Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2024 Quality Performance Category Quick Start Guide

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Purpose:

This resource focuses on the quality performance category, providing the high-level requirements and practical information about quality measure selection, data collection, and submission for the 2024 performance period for individual, group, virtual group, subgroup, and Alternative Payment Model (APM) Entity participation. This resource doesn't address quality requirements under the APM Performance Pathway (APP).

Already know what MIPS is?

Skip ahead by clicking the links in the Table of Contents.

How to Use this Guide

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

The Table of Contents is interactive. Click on a Chapter in the Table of Contents to read that section. You can also click on the icon on the bottom left to go back to the Table of Contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

OVERVIEW

What is the Merit-based Incentive Payment System?

The Merit-based Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

If you're eligible for MIPS in 2024:

- You have to report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances or hardship exception. Detailed information will be available in the forthcoming 2024 Traditional MIPS Scoring Guide, 2024 APP Scoring Guide and 2024 MIPS Value Pathways Implementation Guide. These will be posted to the QPP Resource Library.
- We collect and calculate data for the cost performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances and whether or not you meet case minimum for any cost measures.
- 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 2024 final score above 75.
  - Neutral payment adjustment for clinicians with a 2024 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2024 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

Quality Payment PROGRAM

To Learn More About MIPS Eligibility And Participation Options:

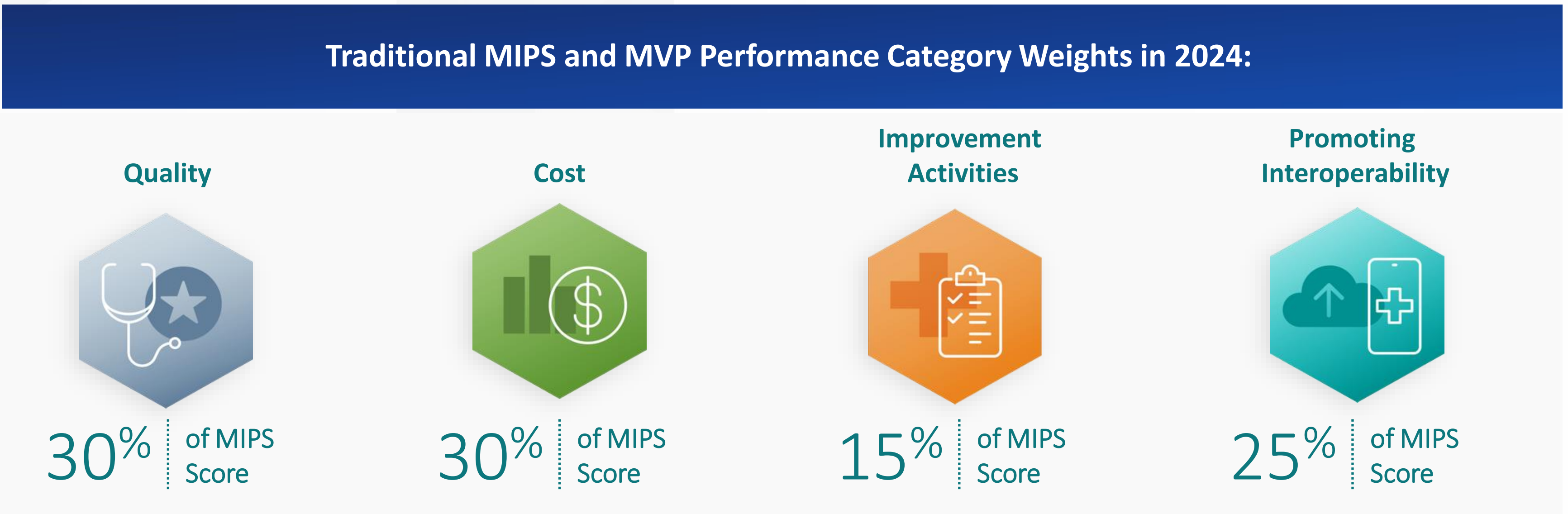
- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

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.

Individual, Group, Subgroup*, and Virtual Group** Participation

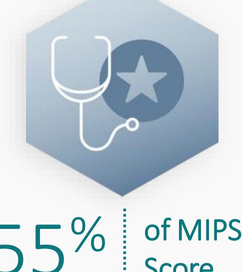


*Available for MVP reporting only.
**Available for Traditional MIPS reporting only.

APM Entity Participation

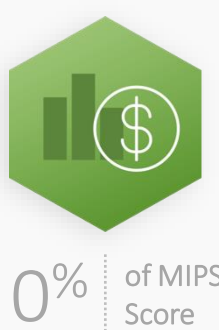
Traditional MIPS and MVP Performance Category Weights in 2024:

Quality



55% of MIPS Score

Cost



0% of MIPS Score

Improvement Activities

15% of MIPS Score

Promoting Interoperability

30% of MIPS Score

Standard Weighting for Small Practices

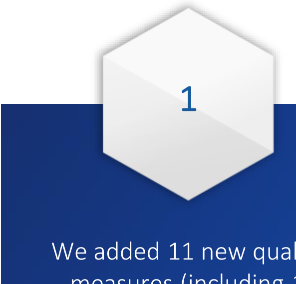
(Promoting Interoperability Automatically Reweighted to 0%)

Traditional MIPS and MVP Performance Category Weights in 2024:

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

What's New with Quality in 2024?

Updates to Quality Measure Inventory



We added 11 new quality measures (including 1 composite measure), removed 11 quality measures from traditional MIPS, and partially removed 3 quality measures (removed from traditional MIPS, but retained for MVPs).

There were 59 existing quality measures with substantive changes, 3 of which won't have a historical benchmark because the changes were so significant that it won't allow for a direct comparison of performance data from prior years to performance data submitted for the 2024 performance period.

For the 2024 performance period, the **data completeness threshold increased to 75%** and will remain at the 75% threshold for the 2025 and 2026 performance periods.

For more information on the new and removed quality measures, please review the Appendix.

This resource examines the quality performance category under traditional MIPS and MVPs.

- For more information about the quality performance category **under the APP**, please refer to the APP Quality Requirements webpage.

What's New with Quality in 2024? (Continued)

Updates to Quality Measures

1

- We're **requiring registered groups, virtual groups, subgroups, and APM Entities** to contract with a CAHPS for MIPS Survey vendor **to administer the Spanish translation of the survey** to Spanish-preferring patients.
  - We're also recommending that registered groups, virtual groups, subgroups, and APM Entities administer the other available translations of the CAHPS for MIPS Survey based on the language needs of their patients.

2

- We modified the criteria used to assess the impact of ICD-10 coding updates to quality measures:
  - **Eliminated the automatic 10% threshold** of coding changes that triggers measure suppression or truncation.
  - **Added a provision that allows us to assess the impact of coding changes on a case-by-case basis** (i.e., assess if coding changes are substantive, particularly to determine whether the coding changes impact the numerator, denominator, exceptions, or exclusions, or other elements that would change the scope or intent of a measure).
  - **Added a provision that allows us to assess each collection type separately** of a given measure to determine the appropriate action to take for a measure impacted by an ICD-10 coding update.

Get Started with Quality in 5 Steps

Get Started with Quality in 5 Steps

Step 1	Step 2	Step 3	Step 4	Step 5
Understand Your Reporting Requirements	Review & Select Your MIPS Quality Measures	Collect Your Data	Submit Your Data	Review Performance Feedback
Any time	Any time	January 1 - December 31, 2024	January 2 – March 31, 2025	Preliminary Feedback: Once Data is Submitted Final Feedback: Summer 2025

Step 1. Understand Your Reporting Requirements

The quality performance category has a **12-month performance period** (January 1 – December 31, 2024), which means you must collect data for each measure for the full calendar year. Your quality reporting requirements are determined by your MIPS reporting option.

Traditional MIPS	MVPs
Select a minimum of 6 quality measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. OR Report 1 **complete specialty measure set.** Did you know? • If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set.	**Select a minimum of 4 quality measures** (including 1 outcome or high priority measure) from your chosen MVP. Did you know? • For small practices reporting through Medicare Part B claims, if your selected MVP includes fewer than 4 Medicare Part B claims measures available, you don't need to report additional measures to meet quality reporting requirements.

Helpful Hints and Reminders:

- If you report more than the required number of quality measures, we'll pick the highest scored outcome measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.

Did you know? Facility-based clinicians, groups, and virtual groups whose assigned facility has a Fiscal Year (FY) 2025 Hospital Value-Based Purchasing (VBP) Program score may have the option to use their Hospital VBP Program score for the traditional MIPS quality and cost performance categories. **However, we won't calculate a facility-based score at the subgroup level.** For more information on facility-based measurement, please refer to the 2024 Facility-Based Measurement Quick Start Guide.

Step 2. Review & Select Your MIPS Quality Measures

Your quality measure options are determined by your MIPS reporting option.

Traditional MIPS	MVPs
There are 198 MIPS quality measures available to report for the 2024 performance period, as well as 212 Qualified Clinical Data Registry (QCDR) measures approved outside the rulemaking process.	Each MVP includes a subset of quality measures that best align with a given specialty or medical condition. Review Explore MVPs for details about the quality measures available in each MVP.

Helpful Hints and Reminders:

- Review your patient population to ensure you'll be able to meet the case minimum requirement (20 cases) on the quality measures you choose to report. You'll earn 0 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark. Small practices will continue to earn 3 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark.
- There are no bonus points available for reporting additional outcome and high priority measures or measures that meet end-to-end electronic reporting criteria.
- You can report measures from multiple collection types to meet quality reporting requirements.
- You can report your quality measures through multiple submission formats (e.g., JSON and QRDA III files).

Step 2. Review & Select Your MIPS Quality Measures (Continued)

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 specification (instructions) for reporting that measure. 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 the Elderly. This measure is available as both a MIPS Clinical Quality Measure (CQM) and Electronic Clinical Quality Measure (eCQM) (distinct specifications). You would use the measure specification that corresponds with how you choose to collect your data.

Collection Type	Quality Measures Available for 2024	What Do You Need to Know About This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2024 eCQM specifications 2024 eCQM flows eCQM Implementation and Preparation Checklists	You can report eCQMs if you use technology that meets the Certified Electronic Health Record Technology (CEHRT) certification from the Office of the National Coordinator for Health Information Technology (ONC) by the time eCQM data is generated for submission. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. Please refer to the Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) website to verify.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2024	What Do You Need to Know About This Collection Type?
Electronic Clinical Quality Measures (eCQMs) (continued)		If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted.
MIPS Clinical Quality Measures (MIPS CQMs)	2024 Clinical Quality Measure Specifications and Supporting Documents 2024 Qualified Clinical Data Registries Qualified Posting 2024 Qualified Registries Qualified Posting	MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you choose this collection type, you may choose to work with a QCDR, Qualified Registry, Health IT vendor, or you can submit them yourself.
Qualified Clinical Data Registry (QCDR) Measures	2024 QCDR Measure Specifications 2024 Qualified Clinical Data Registries Qualified Posting	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures, which are approved along with the entity during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that feel relevant to their practice. You'll need to work with a QCDR to report these measures on your behalf.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2024	What Do You Need to Know About This Collection Type?
Medicare Part B Claims Measures	2024 Medicare Part B Claims Specifications and Supporting Documents 2024 Part B Claims Reporting Quick Start Guide	Medicare Part B claims measures are reported with the clinician's individual (rendering) NPI when reporting as a group, virtual group, subgroup, or APM Entity.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Measure	2024 CAHPS for MIPS Survey Overview Fact Sheet (available on the Quality Payment Program Resource Library in March 2024)	Groups, virtual groups, subgroups, and APM Entities can register between April 1, 2024, and July 1, 2024, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience of care within a group, virtual group, subgroup, or APM Entity. This survey measure must be administered by a CMS-approved survey vendor.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2024	What Do You Need to Know About This Collection Type?
Administrative Claims Measures	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Eligible Clinician Groups Risk-Standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	We calculate administrative claims measures automatically; no additional data submission required outside of routine billing. In traditional MIPS reporting, we evaluate you on every administrative claims measure in the MIPS inventory, and we score you on any measure for which you meet the criteria. In MVP reporting, we evaluate you on the population health measure you select during registration. You also have the option to select an outcomes-based administrative claims measure as 1 of your 4 required measures if available in your selected MVP.

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures)

Note: The data completeness threshold will remain at 75% for the 2025 and 2026 performance periods.

You should start data collection on **January 1, 2024**, to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive **0 points** for the measure, unless you're a small practice, in which case you'll receive 3 points.

NEW: The **data completeness requirement has increased to a threshold of 75%** for the 2024 performance period. Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, numerator exclusions, or denominator exceptions) for at least 75% of the eligible population (excluding denominator exclusions).

Selectively reporting data that misrepresents your performance in a disingenuous manner, commonly referred to as **"cherry-picking,"** results in data that aren't true, accurate, or complete and may subject you to an audit.

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.

Aggregation of Data using an EHR

If you transition from one EHR system to another EHR system during the performance period, you should aggregate the data from the previous EHR system and the new EHR system into one report for the full 12 months prior to submitting the data. If a full 12 months of data is unavailable (for example, if aggregation isn't possible), your data completeness must reflect the 12-month period.

During the 2024 performance period, the EHR system(s) must use technology that meets the CEHRT certification from ONC by the time eCQM data is generated for submission.

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures) (Continued)

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
    - These errors include, but are not limited to:
        - Changes to the active status of codes.
        - The inadvertent omission of codes.
        - The inclusion of inactive or inaccurate codes.
- Updates to ICD-10 codes during the performance period.
    - We publish a list of measures requiring 9 consecutive months of data to be reported on the Quality Payment Program Resource Library by October 1st of the performance period (if technically feasible), but no later than the beginning of the data submission period (for example, January 2, 2025, for the 2024 performance period).
    - Clinical guideline changes.
- Updates to measure specifications during the performance period.

For a quality measure impacted by one of the above items, the **quality measure will have a truncated performance period of 9 consecutive months if there are 9 consecutive months of accurate, available data.**

If there aren't 9 consecutive months of available data and revised clinical guidelines, measure specifications or codes impact a clinician's ability to submit information on the measure, the **measure will be suppressed.**

Step 4. Submit Your Data

We'll assess your performance on the data you submit. If you plan to report an MVP, you're required to include your MVP ID (and subgroup ID if applicable) with your submission.

The data submission period will begin on **January 2, 2025**, and end on **March 31, 2025**. If reporting Medicare Part B claims measures, submission will be continuous throughout the performance period.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Individual, Group, Virtual Group, Subgroup, or APM Entity Representative)	Medicare Part B claims Measures (small practice only)	Through your routine Medicare Part B billing practices	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2025)
	eCQMs	Sign in to the QPP website and upload a QRDA III file	January 2 – March 31, 2025
	MIPS CQMs	Sign in to the QPP website and upload a QPP JSON file	January 2 – March 31, 2025
Third Party Intermediaries QCDRs, Qualified Registries, and Health IT Vendors	eCQMs MIPS CQMs QCDR Measures	Sign in to the QPP website and upload a QRDA III or QPP JSON file **OR** Use the QPP Submission Application Programming Interface (API)	January 2 – March 31, 2025
CMS-Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of the QPP website	Following data collection (standardized annual timeframe)

Step 4. Submit Your Data (Continued)

Did you know?
The level at which you participate in MIPS (individual, group, virtual group, subgroup, or APM Entity) generally applies to all performance categories. We won't combine data submitted at the individual, group, virtual group, subgroup, and/or APM Entity 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 data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all performance categories, but your MIPS payment adjustment will be based on the higher score.

Exception:
- When participating as an APM Entity, the Entity will submit quality measures (and improvement activities if reporting traditional MIPS or an MVP). MIPS eligible clinicians in the Entity may submit Promoting Interoperability data as individuals or as a group and we will calculate an average score for this performance category. However, APM Entities also have the option to choose to report Promoting Interoperability data at the APM Entity level.

NOTE: You can't combine performance data submitted between different reporting options into a single final score or submit performance data for one category and count it for both traditional MIPS and MVP reporting options.

For example, Promoting Interoperability data can't be reported for traditional MIPS and count towards the Promoting Interoperability category for an MVP. The Promoting Interoperability data may be the same, however, there must be 2 separate submissions: one for traditional MIPS and one for MVP reporting (with the appropriate MVP identifier and subgroup identifier, if applicable).

Note: We'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data for another category as a group (signaling their intent to participate as a group).

IMPORTANT: Each MVP submission must include the related MVP ID, signaling your intent to report the measure data for your selected MVP. **Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of the MVP.** If participating through a subgroup, you'll also need to include the subgroup identifier given to you by CMS for your MVP submission.

For a list of MVP identifiers to add to your MVP submission, please review Appendix E.

Step 5. Review Your Performance Feedback

- Measure- and activity-level scores will be available starting on **January 2, 2025,** once data has been submitted.
- Your MIPS final score will be available in **early Summer 2025**, and payment adjustment information will be available in **Summer 2025**. The Targeted Review period will open in **early Summer 2025** when final scores are released and close 30 days after the release of your payment adjustment information in **late Summer 2025**.
- You can review your performance feedback by signing in to QPP website.
- In addition to your final score and payment adjustment, MVP participants will receive "MVP Comparative Feedback." MVP comparative feedback will highlight how your performance compares at the category level to other clinicians reporting the same MVP.

Did you know?

- Small practices (15 or fewer clinicians, reporting individually, as a group, virtual group, subgroup, or APM Entity) that submit at least one quality measure will continue to earn 6 bonus points, which will be added to their quality performance category score.

Help and Version History

Help 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.

Help, Resources, and Version History

Version History

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

DATE	DESCRIPTION
03/09/2024	Updated language on slides 6 and 24 for accuracy and clarity.
01/08/2024	Original Posting.

Appendix

Appendix A: New Measures Finalized for the 2024 Performance Period and Future Years

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
495	MIPS CQM	Patient-Reported Outcome-based Performance	Ambulatory Palliative Care Patients’ Experience of Feeling Heard and Understood
496	MIPS CQM	Process	Cardiovascular Disease (CVD) Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument
497	MIPS CQM	Process	Preventive Care and Wellness (Composite)
498	MIPS CQM	Process	Connection to Community Service Provider
499	MIPS CQM	Process	Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy
500	MIPS CQM	Process	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
501	MIPS CQM	Process	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
502	MIPS CQM	Patient-Reported Outcome-based Performance	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

Appendix A: New Measures Finalized for the 2024 Performance Period and Future Years (Continued)

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
503	MIPS CQM	Patient-Reported Outcome-based Performance	Gains in Patient Activation Measure (PAM®) Scores at 12 Months
504	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behaviors, or Suicide Risk
505	MIPS CQM	Patient-Reported Outcome-based Performance	Reduction in Suicidal Ideation or Behavior Symptoms

Appendix B: Measures Finalized for Removal Starting with the 2024 Performance Period

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
014	MIPS CQM	Process	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
093	MIPS CQM	Process	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
107	eCQM	Process	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
110	Medicare Part B Claims eCQM MIPS CQM	Process	Preventive Care and Screening: Influenza Immunization
111	Medicare Part B Claims eCQM MIPS CQM	Process	Pneumococcal Vaccination Status for Older Adults
138	MIPS CQM	Process	Melanoma: Coordination of Care
147	Medicare Part B Claims MIPS CQM	Process	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
283	MIPS CQM	Process	Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management
324	MIPS CQM	Efficiency	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
391	MIPS CQM	Process	Follow-Up After Hospitalization for Mental Illness (FUH)
402	MIPS CQM	Process	Tobacco Use and Help with Quitting Among Adolescents

Appendix C: Measures Finalized for Removal from Traditional MIPS (Retained for MVPs) Starting with the 2024 Performance Period

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
112	Medicare Part B Claims, eCQM and MIPS CQM	Process	Breast Cancer Screening
113	Medicare Part B Claims, eCQM and MIPS CQM	Process	Colorectal Cancer Screening
128	Medical Part B Claims, eCQM and MIPS CQM	Process	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan

Appendix D: Measures with Substantive Changes Finalized for the 2024 Performance Period, Resulting in No Historical Benchmark for the 2024 Performance Period

MIPS Quality ID	Collection Type	Measure Type	MIPS Quality Measure Title
052	MIPS CQM	Process	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation for Long-Acting Inhaled Bronchodilator Therapy
400	MIPS CQM	Process	One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation
438	eCQM MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Appendix E: MVP Identifiers

MVP ID	MVP Title
G0057	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
M001	Advancing Cancer Care
G0055	Advancing Care for Heart Disease
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0058	Improving Care for Lower Extremity Joint Repair
M0002	Optimal Care for Kidney Health
M0003	Optimal Care for Patients with Episodic Neurological Conditions
G0059	Patient Safety and Support of Positive Experiences with Anesthesia
M0004	Supportive Care for Neurodegenerative Conditions
M0005	Value in Primary Care

Appendix E: MVP Identifiers (Continued)

MIPS Quality ID	Collection Type
M1366	Focusing on Women's Health
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1369	Quality Care in Mental Health and Substance Use Disorders
M1370	Rehabilitative Support for Musculoskeletal Care