barring Congressional action, clinicians will face lower incentives and more challenging thresholds to qualify for this second track of the QPP starting next year.*[1]
- Clinicians who first become enrolled in the Medicare program during the 2025 performance year.
- Clinicians who fall below a CMS-determined "low-volume threshold."

More information about QPP eligibility determinations can be found here.

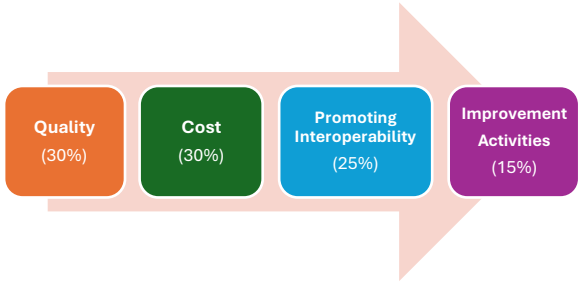
Clinicians may confirm their initial 2025 MIPS eligibility at the individual and group practice level by entering their 10-digit National Provider Identifier (NPI) into the QPP Lookup Tool. This tool will also provide information about QP status. While preliminary eligibility determinations are available throughout the year, CMS will issue final 2025 eligibility determinations in December 2025. It is important to confirm your status at the end of the year since eligibility determinations could change throughout the year.

Keep in mind that MIPS eligibility and compliance is specific to each TIN/NPI combination. Clinicians who practice under multiple TINs should check each TIN/NPI combination for eligibility and reporting requirements since they are unique to each practice.

Also note that MIPS eligible clinicians may apply for an exception if impacted by an extreme and uncontrollable circumstance (e.g., a natural disaster or cyberattack) that interferes with their ability to meet program requirements. In some circumstances, CMS may apply these exceptions automatically. For more information, please visit the QPP Exceptions webpage, keeping in mind that the specific circumstances that qualify for these exceptions may change from year to year and even throughout the performance year.

[1] There have been efforts in Congress to extend the APM incentive and halt the automatic increase in thresholds prescribed under current law. However, the prospects for these initiatives are unclear given the shifting balance of power and other competing priorities.

Performance Categories, Weights, and Thresholds



Under MIPS, a clinician's Medicare Part B payments are adjusted based on their performance in four categories – Quality, Cost, Promoting Interoperability, and Improvement Activities. Performance in each category is assigned a weight and then totaled to produce a clinician's MIPS final score on a scale from 0 to 100 points. A clinician's final score determines their MIPS payment adjustment, which is applied to Medicare Part B services two years after the performance year. Thus, 2025 performance will determine 2027 payment adjustments. Each year, CMS sets a performance threshold, which is the minimum number of points needed to avoid a penalty. The performance threshold for 2025 remains at 75 points.

What's At Stake?

MIPS eligible clinicians who fail to report under MIPS or whose MIPS final score is among the lowest for 2025 will be subject to the maximum Medicare penalty of 9% in 2027. Clinicians who score higher, but still below the 75-point threshold, will receive a slightly lower negative adjustment based on a sliding scale.

A score of exactly 75 points will result in a neutral (0%) adjustment.

Clinicians who score above 75 points are eligible for a positive payment adjustment, also assigned on a sliding scale, where 100 points results in the maximum positive adjustment amount. Since MIPS is a budget neutral program, the maximum positive adjustment amount for a given year cannot be determined until total penalties are known. However, the maximum positive payment adjustment has generally hovered around 2% in recent years, except for the 2024 payment year, when it reached 8.26%.[2]

MIPS payment adjustments are made on a claim-by-claim basis to all Part B payments for covered professional services furnished by a MIPS eligible clinician two years following the performance year. The payment adjustment is applied to the Medicare paid amount and does not impact the portion of the payment that a patient is responsible to pay.

MIPS Participation Options

MIPS eligible clinicians may comply with MIPS through various reporting options:

- **Traditional MIPS**. Through this original reporting option, clinicians select the quality measures and improvement activities that they want to collect and report from the complete MIPS inventory. They are also required to report the complete set of Promoting Interoperability measures and attestations, unless eligible for an exception. CMS calculates data for the cost performance category automatically based on administrative claims (i.e., no data submission)
- **Alternative Payment Model (APM) Performance Pathway (APP).** The APP is a streamlined reporting framework, with a specified quality measure set, that is available to clinicians who participate in a MIPS APM, but do not meet the threshold to qualify as a QP and are thus, not excluded from MIPS. The APP is designed to reduce reporting burden, offer distinct scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. More information about the APP is available here.
- **MIPS Value Pathways or MVPs**. MVPs are the newest way to fulfill MIPS reporting requirements. MVPs are intended to streamline MIPS by connecting existing improvement activities and measures that are relevant to a specific specialty, condition, or population. While MVPs maintain the four performance

[2] Note there were many unique circumstances that contributed to this abnormally high positive adjustment for the 2022 performance year/2024 payment year. The following year, the maximum positive adjustment dropped back down to 2.15%. However, if CMS continues to raise the bar on performance in future years and more clinicians are subject to penalties, the maximum positive adjustment could rise.

categories and many of the scoring rules associated with traditional MIPS, they require the reporting of fewer measures and improvement activities, allowing participants to report on a smaller, more cohesive subset of metrics. There are 21 MVPs available for the 2025 performance year, including a newly revised **Advancing Rheumatology Patient Care MVP**. Additional details about this and other MVPs available for 2025 can be downloaded here or accessed through the search tool here. Unlike traditional MIPS, clinicians must register to participate in an MVP. Registration typically opens in April and closes by early December of the performance year. More information about MVP participation requirements can be found here. Keep in mind that although MIPS participants are not required to use MVPs at this time, CMS intends to replace traditional MIPS with MVPs at some point in the future.

Once a reporting option is selected, a clinician must determine how to participate. Participation options refer to the levels at which MIPS data are collected and submitted to CMS, and include the following:

- **Individual**: Collect and submit data as an individual MIPS eligible clinician.
- **Group**: Collect and submit data for all clinicians in a group practice (i.e., at the Tax ID Number or TIN level).
- **Virtual Group**: Collect and submit data for all clinicians in a CMS approved virtual group. A virtual group is a combination of 2 or more TINs that elect to form a virtual group for the sole purpose of collecting and submitting MIPS data for a performance year. It is only available under traditional MIPS. While there is not a limit to the number of TINs composing a virtual group, it must consist of either solo practitioners, groups consisting of 10 or fewer clinicians, or a mix of both. Virtual groups must submit elections to CMS prior to the performance year.
- **APM Entity**: The APM Entity collects and submits data for all MIPS eligible clinicians identified as participating in the MIPS APM. Note that there are special rules that apply specifically to MIPS APM participants (click here to learn more about MIPS APMs).
- **Subgroup**: Participation at the "subgroup" level means that a TIN can break into smaller groups for purposes of more focused and clinically relevant MIPS reporting. This participation option, which began in 2023, is only available to those reporting MVPs and advance registration is required. Note that subgroup participation will be required for multispecialty practices that choose to participate via MVPs beginning with the 2026 performance year. At that time, MIPS-eligible clinicians and group practices will still have the option to participate in traditional MIPS, which does not require nor allow for subgroup participation.

More information about each of these MIPS participation options is available here. It is important to check with your practice leadership to determine the most appropriate participation option and reporting expectations.

Keep in mind that is is possible to participate in MIPS through multiple pathways. If a clinician has multiple final scores for the same TIN/NPI combination— for example, based on individual and group participation through traditional MIPS or individual participation through traditional MIPS and group participation through an MVP— then CMS will apply the highest final score for purposes of calculating that clinician's payment adjustment.

Special Status

Clinicians who are part of a small practice receive special scoring accommodations under MIPS that can help bolster their MIPS final scores. These include:

- A small practice bonus of 6 points added to the numerator of the Quality performance category score.
- 3 points (instead of 0 points) for reported quality measures that do not meet data completeness or case minimum requirements, or that cannot be reliably scored against a benchmark.
- Fewer reporting requirements under the Improvement Activities performance category.
- An automatic exception from having to meet the requirements of the Promoting Interoperability performance category, which results in a redistribution of that category weight to other performance categories.
- Clinicians in small practices can also report MIPS quality measures using Part B claims, which is an option that is no longer available to other clinicians.

Special status accommodations may also apply for other types of clinicians, including those in rural or health professional shortage areas, hospital-based clinicians, facility-based clinicians, and more. Special status accommodations generally apply across both traditional MIPS and MVPs.[3] To learn more about special status categories, please visit the QPP website.

Performance Category Requirements

Quality

This performance category assesses the quality of care delivered, based on performance measures created by CMS, as well as professional medical societies and other interested parties. Quality requirements differ based on the participation option selected. For 2025, under traditional MIPS, CMS will continue to require clinicians to report at least six quality measures, including one outcome or high priority measure. Those reporting via an MVP must report on at least four quality measures, including one outcome or high priority measure.

There are five collection types for MIPS quality measures:

- Electronic Clinical Quality measures (eCQMs);
- MIPS Clinical Quality measures (CQMs);
- Qualified Clinical Data Registry (QCDR) measures;
- Medicare Part B Claims measures (only available to individuals and groups in small practices – i.e. 15 or fewer eligible clinicians); and
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Depending on the measures selected, there are multiple ways you can submit quality measure data to CMS:

- On your own if using Part B Claims measures, CQMs, or eCQMs;
- Through a third-party intermediary, such as a Qualified Registry (QR) or QCDR;
- Through a CMS-approved CAHPS survey vendor

For traditional MIPS, clinicians can choose from nearly 200 quality measures in the MIPS measure inventory, as well as additional specialty-focused measures offered through QCDRs. To help clinicians navigate this large inventory of measures, CMS organizes non-QCDR measures into specialty sets, including a **Rheumatology set**, which help to guide clinicians with the selection of relevant measures.

Clinicians reporting via an MVP may only select from the measures listed in the MVP.

APP participants adhere to distinct quality reporting requirements, including a limited selection of measures that largely primary care focused. Additional information about these requirements can be found here.

The Explore MIPS Measures webpage provides access to all non-QCDR quality measures being offered for 2025, including downloadable specification documents. The tool also provides access to the **Rheumatology specialty set**. The list of quality measures included in the **Advancing Rheumatology Patient Care MVP** in 2025 can be found here (for both resources, make sure to select the "2025" performance year from the dropdown menu).

QR and QCDR vendors approved for 2025, as well as more detailed information on the measures offered by each of those registries, can be found in the QPP Resource Library. Note that the American College of Rheumatology's (ACR) RISE registry has been approved as a QCDR for 2025, and supports the reporting of numerous rheumatology-specific non-QCDR and QCDR measures, as well reporting of the **Advancing Rheumatology Patient Care MVP.**

[3] One exception is "facility-based" status. Facility-based clinicians and groups can choose to report an MVP (or the APP). However, their facility-based scores in the quality and cost performance categories will be attributed to traditional MIPS and will not apply to quality and cost scores under the MVP (or APP). CMS will calculate a final score based on MVP (or APP) reporting and a separate score based on traditional MIPS (which would reflect facility-based scoring). CMS will then assign the higher of the two scores for purposes of determining the payment adjustment.

Early in 2025, CMS will also post benchmark files to the QPP Resource Library.

It is important to review the inventory of MIPS measures and measure specifications each year since they can change. For example, CMS finalized substantive changes for numerous measures in the Rheumatology specialty set, including:

- #176: *Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy*
- #177: *RA: Periodic Assessment of Disease Activity*
- #178: *RA: Functional Status Assessment*
- #180: *RA: Glucocorticoid Management*

It is also important to review each measure's performance benchmark. Early in each performance year, CMS publishes an historic benchmark file, which lists the range of performance rates that must be achieved to earn a certain number of points on each measure. Historic benchmarks for MIPS quality measures are based on performance data from two years prior, which allows CMS to provide clinicians with performance "targets" heading into the performance year. Keep in mind that some measures are subject to scoring limitations. For example, measures that have been "topped out" for two consecutive years (e.g., median performance rate of 95 percent or higher) are subject to a scoring cap and cannot earn the maximum number of points regardless of performance.

Additional details about quality category requirements can be found here, including downloadable resources that further describe the different collection types and submission options.

Promoting Interoperability
This performance category promotes patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT). The Promoting Interoperability performance category requirements are the same across all reporting options— traditional MIPS, the APP, and MVPs.

Requirements for this category are outlined here (make sure to select the "2025" performance year from the dropdown menu).

As a reminder, small practices, hospital-based, and ASC-based clinicians are automatically exempt from the Promoting Interoperability category. Clinicians may also apply for a hardship exception from this category for specific circumstances outlined here.

Improvement Activities
This category assesses how clinicians improve care processes, enhance patient engagement in care, and increase access to care. This category only requires clinicians to attest to completing certain activities rather than submitting specific data. In the past, activities were assigned a medium or high weight, and clinicians were required to attest to 2-4 activities (1-2 for small/rural practices) depending on which activities were selected.

******NEW for 2025***, CMS has removed improvement activity weighting and reduced the attestation requirement:

- Traditional MIPS
  - Clinicians, groups, and virtual groups with the small practice, rural, non-patient facing, or health professional shortage area special status must attest to 1 activity
  - All other clinicians, groups, and virtual groups must attest to 2 activities
- MVPs
  - Clinicians, groups, and subgroups (regardless of special status) must attest to 1 activity

APP participants automatically receive full credit for this category. More information is available here.

It is important to review the improvement activity inventory each year since CMS removes, adds, and makes changes to specific activities each year (make sure to select the "2025" performance year from the dropdown menu).

Cost

This category is intended to assess MIPS eligible clinicians on their ability to manage the use of health care resources under the Medicare program. No additional reporting is necessary to comply with this category; CMS automatically calculates cost measures based on Medicare claims. While this eliminates reporting burden, it also means that clinicians and groups cannot select the cost measures on which they are evaluated, as they can under the Quality category.

For 2025, there are a total of 35 cost measures that a MIPS eligible clinician could be scored on, including two total cost measures: the Total Per Capita Cost (TPCC) measure, which is a population-based measure that assesses the overall cost of care delivered to a Medicare patient with a focus on the primary care received and the Medicare Spending Per Beneficiary (MSPB), which assesses the overall cost of care for services related to a qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient. There are also 33 episode-based cost measures that focus on more specific procedures, acute inpatient medical conditions, or chronic conditions. In general, these measures assess each MIPS eligible clinician compared to the national average costs of all other MIPS eligible clinicians attributed the same measure for the same performance period. Measures may also include a specialty adjustments to account for the fact that costs vary across specialties and across group practices with varying specialty compositions.

Each cost measure has its own set of specifications that describe how the episode is triggered and defined; which specific costs are assigned to an episode; how costs are risk-adjusted, stratified into subgroups, or excluded; and how episodes are attributed to a clinician and group. Cost data are also subject to payment standardization, which is the process of calculating standardized claim payment amounts to ensure that the same services are assigned comparable amounts, regardless of provider type and geographic area. Additionally, when scoring cost measures, CMS relies on performance year benchmarks, rather than historic benchmarks. This means that, unlike the Quality category, scoring targets are formulated based on performance data collected during the year and are not accessible to clinicians ahead of time.

Clinicians and groups will only be scored on cost measures if they are attributed a sufficient number of patients under a measure's unique attribution methodology[4]:

- For the MSPB measure, at least 35 patients must be attributed to the clinician or group.
- For the TPCC measure, at least 20 patients must be attributed to the clinician or group.
- For acute inpatient medical condition episode-based cost measures, at least 20 episodes must be attributed to the clinician or group.
- For chronic condition episodes, including the new **Rheumatoid Arthritis cost measure** (more information provided below), at least 20 episodes must be attributed to the clinician or group.

Unlike traditional MIPS, MVP participants may only be scored on cost measures specific to the MVP they select, so long as they meet the case minimum. CMS will not score them on other cost measures not included in the MVP, even if the clinician or group meets the case minimum requirement for those measures.

APP participants are not scored on the cost category.

******NEW for 2025***, CMS finalized the adoption of an **episode-based cost measure that evaluates chronic care management of Rheumatoid Arthritis.** This measure aims to evaluate a clinician's or group practice's risk-adjusted and specialty-adjusted cost to Medicare for patients enrolled in Medicare fee-for-service who receive medical care to manage and treat rheumatoid arthritis. The measure focuses on care provided by clinicians in non-

[4] The level of analysis (individual vs. group) will depend on the level at which the clinician opts to participate in MIPS.

inpatient hospital settings (i.e., offices and outpatient hospitals). Under the measure, a clinician-patient care relationship is first established by CMS by looking at service and diagnosis information from administrative claims data. An episode is attributed to a clinician group when it performs two services (a "trigger code" and "confirming claim") indicating relevant care within the trigger window (i.e., 180 days). Both claims must have a diagnosis code indicating rheumatoid arthritis. An episode is attributed to any clinician within the attributed group that billed at least 30% of the trigger or confirming codes on Part B Physician/Supplier claim lines during the episode. Additional checks are used to ensure that clinicians are appropriately attributed. Once a trigger event is identified, it opens a year-long attribution window, during which Medicare Parts A, B, and D services, and their costs, are assigned to an episode if they are clinically related to the management and treatment of the patient's rheumatoid arthritis, as defined in the CMS measure specifications. As a result, rheumatologists could be assigned and scored on costs related to the episode even if they have little or no direct control over the ordering of those items and services. Assigned services may include treatment and diagnostic services, ancillary items, services directly related to treatment, and those furnished as a consequence of care (e.g., complications, readmissions, unplanned care, and emergency department visits). Unrelated services (i.e., a knee arthroplasty that occurs during the episode) are not assigned to the episode. CMS then applies exclusions, risk and other adjustments before calculating the measure score, which, in simple terms, is based on a weighted observed to expected ratio.

A more detailed description of this measure's construction and calculation methodology, as well as a detailed list of the codes and descriptors used to support these specifications, are available for download here (see Measure Codes Lists and Measure Information Forms, under "2025 Physician Fee Schedule Final Rule Resources").

Note that this measure was finalized despite numerous objections and concerns raised by CSRO and other stakeholders, including the fact that the measure holds rheumatologists accountable for costs outside of their control (in particular for medications that are used following the recognized standards of care) and that current Medicare coverage guidelines and payment policies— such as Part D formulary restrictions and step therapy requirements (i.e., "fail-first") requirements, the Self-Administered Drug Exclusion List, and inadequate payment for most biosimilars— limit the care that clinicians can provide to these patients, which inevitably impacts cost.

******NEW for the 2024 performance year and beyond***, CMS recently finalized a revised methodology for benchmarking and scoring clinicians on cost measures to address historically lower scores in the category compared to other categories. The new methodology, which applies universally to all cost measures in the program, is expected to generally raise cost category scores for clinicians whose spending is around the national median.

Additional information about the cost category, including a link to 2025 measure specifications (available in early 2025), can be found here. 2025 cost measure benchmark files will be posted to the QPP Resource Library in mid-2026.

Performance Feedback

Each year, CMS provides clinicians with a summary of their MIPS performance data, including a summary of category-level scores and weights, bonus points and improvement scoring, measure-level performance data and scores, payment adjustment information, and supplemental reports for administrative claims quality and cost measures, where applicable. MIPS performance feedback is accessible to clinicians and authorized representatives of practices, virtual groups, and APM Entities through a secure portal. CMS typically releases MIPS performance feedback and final scores 8 months after the close of a performance period, at which point clinicians may submit a Targeted Review if they believe there is an error. Additional information about these processes is available through the QPP Resource Library.

Additional Resources

Please visit the QPP website and the QPP Resource Library for additional guidance, fact sheets, videos and FAQs.