



All About MIPS: Getting the Most From CMS's Merit-Based Incentive System

October 16, 2025



Housekeeping



- All participants have been muted to maintain the integrity of the webinar discussion
- Submit all questions to the **Q&A box** within your participant controls on the bottom. We will answer questions at the end of the webinar, but you can submit at any time.
- All registrants will receive a webinar recording via e-mail
- Please fill out our post-webinar survey

Meet Our Panelists



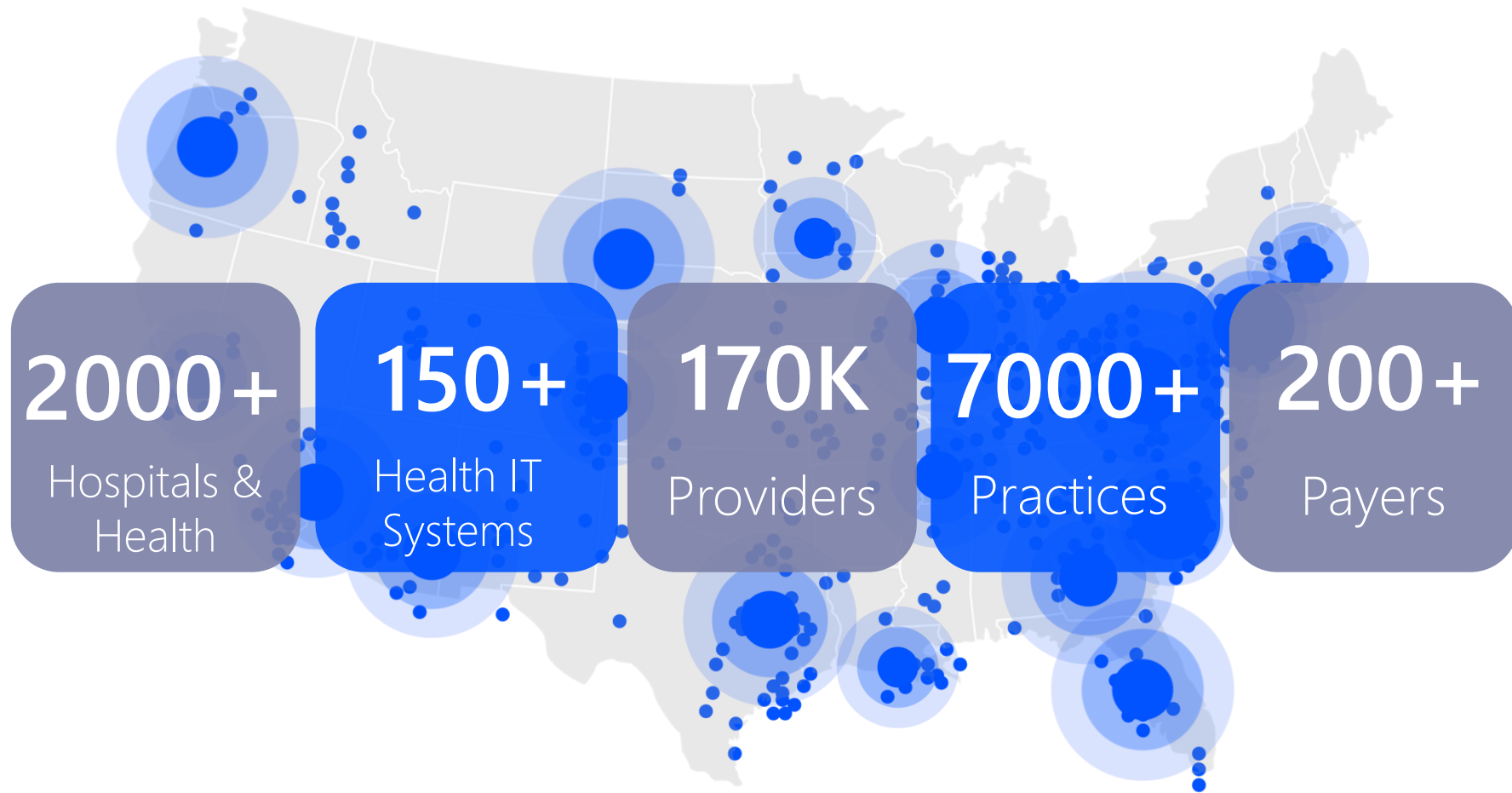
Heather Weerda
Director of Clinical Quality
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Management at MRO



Amy Ardisana
Director of Registry
Account Management at
MRO

About MRO

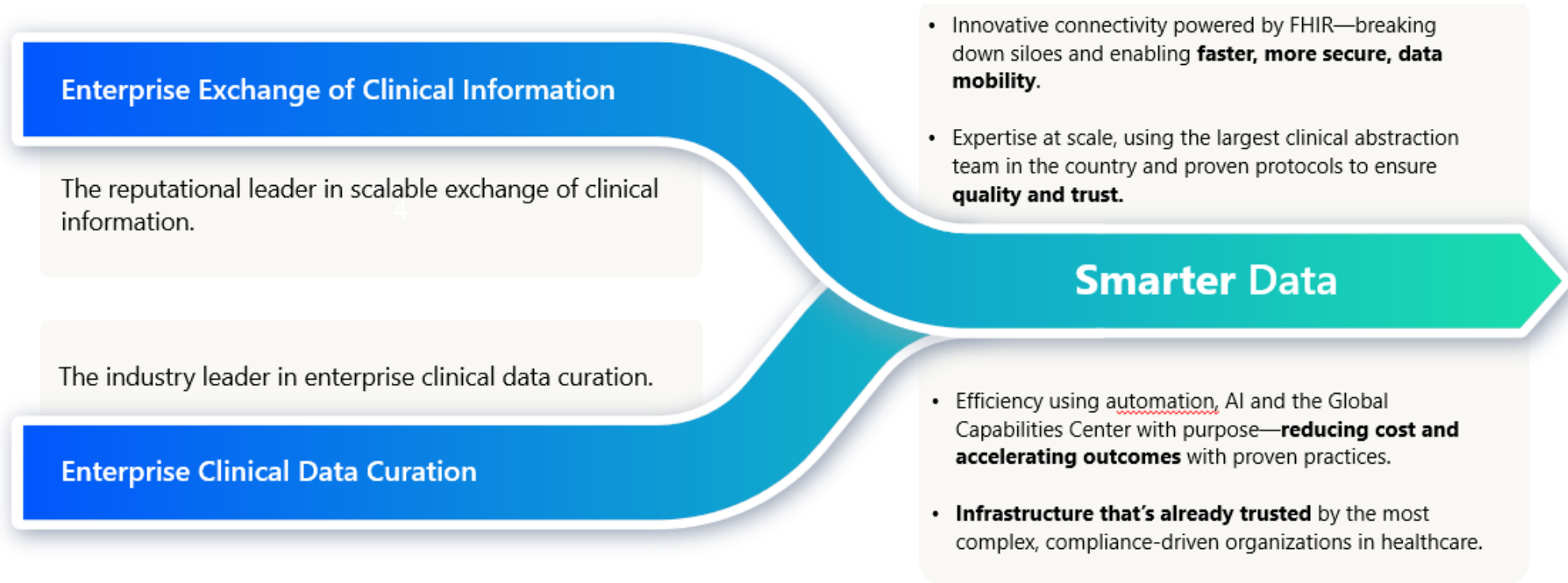
The One Source for Smarter Data Across the Healthcare Ecosystem



Q-Centrix is Now Part of MRO



Now that Q-Centrix has joined MRO, our combined solutions elevate the value of clinical data across healthcare organizations and provide system-wide visibility that powers better decisions, stronger performance, and new opportunities for innovation and growth. *The single source for smarter data.*



CMS Quality Payment Program Overview

What is the CMS Quality Payment Program



Encourage better care and patient experience.

Reward efficient, high-value care.

Promote secure, interoperable health data.

Reduce wasteful variation across the system.

CMS Quality Payment Program Overview



- 1) The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). Under MIPS, you earn a payment adjustment for Medicare Part B-covered professional services based on our evaluation of your performance across different performance categories.
- 2) There are **3 MIPS reporting options** available in 2025 to MIPS eligible clinicians to meet MIPS reporting requirements that can report as individuals, groups, virtual groups, AMP Entities, or third-party intermediaries.

Traditional MIPS

This is the original MIPS reporting options and your performance is measured across 4 areas ~ quality, improvement activities, Promoting Interoperability and cost

- Select quality measures and improvement activities from the complete MIPS inventory
- Report the complete Promoting Interoperability measure set
- CMS collects and calculates data for the cost performance category for you

MIPS Value Pathways (MVPs)

This is the newest option for meeting your MIPS reporting requirements, offering clinicians subsets of measures and activities relevant to a given specialty or medical condition

- MVPs offer more meaningful groupings of measures and activities to provide a more connected assessment of the quality of care
- Once registered, clinicians select from the quality measures and activities available within their selected MVP
 - Population health measures are scored as part of the quality performance category
- Report the complete Promoting Interoperability measure set
- Will be scored on every cost measure available in their selected MVP for which they meet case minimum

APM Performance Pathway (APP)

This streamlined reporting option, with a predefined measure set, is only available to MIPS APM participants

- The APP is designed to reduce reporting burden and encourage participation in APMs

Eligibility Highlights



- [Determine MIPS Eligibility](#)
- The low-volume threshold must be met. You exceed the low-volume threshold if you:
 - Bill more than \$90,000 for Medicare Part B covered professional services, and
 - See more than 200 Medicare Part B patients, and
 - Provide more than 200 covered professional services to Medicare Part B patients.
- The determination period for 2025 Performance Year is from October 1, 2023 - September 30, 2024 (historical period) and October 1, 2024, to September 30, 2025.


Types of Clinicians who are eligible to report:





- Doctors of Medicine
- Osteopathy
- Dental Surgery
- Dental Medicine
- Podiatric Medicine
- Optometry
- Osteopathic Practitioners
- Chiropractors
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Registered Dietitians or Nutrition Professionals
- Clinical Social Workers
- Certified Nurse Midwives


How It Works



 The Eligible Provider (EP) submits data for the following categories: Quality, Promoting Interoperability Measures, and Improvement Activities, that are collected during the Performance Year (PY) January 1st – December 31st.

 CMS will collect and calculate the Cost measures category for the EP.

 The 4 performance categories are scored and make up the EP's MIPS final score. The final score determines the payment adjustment applied to the EP's Medicare Part B claims.

 Each category is assigned a weight by CMS.

Category Name	Category weight assigned by CMS*
Quality**	30%
Promoting Interoperability**	25%
Improvement Activities**	15%
Cost	30%

**This standard weighting for the Traditional MIPS and MVP reporting options.*

*** Can change if certain CMS approved conditions are met.*

****The Cost Category is collected and calculated by CMS, and vendors have no impact or influence over them.*

Reporting Requirements - Traditional MIPS



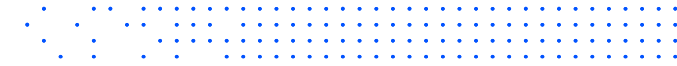
- **Quality** – report 6 measures (one measure must be an outcome measure. If an outcome measure is not available, then a High Priority measure must be reported). Data for each measure should be for the 12-month performance period (January 1-December 31) for the reporting year.
- **PI** – Report all measures (unless exclusions claimed) for a period of minimum 180 consecutive days in the reporting year. Clinicians automatically exempt from the category and other categories reweighted are non-patient facing clinicians, small practices, ASC-based, or hospital-based.
- **IA** – Beginning in 2025, category is no longer assigned weights. Report 2 activities for a minimum of 90 consecutive days in the reporting year. Clinicians with certain special statuses have reduced reporting requirements.
- **Cost** – Calculated by CMS.

Reporting Requirements - MVP



- **Quality** – 4 measures within the MVP (one must be an outcome measure. If an outcome measure is not available, then a High Priority measure must be chosen). Data for each measure should be for the 12-month performance period (January 1- December 31, 2024).
- **PI** – Report all measures (unless exclusions claimed) for a period of minimum 180 consecutive days in the reporting year. Clinicians automatically exempt from the category and other categories reweighted are non-patient facing clinicians, small practices, ASC-based, or hospital-based.
- **IA** – Beginning in 2025, category is no longer assigned weights. Report 2 activities for a minimum of 90 consecutive days in the reporting year. Clinicians with certain special statuses have reduced reporting requirements.
- **Cost** – Calculated by CMS.
- Unlike the MIPS reporting option, if you plan to participate in MVPs, you must register with CMS by November 30th.

Reporting Requirements - APP



- **Quality** – Collect data for a set of 6 measures (3 CQMs/eCQMs/Medicare CQMs + 1 CAHPS + 2 Administrative Claims Based Measures) for the 12-month performance period (January 1- December 31, 2024). MSSP ACO's are required to report the new APP Plus quality measure set. Providers need to register for reporting 1 CAHPS (Consumer Assessment of Healthcare Providers & Systems)* measure as well.
- **PI** – Report all measures (unless exclusions claimed) for a period of minimum 180 consecutive days.
- **IA** – No reporting required. Automatic full credit.
- No Cost category considered for APP



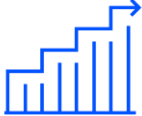

*MRO is not an approved CAHPS vendor.

MIPS Performance Category Performance Periods



What is a Performance Period Under MIPS?

A performance period is the length of time that you're required to collect data for a specific MIPS performance category

Performance Category	Performance Periods for 2025
 Quality	12 months
 Cost (Traditional MIPS and MVPs)	12 months
 Improvement Activities	90 days (per activity)
 Promoting Interoperability	180 days

Note: Most improvement activities have a continuous 90-day performance period minimum per activity, but several improvement activities require completion of modules where there's a year-long or alternate performance period. The performance period for improvement activities is 90 days, unless otherwise stated in the activity description and in the [MIPS Data Validation Criteria](#)

Source: [Traditional MIPS Overview - QPP](#)

Performance Threshold and Payment Adjustments



The **performance threshold** for the 2025 performance year will remain at **75 points**

Performance Threshold for 2024*

- The performance threshold is set at **75 points**
- This is the minimum final score needed to avoid a negative payment adjustment in the 2024 performance year
- We'll compare your final score to the performance threshold to determine your payment adjustment

2026 Payment Adjustment is based on 2024 Final Score	
2024 Final Score	2026 Payment Adjustment
75.01-100 points	• Positive adjustment greater than 0%
Performance Threshold: 75 points	• Neutral payment adjustment (0%)
18.76 – 74.99 points	• Negative payment adjustment between -9% and 0%
0 – 18.75 points	• Negative payment adjustment of - 9%

Source: <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2962/2025-MIPS-Payment-Adjustment-User-Guide.pdf>

Polaris Overview



About Polaris

Polaris is a CMS-approved Qualified Registry (QR) that simplifies, automates, and optimizes clinical data quality reporting for a broad range of practices.



Supports **over 200** Quality Payment Programs (QPPs) and electronic Clinical Quality Measures (eCQMs)

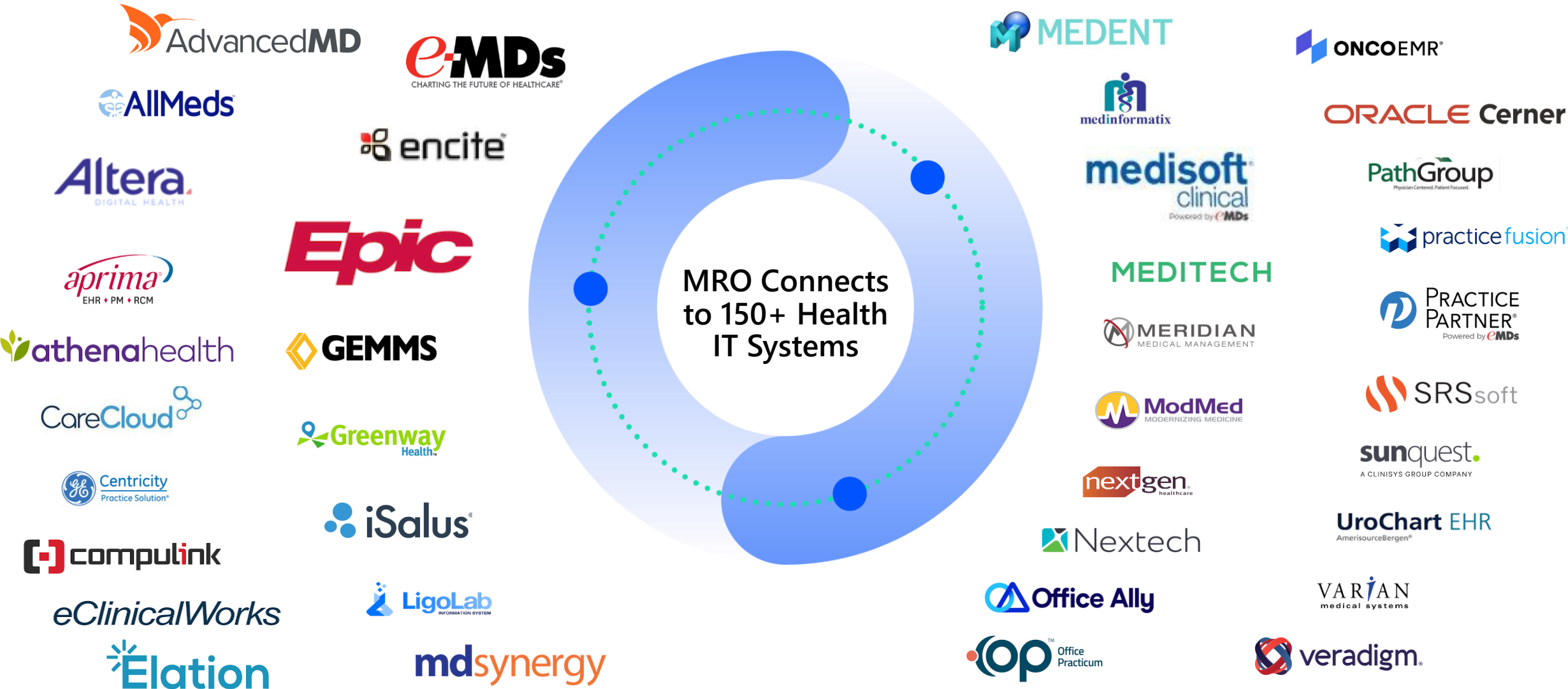


Accommodates **all specialties** and facilitates MIPS reporting, MVPs, and Accountable Care Organization (ACOs) submissions.



MRO has helped **40,000+ providers** with their MIPS submission in last three years.

One of MRO's key strengths is its extensive connectivity. We are connected to 150+ Health IT systems, made up of EHRs, practice management, and lab information systems.



Compare Performance Against Benchmarks

Polaris Dashboard (Landing Page)



TOUR



Quality Performance Dashboard

Practice: 1011 - DeliveryQA Polaris TEST ...

PRACTICE CLINICIANS (13) LOCATIONS (40)

2024 All Measures 01-01-2024 12-31-2024 CHANGE

Practice selected measures ALL Favorites EXPORT ALL

Updated on: Feb 7th, 2024 10:53 Data available till: Jun 18th, 2024

FAVORITE	ID	MEASURE		ACHIEVED PERFORMANCE	DC		
	ECQM122V7	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) Verification in Progress	M ⓘ 📄 ↓	<div style="border: 2px solid blue; padding: 2px;">37.82%</div> 43.53%	0 %	0 %	👤 EXPORT ▾
	ECQM128V7	Anti-depressant Medication Management Measure Operational	M ⓘ 📄 ↑	0% 78.6%	58.19 %	100 %	👤 EXPORT ▾ ▾
	QPP130	Documentation of Current Medications in the Medical Record Verification in Progress	M ⓘ 📄 ↑	91.24% 90.69%	0 %	100 %	👤 EXPORT ▾
	QPP137	Melanoma: Continuity of Care – Recall System Verification in Progress	M ⓘ 📄 ↑	87.2% 96.54%	0 %	0 %	👤 EXPORT ▾
	QPP238	Use of High-Risk Medications in Older Adults Verification in Progress	M ⓘ 📄 ↓	0%	78.51 %	100 %	👤 EXPORT ▾ ▾
	ECQM137V7	Initiation and Engagement of Substance Use Disorder Treatment	M ⓘ 📄 ↑	0%	73.35 %	100 %	👤 EXPORT ▾ ▾

Easily Identify Gaps with Met/Not Met Drill Downs



< 1011 - DeliveryQA Polaris TEST SI integration



Achieved Performance **84.42%** CMS Benchmark **78.6%** Registry Average **0%**



ECQM128V7_1 Anti-depressant Medication Management



PERFORMANCE TREND CLINICIANS (13) LOCATIONS (40) All



You have selected custom duration from [Jan 1st 2024](#) to [Dec 31st 2024](#)



DEN	DEN EXCL	DEN EXPT	NUM	NUM EXCL	MET	NOT MET	DC NOT MET	PR
<u>459</u>	<u>28</u>	<u>1</u>	<u>363</u>	<u>0</u>	<u>363</u>	<u>67</u>	<u>0</u>	84.42 %

DEN: Denominator, DEN EXCL: Denominator Exclusion, DEN EXPT: Denominator Exception, NUM: Numerator, NUM EXCL: Numerator Exclusion, DC NOT MET: Data Completeness Not Met, PR: Performance Rate

Aneysha	T	Larson	TM_0qJ3_1100 1000	female	08/12/1909
Angala	N	Satterfield	TM_QXnL_1100 1000	male	06/18/1964
Angelith	J	Schumm	TM_NiHe_1100 1000	female	12/31/2007
Anjel-Lee	S	Moen	TM_ctXn_1100 1000	female	12/22/1959
Aransa	D	Nolan	TM_leAq_1100 1000	female	04/15/1982
Arawan	S	Langworth	TM_2rOJ_1100 1000	male	01/19/1999
Ariyelle	R	King	TM_i5bu_11001 000	female	03/11/1942
Aurora	L	Quigley	TM_MlpW_110 01000	male	12/03/1946

Show 10 Records per page

Records 1-10 of 67 « « 1 2 3 4 5 » »

Track Estimated Performance by Category

Polaris MIPS Dashboard



Switch To: **Group Reporting** Practice: **1011 - DeliveryQA Polaris TEST SI integra...** Performance Year: 2024

Quality, PI and IA contribute to 70 points, the performance threshold is 75 points. Click on 'Refresh Score' to see the most recent score updates.

TIN ⓘ	MIPS ELIGIBILITY	SETTINGS	DRCF STATUS	QUALITY	PI	IA	TOTAL ESTIMATED SCORE ⓘ	SUBMISSION ⓘ
000000011	✓	⌵	📄	🚨 14.93/40	NA	🚨 30.00/30	44.93	SUBMIT

Total Records: 1

Let Us Know if you want a full, dashboard demo!



Multiple Plans to Meet Your Needs

2025 Plans	mBronze (manual data entry)	eGold	ePlatinum	eDiamond
Measure Selection	All Quality measures	Up to 6 measures	Up to 10 measures	MVP included

Features

- All Promoting Interoperability (PI) measures
- All Improvement Activities (IA)
- Patient level drill down
- 24x7 accessible performance dashboard
- MIPS/MVP dashboard with estimated score predictor for all the Quality, PI and IA categories

Q&A with Amy and Heather

Thank You!

Questions?

If you are a Q-Centrix partner, contact your
Partner Success Advisor

-OR-

Email us at
info@q-centrix.com