2025 Merit-based Incentive Payment System (MIPS) Suggested Timeline

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Quality (Traditional MIPS)	• 2015 21st Century CEHRT required. • Review EHR-supported measures; assess any needed changes in documentation, specifications, or workflow to improve performance. • Select 8-10 measures for focus, ensuring at least 2 outcome or high-priority measures are included. • Note any measures removed, had their benchmarks removed, or measures no longer supported by your EHR. • New measures in first year have a 7-point benchmark floor, review new measures for consideration. • Ensure 75% data completeness can be met • **Consider eCQM reporting if APM Entity reporting or Virtual Group reporting for additional points**	• Monitor quality measure performance bi-weekly or at least monthly. • Share results with clinicians and care team, adjust workflow, and re-train based on performance. • Periodically review CMS Quality Benchmarks for updates or changes		• Review quality measure reports and determine which 6 measures earn the most points, ensuring at least 1 outcome or 1 high-priority measure included. • Review measures and select 2026 measures • Note any measures that had their benchmarks removed, or are no longer supported by your EHR for 2026 • **Consider eCQM reporting if APM Entity reporting or Virtual Group reporting for additional points**
Promoting Interoperability	• 2015 21st Century CEHRT required. • Prepare to report a continuous 180-day reporting period. • Determine 180-day Promoting Interoperability reporting period for 2025. • Review measures with staff • Have active engagement or meet the exclusions for the 2 required Public Health Registries: Immunization Registry and Electronic Case Reporting • If applicable to the practice, ensure active engagement with one of the other Public Health Registries for 5 bonus points	• Start 180 period no later than this quarter. • Provide staff training as needed to improve scores. • Share progress and performance reports with leadership and care teams bi-weekly or at least monthly. • Begin Security Risk Assessment, conduct site assessment at all practice locations, create or update documentation. • Begin SAFER High-Priority Guide required for 2025	• Monitor measure performance for any hot spots and re-educate on workflow if needed. • Ensure clinicians have data for all measures or can claim an exclusion. • Create Security Risk Assessment Corrective Action Plan and communicate with leadership team and site managers. • Continue SAFER High-Priority Guide assessment. • Ensure active engagement with Immunization and Electronic Case Reporting registries.	• Complete action items on the Security Risk Assessment Corrective Action Plan prior to end of year • Final check to ensure clinicians have data for all measures or can claim an exclusion. • Complete SAFER High-Priority Guide assessment, required to be completed for 2025.

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Cost (Traditional MIPS)	• Review cost category measure specifications and episodes to determine if any of the episode-based measures may apply to your clinicians	• Set strategies for reducing cost (cost to Medicare)	• Review cost measure results from 2024 and adjust strategies for reducing cost if indicated from results.	
Improvement Activities (Traditional MIPS)	• Review the 2025 list of Improvement Activities and decide if practice will continue 2024 activities, (if available) or select new activities. • Consider new activities that may improve performance in Quality, Promoting Interoperability, or EOM requirements. • Create an Implementation timeline for any new activities. • Large practices complete 2 activities • Small Practices and those with special status complete 1	• Create a playbook for new Improvement Activities, including policies and procedures related to activities. • Refer to the CMS Data Validation resource as a guide for additional required documentation to be prepared for an audit. • Monitor and set goals for 2025 activities	• Monitor Improvement Activity processes and workflows	• Select 90-day reporting period. • Audit Improvement Activities for compliance; archive information as proof of implementation

MVP (MIPS Value Pathways)	• Review all available MVPs, select your relevant MVP.
	• Select 4-6 quality measures in the MVP for focus.
	• Select 1 Improvement Activity in the MVP
	• Continue with Promoting Interoperability measures as required.
	• Review the specifications for any Cost measure in the MVP.
	Sub-group
	  • If multispecialty or large group, consider a sub-group for reporting MVP.
	  • Identify included NPIs and create a name for your sub-group
		• Register your intent to report your selected MVP on QPP.cms.gov
		• Select population health measure.
		• Continue to monitor quality, PI, and IA measures.
		Sub-group
		• Register your sub-group on QPP.cms.gov.
		• Select population health measure.
		• Include all NPIs in sub-group.
		• Register the MVP the sub-group intends to report.
			• Continue to monitor all measures	• Identify your Improvement Activity 90-day period and confirm activity documentation.
				• Identify your Promoting Interoperability 180-day period.
				• Ensure documentation meets data validation requirements

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Program Level Decisions and Action Items	• Attest and submit 2024 data for Quality, Promoting Interoperability, and Improvement Activities • Communicate estimated 2024 results to practice leadership and care teams. • Set goals for areas to improve in 2025. • Educate clinicians and staff on all changes and new requirements for 2025. • Review eligibility for group and all clinicians on the QPP site and create a 2025 tracking form, note any clinicians who may be eligible to Opt-In or any showing participation in an APM or AAPM • **Review increased QP and Partial QP threshold requirements for 2025.**	• Review reporting options and identify submission method for each MIPS category. • Ensure CEHRT has capability to interface with state's Electronic Case Reporting Registry	• Calculate estimated mid-year MIPS Composite Performance Scores • Check MIPS eligibility status for all clinicians and create 2025 tracking form, note any clinicians who may be eligible to Opt-In or have achieved QP or Partial-QP status in an AAPM. • Review progress for improvement goals identified in first quarter. • Communicate results to clinicians and practice leadership. • Review MIPS 2024 final results on CMS portal and communicate those results to leadership	• Calculate preliminary MIPS Composite Scores by clinician and group. • Check MIPS eligibility status for all clinicians and note any clinicians who have achieved QP or Partial-QP status in an AAPM. • Based on scores, decide on group, individual, or both for data submission • Communicate preliminary results to practice leadership. • Complete any action needed for registry or QCDR and/or obtain access to CMS Portal • Complete any Hardship Exception Applications that may apply by end of year deadline (TBA) • Plan for 2026 reporting period