Quality Payment
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Merit-based Incentive Payment System (MIPS)

Eligibility and Participation in the 2026 Performance Year

TO DO:

- Review the MIPS Quick Start Guide (PDF, 1MB) before you review this resource.

PURPOSE:

- This User Guide provides BASIC and DETAILED information about MIPS eligibility and participation.

The Basics

Introductory information for readers that want to:

- Learn basic concepts related to MIPS eligibility and participation.
- Find out how to check their MIPS eligibility.

The Details

More detailed information for readers that want to:

- Learn the detailed policies

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Purpose: This detailed resource focuses on eligibility determinations and participation options for the 2026 MIPS performance year, including traditional MIPS, the Alternative Payment Model Pathway (APP), and MIPS Value Pathways (MVPs).

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MIPS Overview

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What is the Merit-based Incentive Payment System?

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

If you're eligible for MIPS in 2026:

- You must 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, extreme and uncontrollable circumstances (EUC) or hardship exception. Detailed information will be available in the forthcoming 2026 Traditional MIPS Scoring Guide, 2026 APP Scoring Guide and 2026 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 the case minimum for any cost measures. Detailed information will be available in the forthcoming 2026 MIPS Cost User Guide, which will be posted on the QPP Resource Library.

DO NOW:

- Check your current participation status by entering your National Provider Identifier (NPI) on the QPP Participation Status Tool.

What is the Merit-based Incentive Payment System? (Continued)

If you're eligible for MIPS in 2026 (Continued)**:**

- 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 **2026 MIPS final score will determine your MIPS payment adjustment in the 2028 payment year**.

Your 2025 Final Score	Your 2027 MIPS Payment Adjustment
0.00 – 18.75 points	Negative MIPS payment adjustment of -9%
18.76 – 74.99 points	Negative MIPS payment adjustment, between -9% and 0%, on a linear sliding scale
75.00 points	Neutral MIPS payment adjustment (0%)
75.01 – 100.00 points	Positive MIPS payment adjustment, greater than 0% (subject to a scaling factor to preserve budget neutrality)

- Your MIPS payment adjustment is based on your performance during the 2026 performance year and applied to payments on a claim-by-claim basis for your Medicare Part B-covered professional services beginning on January 1, 2028.

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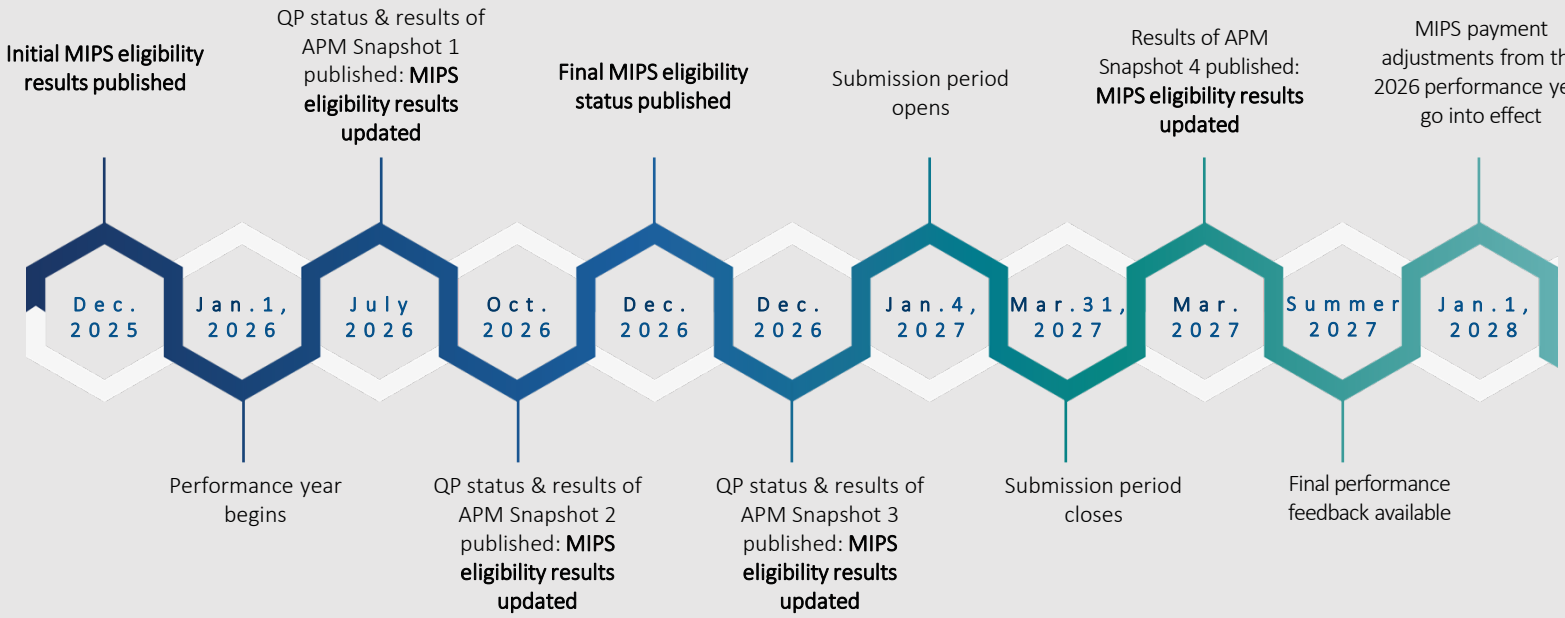
MIPS Eligibility and Participation Overview

MIPS Eligibility and Participation Timeline

Key Dates for the 2026 Performance Year



MIPS Eligibility and Participation at a Glance

What's New in 2026?

There are no changes to MIPS eligibility requirements for the 2026 performance year.

Beginning in the 2026 performance year, when reporting a MIPS Value Pathway, the group participation option is only available to single specialty practices and small practices. Multispecialty practices with more than 15 clinicians will need to register as subgroups or individuals to report an MVP beginning in the 2026 performance year.

- The group participation option remains available for all practice types when reporting traditional MIPS or the APM Performance Pathway.

How to Check Your Eligibility and Participation

To quickly assess your eligibility status, you may:

- Check your eligibility the QPP Participation Status Tool.
- Sign in to the Quality Payment Program website. You'll need a QPP account and credentials to sign in. For more information, review the Quality Payment Program Access Guide (ZIP, 4MB).

Helpful Hint

Your initial eligibility status is available until December 2026, after which your final eligibility status will be available.

Did you know?

If you work at multiple practices, you may be eligible (i.e., required to report) at one practice, but not at another.

Eligibility Basics

Your eligibility is determined by your:

- National Provider Identifier (NPI) and
- Associated Taxpayer Identification Number (TIN) or TINs.

A TIN can belong to:

- You, if you're self-employed or a solo practitioner,
- A group or practice, or
- An organization like a hospital.

When you reassign your Medicare billing rights to a TIN, your NPI becomes associated with that TIN. This association is referred to as a **TIN/NPI combination**.

If you reassign your billing rights to multiple TINs and/or bill Medicare Part B claims under multiple TINs, you'll have multiple TIN/NPI combinations. We evaluate each TIN/NPI combination for MIPS eligibility, so you'll need to check the eligibility status for each of your TIN/NPI combinations.

Your MIPS eligibility is determined by:

- ✓ Your clinician type (learn which clinician types are MIPS eligible)
- ✓ The volume of care you provide to Medicare patients (learn more about the low-volume threshold)
- ✓ The date you enrolled as a Medicare provider (before January 1, 2026, to be eligible for the 2026 performance year)
- ✓ The degree to which you participate in an Advanced APM (your Qualifying APM Participant (QP) status)

MIPS Determination Period

To determine MIPS eligibility, we review Medicare Part B claims and Provider Enrollment, Chain, and Ownership System (PECOS) data for clinicians and practices twice for each performance year. Each review analyzes a 12-month period or "segment".

- Analysis of data from the first segment is released as preliminary eligibility determinations.
- Analysis of data from the second segment is reconciled with the first segment and released as the final eligibility determination.
- Appendices 2A and 2B illustrate how eligibility is reconciled between the first and second segment.

Clinicians and practices generally **must exceed the low-volume threshold during both segments** of the MIPS Determination Period **to be eligible** for MIPS. **Exception**: Eligibility will be based solely on segment 2 data when a TIN or TIN/NPI combination is newly established during segment 2 of the MIPS Determination Period.

MIPS Eligible Clinician Types

If you're not one of the following clinician types, you're excluded from MIPS reporting:

[1] Includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry.

[2] With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

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Check Your Eligibility (Step-by-Step Instructions with Screenshots)

Option 1. Use the QPP Participation Status Tool

To use the status tool, enter a 10-digit National Provider Identifier (NPI) on the Quality Payment Program website.

- Click here for step-by-step instructions and screenshots.

This is a good option for:

- ✓ Users without credentials to sign into the QPP website (review the QPP Access Guide (PDF, 4MB) for information on getting these credentials)
- ✓ Users looking up MIPS eligibility for a limited number of clinicians, or 1 clinician who works at multiple practices (has multiple TIN/NPI combinations)
- ✓ Users who don't need low-volume threshold details (specific volume of allowed charges, number of services, number of patients) for the clinician or practice

Option 2. Sign in to the Quality Payment Program website

Groups identified by a single TIN can review and download eligibility information for all clinicians in the practice (TIN) by signing in to the Quality Payment Program website.

- Click here for step-by-step instructions and screenshots.

This is a good option for:

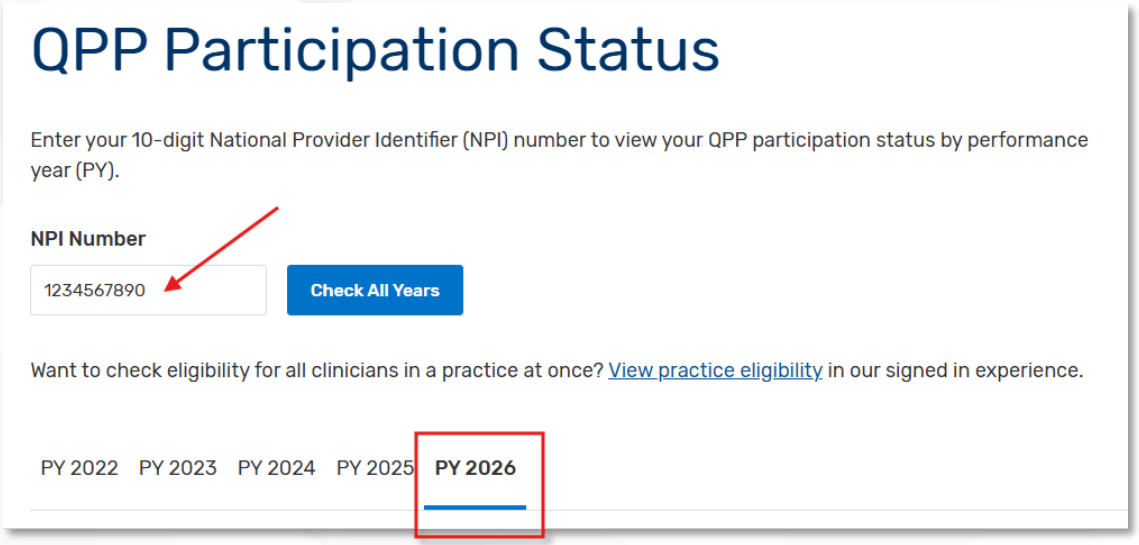
- ✓ Users with QPP credentials (a HARP ID and permission to access data for a specific practice/TIN)
- ✓ Users who want to download eligibility information
- ✓ Users who want low-volume threshold details (specific volume of allowed charges, number of services, number of patients) for the clinician or practice

Option 1. Use the QPP Participation Status Tool

Go to the QPP website to enter your NPI and check your eligibility and participation status. Make sure you're viewing "PY 2026".

As a reminder:

- Your **initial MIPS eligibility** for the 2026 performance year is **available now** (as of December 2025).
- Your **final MIPS eligibility** for the 2026 performance year will be **available by December 2026**.



Option 1. Use the QPP Participation Status Tool (Continued)

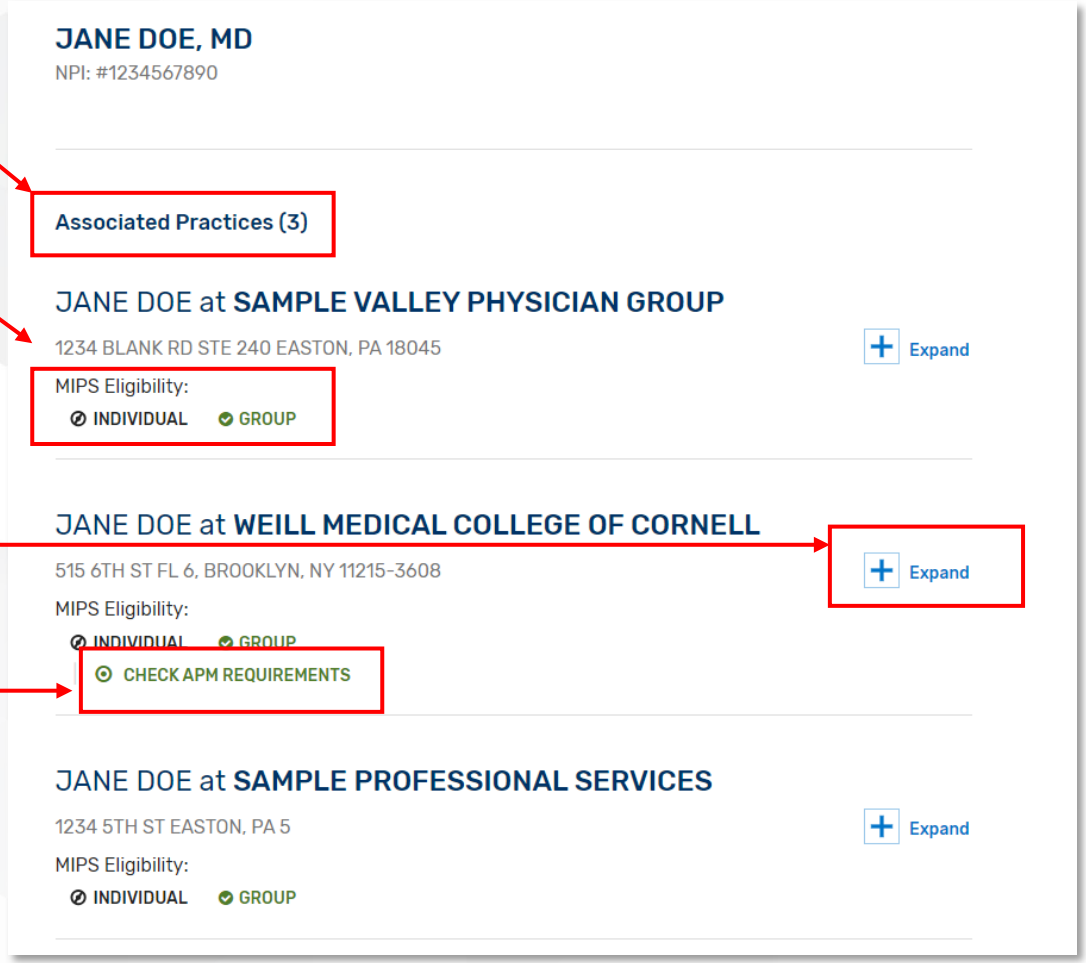
Beneath each **practice association** (defined by a TIN/NPI combination), you'll see an indicator of your **individual** and **group** eligibility statuses.

In this screenshot, Jane Doe has 3 practice associations and will need to check her eligibility at all 3.

Click the **+ Expand** option to the right of each **associated practice** name to view information about your MIPS Participation details.

Check APM Requirements

If Check APM Requirements appears below your MIPS Eligibility statuses, you're associated with an Alternative Payment Model (APM). Learn more on page 21.



Option 1. Use the QPP Participation Status Tool (Continued)

Review your **MIPS reporting requirements**, **reporting & participation options** (review pages 31 - 37 for more information), and **payment information** for each practice.

MIPS Participation

MIPS Eligibility: ✔ INDIVIDUAL ✔ GROUP

MIPS REPORTING REQUIREMENTS

This clinician is required to report because they're a MIPS eligible clinician type, enrolled in Medicare before the performance year, and exceed the individual low-volume threshold.

MIPS REPORTING & PARTICIPATION OPTIONS

This clinician can report traditional MIPS or a MIPS Value Pathway (MVP), participating as an individual or as part of a group.
If reporting an MVP, this clinician may also participate as part of a subgroup.
Advance registration required to report an MVP.

PAYMENT INFORMATION

This clinician will receive the MIPS payment adjustment associated with the highest final score available to them at this practice - from individual, group or subgroup participation.

Learn more about the MIPS reporting options and participation options.

+ Expand

Helpful Hint

You're MIPS eligible if you see a **checkmark** ✔ **and green font**

You're excluded from MIPS if you see a **no symbol** ⊘ **and black font**

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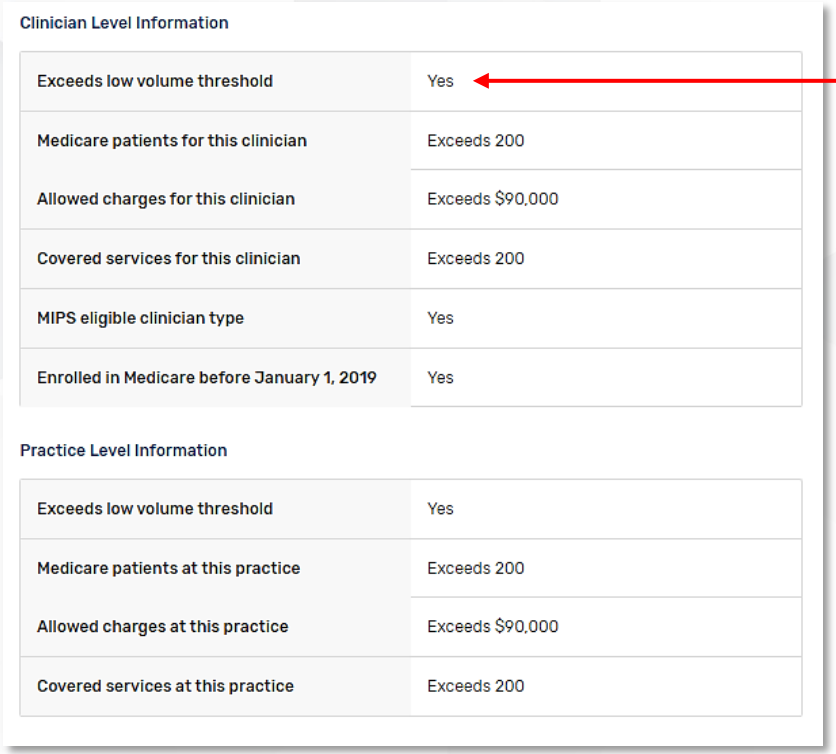
Option 1. Use the QPP Participation Status Tool (Continued)

Eligibility Information

Keep scrolling to view more information about your eligibility, including whether you meet the low-volume threshold and qualify for any special status at the **Clinician Level** (for individual participation) and the **Practice Level** (for group and subgroup* participation).
*Subgroups inherit the special status of their affiliate group; subgroups aren't independently evaluated for special status.



Clinician Level Information

Exceeds low volume threshold	Yes
Medicare patients for this clinician	Exceeds 200
Allowed charges for this clinician	Exceeds $90,000
Covered services for this clinician	Exceeds 200
MIPS eligible clinician type	Yes
Enrolled in Medicare before January 1, 2019	Yes

Practice Level Information

Exceeds low volume threshold	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Exceeds $90,000
Covered services at this practice	Exceeds 200

Helpful Hint

You'll see "Yes" when you exceed all 3 elements of the low-volume threshold.

You will see "No" if you don't exceed one (or more) of these elements.

TIP: If you sign in to the QPP website, you'll see actual patient counts, allowed charges, and number of covered services at the group level and for each clinician in the practice.

Option 1. Use the QPP Participation Status Tool (Continued)

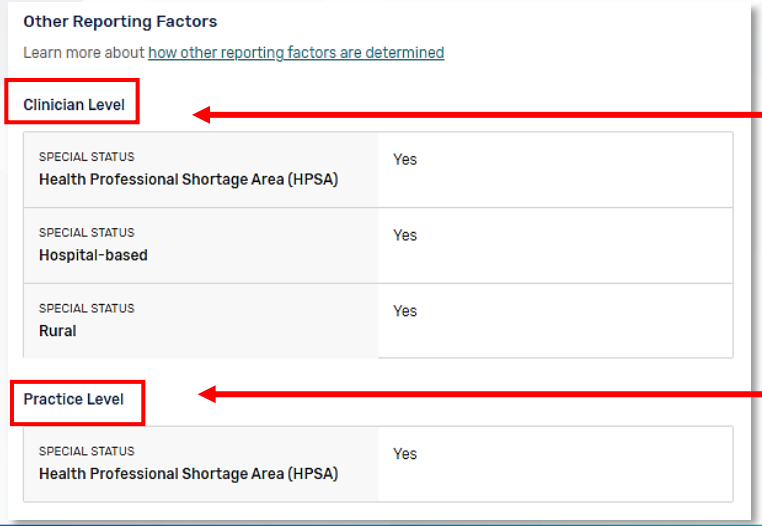
Other Reporting Factors

Special statuses can affect your MIPS participation options and reporting requirements. These statuses are determined at the clinician (unique TIN/NPI combination) level, practice (TIN) level, and virtual group level. (Subgroups inherit the special status of their affiliate group.)

- There's more information on special statuses (how they're determined and how they affect your reporting requirements) on pages 52 - 58 of this guide.

Other reporting factors, such as special status designations, only apply at the level (i.e., clinician or practice) indicated and are not transferrable to other levels.

Note: The QPP Participation Status Tool will only display other reporting factors at the clinician and practice level. You must sign in to QPP to view these factors for your virtual group.



Special statuses at the **clinician level** ONLY apply to **individual reporting**.

Example on page 58

Special statuses at the **practice level** ONLY apply to **group and subgroup reporting.**

Option 1. Use the QPP Participation Status Tool (Continued)

Check APM Requirements

We'll update the QPP Participation Status Tool to identify 2026 APM participation beginning in July 2026.

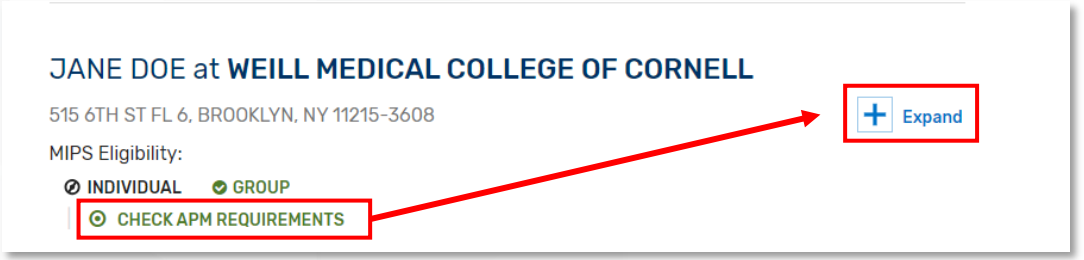
No APM participation information is available on the QPP website before July 2026.

- **July 2026:** We'll publish results from the 1st APM snapshot. (Clinicians who participate in an APM for PY2026 won't see Check APM Requirements before this update.)
- **September 2026:** We'll publish results from the 2nd APM snapshot.
- **December 2026:** We'll publish results from the 3rd APM snapshot.
- **March 2027:** We'll publish results from the 4th APM snapshot.

Learn more about APM snapshots on the QPP website.

Beginning July 2026.

1. Click **+ Expand** to find out more about your APM participation, its effect on your MIPS reporting requirements/options, and your APM reporting requirements/options.



Option 1. Use the QPP Participation Status Tool (Continued)

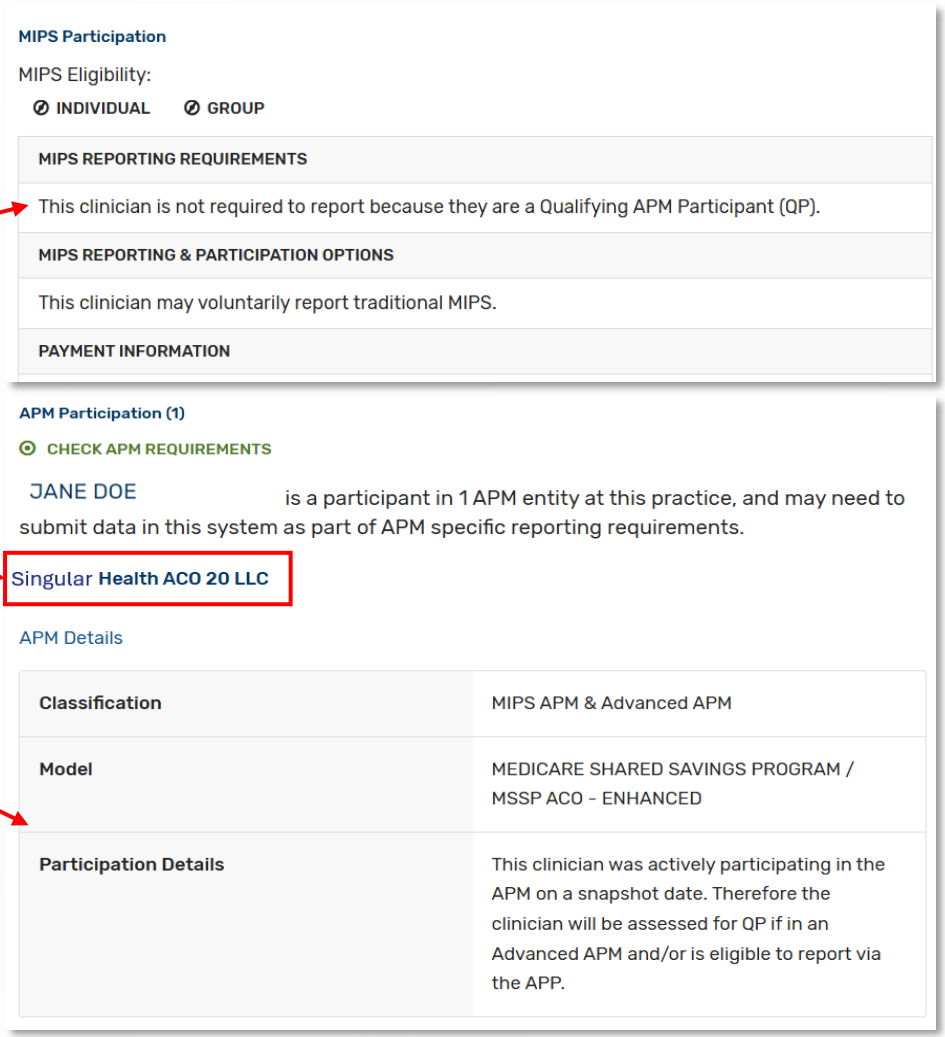
Check APM Requirements (Continued)

2. Review the information listed under **MIPS Participation**.

   MIPS Eligibility: This will indicate if your APM participation affects your MIPS reporting requirements, your MIPS reporting and participation options, as well as any applicable payment information.

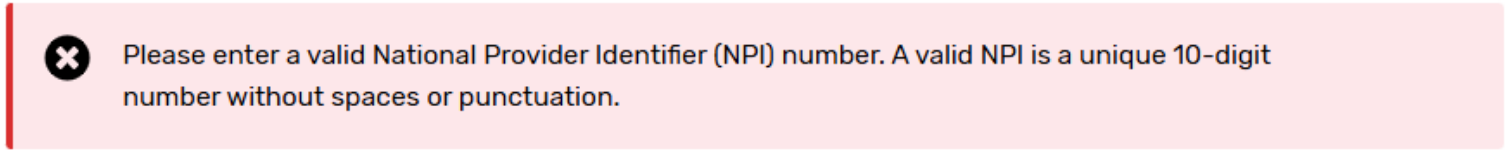
3. Scroll down to **APM Participation**

   From this section, you can view the **name** of the associated APM Entity, along with the **model and participation details**.

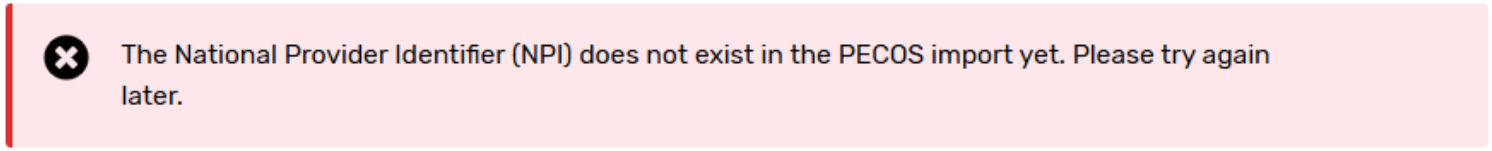


Option 1. Use the QPP Participation Status Tool (Continued)

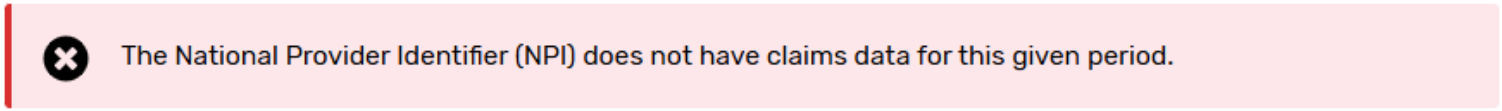
Error Messages:



If you see the message above, you've entered an invalid NPI. Try retyping the NPI.



If you see the message above, the NPI you've entered was valid, but there's no associated provider data in the most recent data imported from PECOS.



If you see the message above, the NPI you've entered was valid, but there are no Medicare Part B claims (e.g., services, patients, or charges) associated with the NPI in the most recent 12-month segment of the MIPS Determination Period.

Option 1. Use the QPP Participation Status Tool (Continued)

Don't see your current practice (TIN) listed on the status tool? This means we didn't find Medicare Part B claims data for you at this practice in segment 1 of the MIPS Determination Period.

We'll update eligibility status information by December 2026 to show clinicians who started billing Medicare Part B services under a new practice (identified by their TIN) between October 1, 2025, and September 30, 2026.

You may become MIPS eligible at a new practice when we update eligibility status information in December 2026.

Where can I learn more?

Visit the QPP website for more information about how eligibility is determined and how special status can affect how much data you need to report.

If you want to skip how to check eligibility by signing in to the QPP website, click here to skip ahead to MIPS Reporting and Participation Options.

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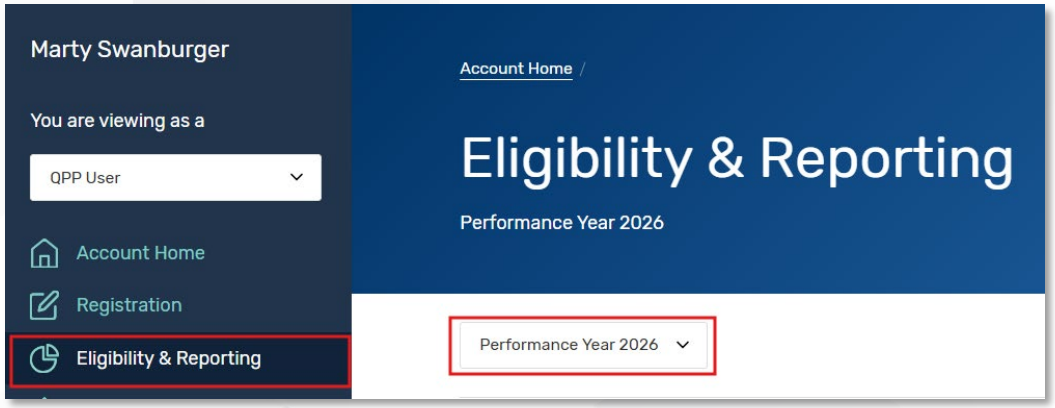
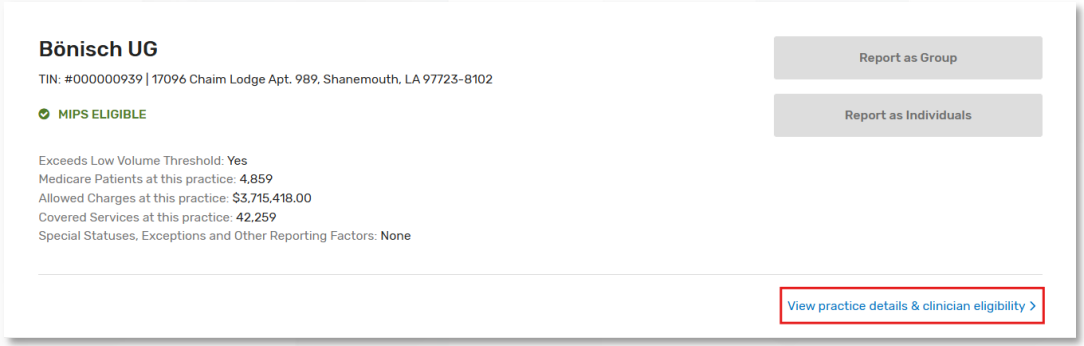
Option 2. Sign in to the Quality Payment Program website

Click Eligibility & Reporting and select “Performance Year 2026” from the drop down at the top of the page:



Click "View practice details and clinician eligibility”



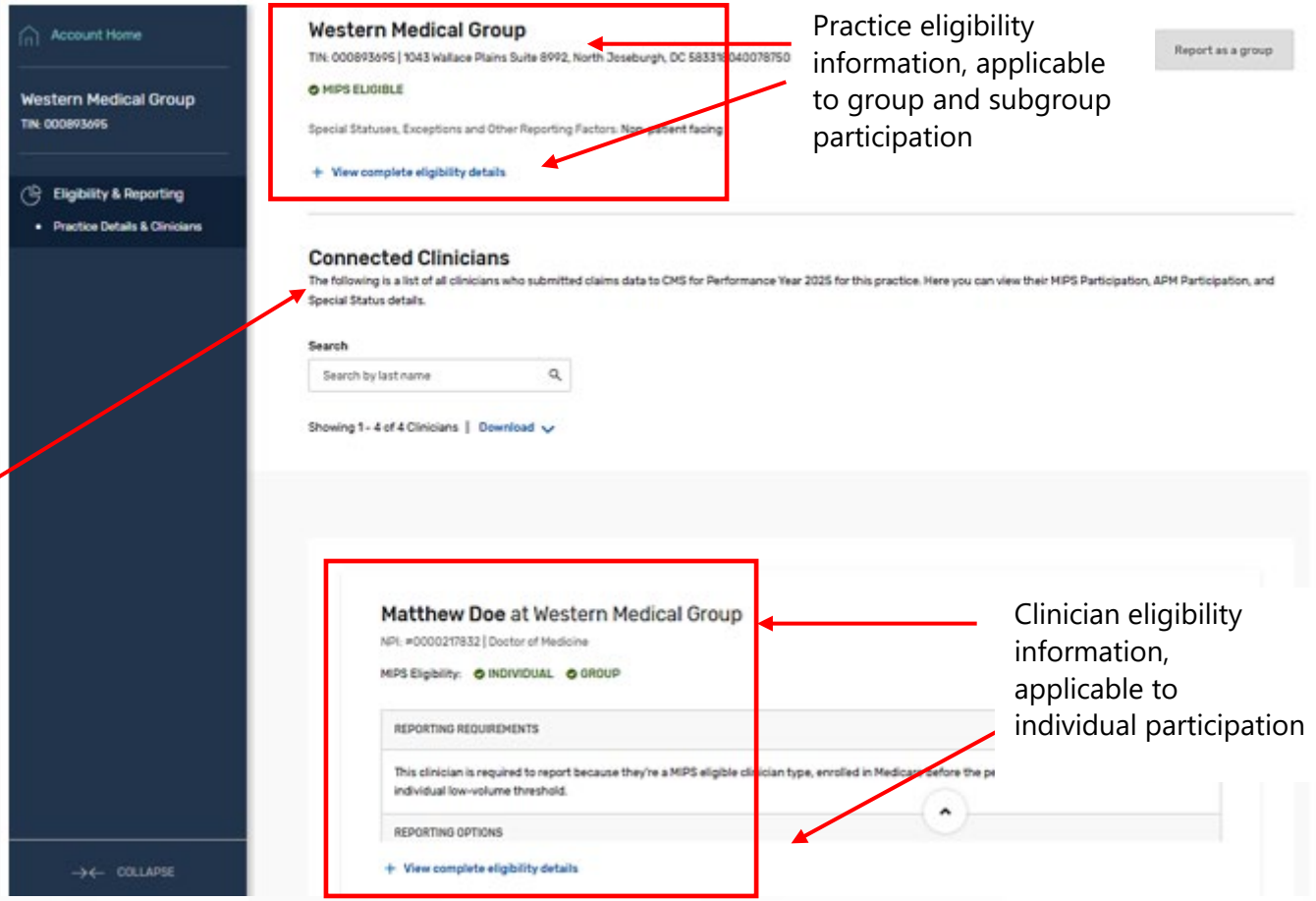
Quality Payment PROGRAM

Option 2. Sign in to the Quality Payment Program Website (Continued)

The **Practice Details & Clinicians** page provides the current eligibility status for your practice (for group and subgroup participation) and the individual clinicians in the practice.

What's a Connected Clinician?

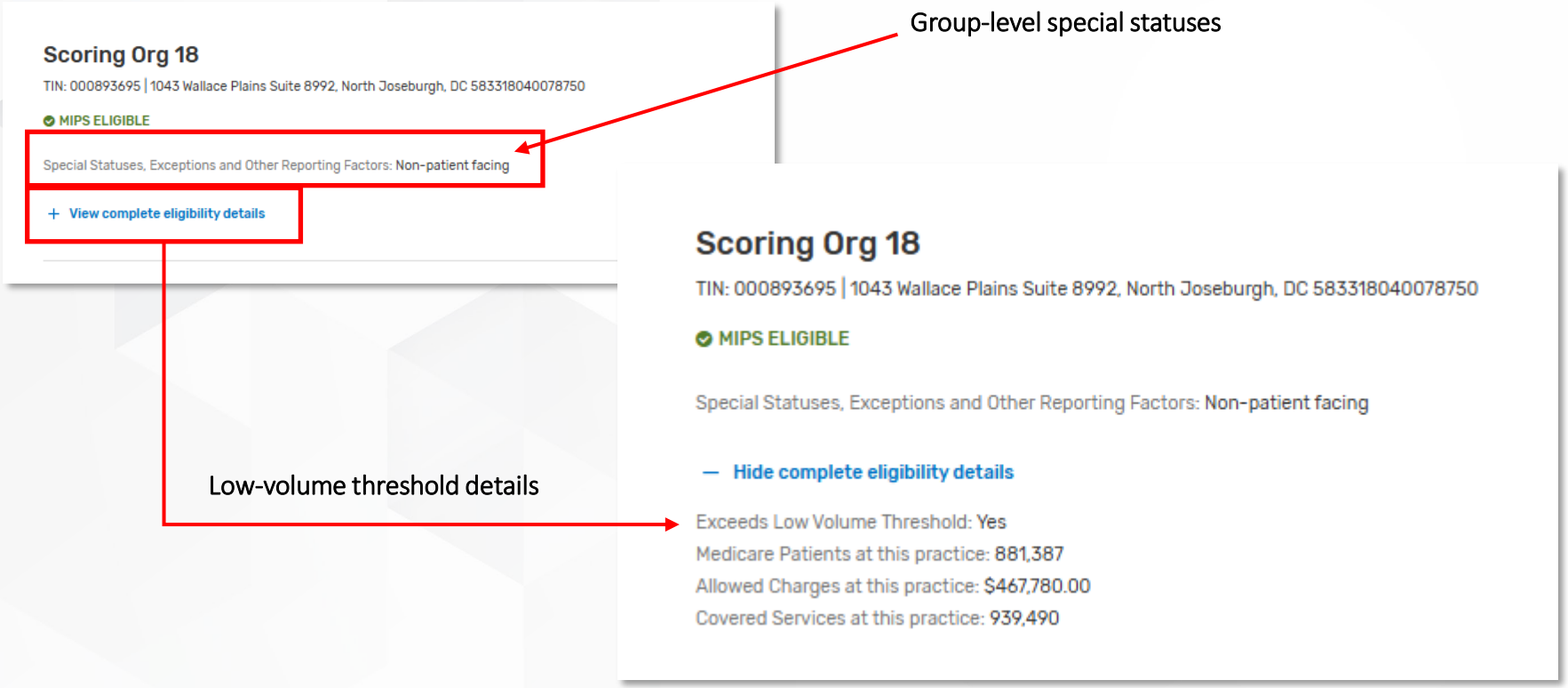
These are the clinicians associated with your TIN through Medicare Part B claims billing during the MIPS Determination Period.



Quality Payment PROGRAM

Option 2. Sign in to the Quality Payment Program Website (Continued)

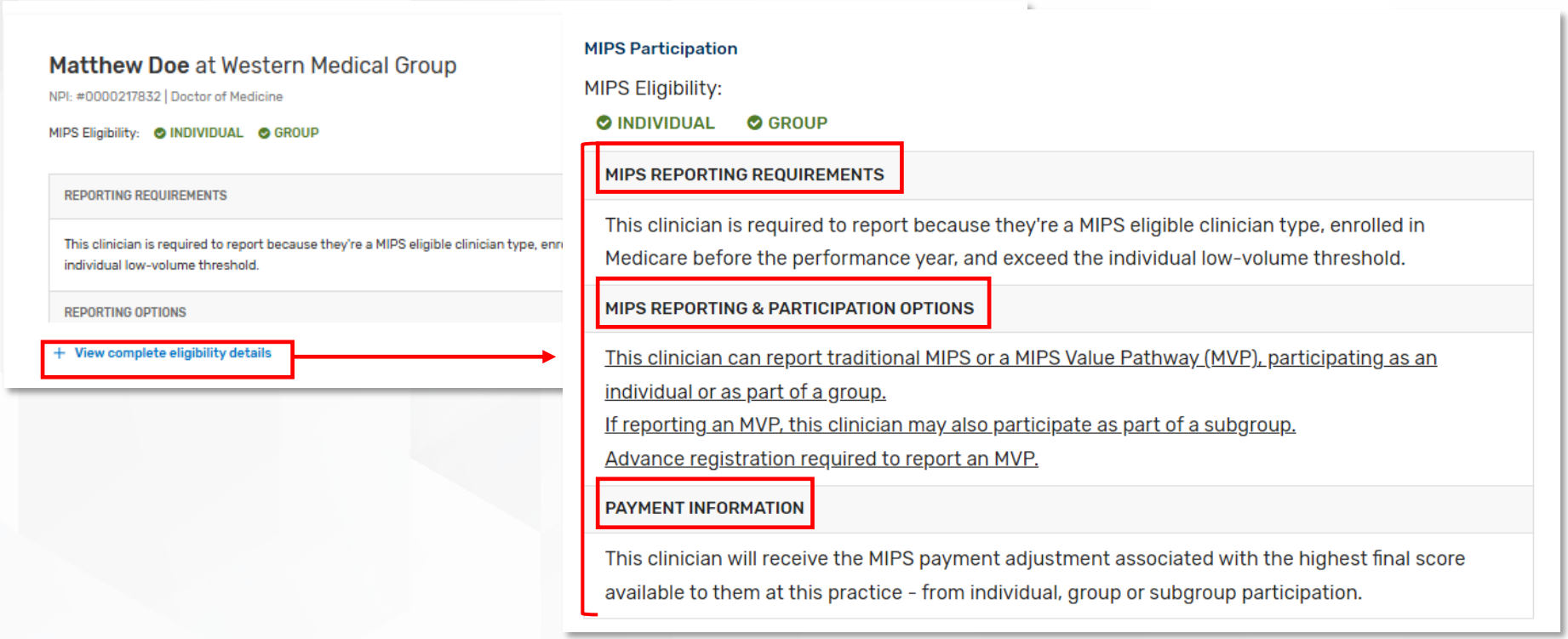
The **Practice Details & Clinicians** page displays the **group's special status(es)** and allows access to details about the group's low-volume threshold evaluation. Click **View complete eligibility details for the low-volume threshold information**.



Quality Payment PROGRAM

Option 2. Sign in to the Quality Payment Program Website (Continued)

The **Practice Details & Clinicians** page also provides information on which reporting options are available to each clinician as well as payment adjustment information. Click **View complete eligibility details** for information about the reporting and participation options available to each clinician as well as payment adjustment information. (Review pages 31 - 37 for more information about MIPS reporting and participation options.)



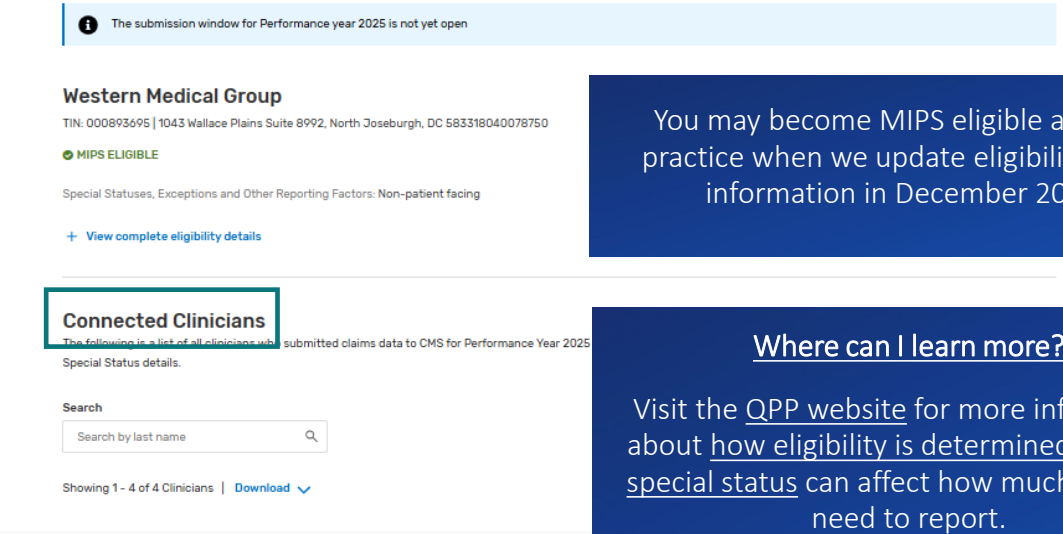
Quality Payment PROGRAM

Option 2. Sign in to the Quality Payment Program Website (Continued)

Are you missing clinicians in your Connected Clinicians list when you sign in to the QPP website?

This means we didn't find Medicare Part B claims data for you at this practice in segment 1 of the MIPS Determination Period.

We'll update eligibility status information by December 2026 to show clinicians who started billing Medicare Part B services under a new practice (identified by their TIN) between October 1, 2025, and September 30, 2026.



You may become MIPS eligible at a new practice when we update eligibility status information in December 2026.

Where can I learn more?

Visit the QPP website for more information about how eligibility is determined and how special status can affect how much data you need to report.

Option 2. Sign in to the Quality Payment Program Website (Continued)

Did you know?

When you sign in **before** eligibility statuses are updated in **early December 2026**:

- The Practice Details & Clinicians page lists the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from **October**. 1, 2024, to September 30, 2025, and received by CMS by October 30, 2025.

When you sign in **after** eligibility statuses are updated in **early December 2026**:

- The Practice Details & Clinicians page lists the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from **October**. 1, 2025, to **September** 30, 2026, and received by CMS by October 30, 2026.
- **Sign in to view final 2026 MIPS eligibility in December 2026.**

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Your Participation and Reporting Options

MIPS Reporting Options

There are **3 reporting options** available to MIPS eligible clinicians to meet MIPS reporting requirements:

To determine which reporting option may be the best for you and/or your practice, review the MIPS Reporting Options Comparison Resource.

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.	• This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. **Advance registration required.** • 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 1 of 2 predetermined sets 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 all applicable measures in the cost performance category for you, along with the administrative claims quality measures.	• We collect and calculate data for you for all applicable cost measures included in the selected MVP and the population health measures.	• Cost isn't evaluated under the APP.

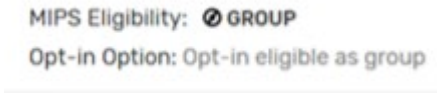
MIPS Participation Options

You may be eligible to participate in MIPS at different levels: as an individual, group, virtual group, subgroup for MVP reporting, or APM Entity. Because these participation options are tied to your eligibility, they're specific to each practice with which you're associated.

The QPP website will be updated throughout the year to identify which clinicians are MIPS APM participants. The first update will be in July 2026. All MIPS reporting and participation options are open to MIPS eligible individuals who are also MIPS APM participants. **Only MIPS APM participants can participate at the APM Entity level.**

You See…	This Means…
MIPS Eligibility: ✓ INDIVIDUAL ✓ GROUP	**You, as an individual clinician, are required to report** either individually or as part of a group or subgroup. • 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 you're in a subgroup that submits any data as a subgroup, **you'll be evaluated for all performance categories as a subgroup.** • If data is submitted at multiple levels, you'll be evaluated for all performance categories at each level, but your payment adjustment will be based on the highest score (individual, group, or subgroup). **You'll receive a payment adjustment regardless of whether you report any data.**
MIPS Eligibility: ∅ INDIVIDUAL ✓ GROUP	You, as an individual clinician, aren't required to report. Your practice exceeds the low-volume threshold and has the option to participate as a group or subgroups. There is no requirement to participate as a group or subgroup. • If your practice doesn't participate as a group or subgroups, the MIPS eligible clinicians in the practice who exceed the low-volume threshold as individuals will need to participate as individuals. • If your practice chooses to participate as a group, you'll receive a payment adjustment. • If you're in a subgroup that reports an MVP, you'll receive a payment adjustment.
MIPS Eligibility: ∅ INDIVIDUAL ∅ GROUP	• You, as an individual clinician, are not required to report and your practice doesn't exceed the low-volume threshold. • You won't receive a payment adjustment, even if you or your practice chooses to submit data voluntarily.
MIPS Eligibility: ✓ VIRTUAL GROUP	• You're eligible for MIPS and can only participate through your virtual group. • We'll add virtual group information once we have finished processing virtual group election submissions (~March 2026)

MIPS Participation Options (Continued)

You See...	This means...
	You can: • Make an individual election to opt-in or voluntarily report to traditional MIPS so you can submit data as an individual. • **Individual clinicians who are also MIPS APM participants (you'll see "Check APM Requirements")**: Make an individual election to opt-in to report the APP as an individual. You can't voluntarily report the APP. • Do nothing (you're not required to participate in MIPS as an individual or more an election). Opt-in eligible individuals can't report an MVP as an individual. However, they can report an MVP as part of an eligible group or subgroup.
	The group can: • Make a group election to opt-in or voluntarily report to traditional MIPS so you can submit data as a group. • **Groups with clinicians who are MIPS APM participants**: Make an election to opt-in to report the APP as a group. The final score earned by the group through the APP would be applied only to those MIPS eligible clinicians who appear on a MIPS APM's Participation List or Affiliated Practitioner List on one or more snapshot dates. You can't voluntarily report the APP. • Do nothing (You're not required to participate as a group or make an election). Opt-in eligible groups can't report an MVP.

Learn more about opt-in eligibility and voluntary reporting on page 48.

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MIPS Participation Options (Continued)

"Participation options" refers to the levels at which data can be collected and submitted, or "reported", to CMS for MIPS. Your participation options are determined by your eligibility and reporting option.

Participation Options When Reporting Traditional MIPS

Individual Clinician

1. As an Individual

Clinician, identified by their NPI and the TIN where they reassign benefits

Group

2. As a Group

2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN

Virtual Group

3. As a Virtual Group

Made up of solo practitioners and/or groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance year

APM Entity

4. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity

MIPS Participation Options (Continued)

"Participation options" refers to the levels at which data can be collected and submitted, or "reported", to CMS for MIPS. Your participation options are determined by your eligibility and reporting option.

Participation Options When Reporting an MVP

1. As an Individual

Clinician, identified by their NPI and the TIN where they reassign benefits.

2. As a Group

2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN. Beginning in 2026, this MVP participation option is only available to groups who attest they are a single specialty practice (of any size) or small practice.

3. As a Subgroup

A subset of clinicians (2 or more NPIs, including at least one individually eligible clinician) in the group who have reassigned their billing rights to a single TIN.

4. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity.

MIPS Participation Options (Continued)

"Participation options" refers to the levels at which data can be collected and submitted, or "reported", to CMS for MIPS. Your participation options are determined by your eligibility and reporting option.

Participation Options When Reporting the APP

1. As an Individual

Clinician, identified by their NPI and the TIN where they reassign benefits

2. As a Group

2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN

3. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity

Quality Payment
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THE BASICS

Your Eligibility Can Change

Understand How Your Eligibility Status Could Change

As of December 2025, we're displaying your initial 2026 eligibility status.

Between now and December 2026, your eligibility status and associated participation options can change if you:

- Reassign billing rights to a new TIN, **OR**
- Are identified as a QP or lose your status as a QP, **OR**
- Are identified as a MIPS APM participant and are eligible to report via the APP, **OR**
- See a decrease in the volume of care you provide to Medicare patients at a current practice.

For example, you could become eligible (required to participate) at a new practice, identified by TIN, if you start billing Medicare Part B claims under that TIN between October 1, 2025, and September 30, 2026.

If you're currently eligible, you should **start collecting your quality data now** so that you're prepared to submit this information in January 2027.

Why? The quality performance category has a 12-month performance period (January 1, 2026 – December 31, 2026).

NOTE: A subgroup must include one individually eligible clinician, which is based solely on initial – not final – eligibility results.

Understand How Your Eligibility Status Could Change (Continued)

Here's how your eligibility status can change between now and December 2026 for each practice (TIN) you're currently associated with:

Eligible	Opt-in Eligible	Exempt
If you're **currently eligible**, you could: • Remain eligible; • Become opt-in eligible; OR • Become ineligible.	If you're **currently opt-in eligible**, you could: • Remain opt-in eligible; OR • Become ineligible	If you're **currently ineligible**, you will remain ineligible. **Exception:** If you're only ineligible because you're a QP, it's possible to lose your QP status in a later APM snapshot and become MIPS eligible.

Your available participation and reporting options, but not your eligibility status, will change if you're later identified as a participant in a MIPS APM.

Clinicians who are individually MIPS eligible and who are also MIPS APM participants are required to report to MIPS. These clinicians can choose to report the APP, traditional MIPS or an MVP.

- You can't opt-in to MIPS and report an MVP.
- You can't voluntarily report the APP or an MVP.

Reasons Eligibility Status Can Change

Reason	Effect on Eligibility Status
You start to bill Medicare Part B claims under a new practice (TIN) during the second 12-month segment	If you bill Medicare Part B claims under a new TIN/NPI combination during the second 12-month segment, your eligibility status is based solely on the data collected during that 12-month segment.
You bill Medicare Part B claims during the first 12-month segment, but not the second 12-month segment	If you bill Medicare Part B claims during the first 12-month segment, but not the second 12-month segment, you won't be eligible for MIPS under that particular TIN/NPI combination.
You fall below the low-volume threshold during the second 12-month segment	If you exceed the low-volume threshold during the first 12-month segment, but not the second 12-month segment, you won't be required to participate in MIPS as an individual under that TIN/NPI combination.
You change your provider type/specialty code between 12-month segments	If you change your provider type/specialty code between 12-month segments, your clinician type may change and impact your MIPS eligibility status. For example, if your initial provider type/specialty code was considered an eligible clinician type and your new provider type/specialty code isn't an eligible clinician type, you'll no longer be MIPS eligible.
You're identified as a QP	If you're identified as a QP, you'll be excluded from MIPS.
You're identified as a partial QP	If you're identified as a partial QP, you may opt-in to MIPS.

If you start billing Medicare Part B claims under a new TIN between October 1 and December 31, 2026, you'll:

- Get a neutral payment adjustment if the TIN **doesn't** report as a group.
- Receive a payment adjustment based on group-level performance if the TIN reports as a group.

TIP: See Appendix 1 for examples of changing eligibility status.

THE DETAILS

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THE DETAILS
Low-Volume Threshold

MIPS Low-Volume Threshold

We look at your Medicare Part B claims data from the two 12-month segments of the MIPS Determination Period to assess the volume of care you provide to Medicare patients against the low-volume threshold.

The 3 low-volume threshold criteria are:

Charges: bill more than $90,000 for Medicare Part B covered professional services under the Physician Fee Schedule (PFS)

AND

Patient count: see more than 200 Medicare Part B patients

AND

Covered services: provide more than 200 covered professional services to Medicare Part B patients

Clinicians and practices must exceed all 3 of the low-volume threshold criteria during both 12-month segments of the MIPS Determination Period to be eligible for MIPS.

TIP: One professional claim line with positive allowed charges is considered one covered professional service.

Exception: Eligibility will be based solely on segment 2 data when a TIN or TIN/NPI combination is newly established during segment 2 of the MIPS Determination Period.

If you or your group exceed 1 or 2 but not all 3 low-volume threshold criteria during one of the 12-month segments of the MIPS Determination Period and aren't otherwise excluded from MIPS, you have the option to participate in MIPS through the following means:

- Opt-In Reporting (traditional MIPS and the APP)
- Voluntary Reporting (traditional MIPS only)

Applying the Low-Volume Threshold (Individual Level)

We evaluate eligible clinicians under each TIN/NPI combination for eligibility against the low-volume threshold at both the individual and group level. The participation options available to you are informed by your eligibility status:

Individual (TIN/NPI) Level		
If you **exceed** all 3 low-volume threshold criteria (in both segments) as **an individual**: You are **eligible** for MIPS and **are required** to participate and report MIPS data.		
If you're individually eligible, you can report:		
Traditional MIPS	**An MVP*** **	**The APP/APP Plus (MIPS APM participants only**)**
Individual | Group | Virtual Group* APM Entity**	Individual | Group*** | Subgroup*** APM Entity**	Individual | Group | APM Entity**

*Virtual group participation requires an election and CMS approval prior to the performance period. We don't evaluate virtual groups for the low-volume threshold. If you're part of a CMS-approved virtual group, you can't choose any other participation option.

**APM Entity participation and/or APP reporting requires that you're identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the four snapshot dates (March 31, June 30, August 31, and December 31) during the performance period. If a group reports the APP and includes clinicians that aren't on a Participation List, they'll also need to report traditional MIPS.

***Subgroup participation and/or MVP reporting requires advance registration. We don't evaluate subgroups for the low-volume threshold, but in order to participate as a subgroup, the affiliated group must exceed the low-volume threshold at the TIN level and the subgroup must include at least one individually eligible clinician (based on initial – not final – MIPS eligibility results). **NOTE:** Group MVP reporting is now limited to groups that attest to being a single specialty practice or small practice.

Applying the Low-Volume Threshold (Group Level)

We evaluate eligible clinicians under each TIN/NPI combination for eligibility against the low-volume threshold at both the individual and group level. The participation options available to you are informed by your eligibility status:

Group (TIN) Level		
If your practice **exceeds** all 3 low-volume threshold criteria (in both segments) as a group: The practice is **eligible** for MIPS and **can choose** whether or not to participate as a group.		
If you're eligible at the group level, you can report:		
Traditional MIPS	**An MVP*** **	**The APP/APP Plus (MIPS APM participants only**)**
Group | Virtual Group* | APM Entity**	Group*** | Subgroup*** | APM Entity**	Group | APM Entity**

*Virtual group participation requires an election and CMS approval prior to the performance period. We don't evaluate virtual groups for the low-volume threshold. If you're part of a CMS-approved virtual group, you can't choose any other participation option.

**APM Entity participation and/or APP reporting requires that you're identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the four snapshot dates (March 31, June 30, August 31, and December 31) during the performance period. If a group reports the APP and includes clinicians that aren't on a Participation List, they'll also need to report traditional MIPS.

***Subgroup participation and/or MVP reporting requires advance registration. We don't evaluate subgroups for the low-volume threshold, but in order to participate as a subgroup, the affiliated group must exceed the low-volume threshold at the TIN level and the subgroup must include at least one individually eligible clinician **(based on initial – not final – MIPS eligibility results). NOTE: Group MVP reporting is now limited to groups that attest to being a single specialty practice or small practice.**

Applying the Low-Volume Threshold (Continued)

Individual (TIN/NPI) Level	Group (TIN/NPI) Level
If you **don't exceed** all 3 low-volume threshold criteria (in one or both segments) as an individual: • You **aren't required** to participate in MIPS and won't receive a MIPS payment adjustment unless **1)** Your practice is eligible and chooses to participate as a group, **2)** You're part of a registered subgroup that submits MVP data, or **3)** You're part of a CMS-approved virtual group. • You can voluntarily report traditional MIPS as an individual. (You can't voluntarily report an MVP or the APP.) • You may be eligible to opt-in as an individual and report traditional MIPS or the APP. (You can't opt-in and report an MVP.)	If your practice **doesn't exceed** all 3 low-volume threshold criteria as a group: • The practice can voluntarily report traditional MIPS as a group. • The practice may be eligible to opt-in as a group and report traditional MIPS or the APP.

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Opt-In Eligibility and Voluntary Reporting

Opt-In and Voluntary Reporting

You can still participate in MIPS if you don't exceed the low-volume threshold.

Opt-In Eligible

If you or your group is otherwise eligible for MIPS and exceeds 1 or 2, but not all 3 low-volume threshold criteria, you're considered "opt-in eligible".

If you're opt-in eligible, you can:

- **Do nothing.** You don't exceed the low-volume threshold and aren't required to participate in MIPS.
- **Elect to opt-in (traditional MIPS and APP only. Opt-in eligible clinicians can't report an MVP.)** If you choose to opt-in, you'll submit data, receive performance feedback, and receive a MIPS payment adjustment in 2028.
- **Elect to voluntarily report (traditional MIPS only.)** If you don't want to receive a MIPS payment adjustment in 2028, but want to participate in MIPS, you can **voluntarily report** data and receive limited performance feedback on the data you report.

Your election to opt-in or voluntarily report is irreversible. If you're considering an opt-in election, be sure to explore program requirements to ensure you're prepared to collect and report data needed to demonstrate successful performance.

TIP: See Appendix 2 for examples of changing eligibility status (2A for individuals and 2B for groups)

Voluntary Reporting

If you choose to voluntarily report, you'll receive performance feedback based on the measures and activities for which you submitted data. You'll submit data, receive limited performance feedback, but won't receive a payment adjustment. Elections are only required for voluntary reporting if you're opt-in eligible. You can't voluntarily report the APP or an MVP.

MIPS Eligible vs. Vs. Opt-In Eligible Vs. Voluntary Reporting

	You're MIPS Eligible	You're Opt-In Eligible and Elect to Opt-in	You Choose to Voluntarily Report
Are you required to **make an active election**?	NO	YES	YES (If you are opt-in eligible) NO (If you are ineligible)
Will you **receive performance feedback**?	YES	YES	YES (limited)
Will you **receive a** positive, neutral, or negative **payment adjustment**?	YES	YES	NO
Are you **eligible for data to be publicly reported** in the Doctors & Clinicians section of Medicare Care Compare?	YES	YES	YES (but able to opt-out of public reporting during preview period)
Will your quality measure submissions be **included** in the calculation of **historical benchmarks** for future program years?	YES	YES	NO

Virtual Groups: Opt-In and Voluntary Reporting

If you (as a solo practitioner or group) elected to be a part of a virtual group for the 2026 performance year and exceeded 1 or 2, but not all 3 of the low-volume threshold criteria, then the virtual group's election to participate in MIPS as a virtual group also serves as your election to opt-in to MIPS and be subject to the MIPS payment adjustment.

As a result, solo practitioners and groups participating in a virtual group don't need to independently make elections to opt-in to MIPS. Solo practitioners and clinicians in groups who are part of an approved virtual group are considered MIPS eligible and will be subject to the MIPS payment adjustment.

If you participate as a virtual group, you'll receive a payment adjustment based on the virtual group's final score, even if you have additional final scores from other participation options.

As a reminder, virtual groups can only report traditional MIPS in the 2026 performance year.

Groups and solo practitioners who are included in a CMS-approved virtual group **aren't** able to voluntarily report.

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Special Statuses and Their Impact on Reporting Requirements

Overview

There are certain factors, such as QPP exceptions and special statuses that can affect your reporting requirements for different performance categories under traditional MIPS, MVPs, or the APP.

- These factors can result in bonus points or reduced reporting requirements for a specific performance category.
- These designations only apply at the level (i.e., clinician or practice) indicated and are not transferrable to other levels. See reporting factors example.

Special Status Designations

To determine if a MIPS eligible clinician, practice, virtual group or APM Entity will be assigned a special status, we retrieve and analyze Medicare Part B claims data. Special statuses are generally assigned if you fulfill the requirements for at least 1 of the 2 segments of the MIPS Determination Period.

To see if you've been assigned a special status designation, check your eligibility status in the QPP Participation Status Tool or sign in to the QPP website. You must sign in to see special status information at the virtual group or APM Entity level. The only special status available to APM Entities is "small practice."

For demonstration on how to view this information, check out the Do I Need to Participate in MIPS? How to Check Eligibility Status video.

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement (Applicable to All Reporting Options Unless Otherwise Noted)
Ambulatory Surgical Center (ASC)-based	**Clinician (Individual Reporting)**: You furnish more than 75% of your covered professional services in sites of service identified by Place of Service (POS) code 24 during one or both 12-month segments of the MIPS Determination Period.	You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data.
	Practice (Group and Subgroup Reporting): All MIPS eligible clinicians associated with your practice are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	
	Virtual Group: All MIPS eligible clinicians associated with your virtual group are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	
Hospital-based	**Clinician (Individual Reporting)**: You furnish 75% or more of your covered professional services in a hospital setting identified by POS codes 19, 21, 22, and 23 during one or both 12-month segments of the MIPS Determination Period.	You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data.
	Practice (Group and Subgroup Reporting): More than 75% of the clinicians associated with your practice are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	
	Virtual Group: More than 75% of the clinicians associated with your virtual group are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement (Applicable to All Reporting Options Unless Otherwise Noted)
Non-patient Facing	**Clinician (Individual Reporting)**: You have 100 or fewer Medicare Part B patient-facing encounters (including telehealth services) during one or both 12-month segments of the MIPS Determination Period	You only need to perform and attest to one improvement activity, whether reporting traditional MIPS or a MIPS Value Pathway. You also qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category or categories unless you choose to submit Promoting Interoperability data.
	Practice (Group and Subgroup Reporting): More than 75% of the clinicians billing under your practice's TIN meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	
	Virtual Group: More than 75% of the clinicians in your virtual group meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	
Small Practice	**Clinician (Individual Reporting)**: You're a MIPS eligible clinician who is one of 15 or fewer clinicians billing under the practice's TIN during one or both 12-month segments of the MIPS Determination Period.	You only need to perform and attest to one improvement activity, whether reporting traditional MIPS or a MIPS Value Pathway. If you submit at least one quality measure, you'll also receive 6 bonus points in the quality performance category. You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data. You qualify for a different reweighting distribution when Promoting Interoperability is reweighted.
	Practice (Group and Subgroup Reporting): There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.	
	Virtual Group: There are 15 or fewer clinicians billing across all the TINs participating in the virtual group during one or both 12-month segments of the MIPS Determination Period.	
	APM Entity: There are 15 or fewer clinicians associated with the APM Entity.	

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement (Applicable to All Reporting Options Unless Otherwise Noted)
Health Professional Shortage Area (HPSA)	**Clinician (Individual Reporting)**: You're a MIPS eligible clinician who practices in an area designated as an HPSA under section 332(a)(1)(A) of the Public Health Service Act.	You only need to perform and attest to one improvement activity, whether reporting traditional MIPS or a MIPS Value Pathway.
	Practice (Group and Subgroup Reporting): More than 75% of clinicians billing under the group's TIN are in an area designated as an HPSA.	
	Virtual group: More than 75% of the clinicians in your virtual group are in an area designated as an HPSA.	
Rural	**(Individual Reporting)**: You're a MIPS eligible clinician associated with a practice (TIN) billing claims within a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP code file available.	You only need to perform and attest to one improvement activity, whether reporting traditional MIPS or a MIPS Value Pathway.
	Practice (Group and Subgroup Reporting): More than 75% of the clinicians billing under the practices TIN are in a ZIP code designated as rural using the most recent FORHP ZIP code file.	
	Virtual Group: More than 75% of the clinicians in the virtual group are in a ZIP code designated as rural using the most recent FORHP ZIP code file.	

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement (Applicable to All Reporting Options Unless Otherwise Noted)
Facility-based	**Clinician (Individual Reporting)**: During the first 12-month segment of the MIPS Determination Period, you: • Furnished 75% or more of your covered professional services in a hospital setting identified by POS codes 21, 22, and 23; AND • Billed at least one service in an inpatient hospital or emergency room; AND • Can be assigned to a facility with a FY 2027 Hospital VBP Program score.	Facility-based scoring offers clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the appropriate Fiscal Year score for the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility. *To receive facility-based scoring as a group or virtual group, your group or virtual group must submit group/virtual group level data for the improvement activities and/or Promoting Interoperability performance category(ies) to signal your practice's intent to participate as a group. **REMINDER:** Your facility-based status still will be removed if assigned facility doesn't receive a Fiscal Year (FY) 2027 Hospital VBP Program score. The facility-based status currently displayed is predictive until the end of 2026 when the FY 2027 scores are available.
	Practice (Group Reporting): 75% or more of the clinicians in the TIN are facility-based as individuals. Groups are assigned to the facility at which the plurality of clinicians in the TIN were assigned as individuals.	
	Virtual Group: 75% or more of the clinicians in the virtual group are facility-based as individuals. Virtual groups are assigned to the facility at which the plurality of clinicians in the virtual group were assigned as individuals.	

Clinician Level vs Practice Level

Example: Tyler is a physician assistant who practices in a rural community. He is **MIPS eligible at the individual and group level**. He qualifies for various special status designations at both the clinician (individual reporting) and practice (group reporting) levels.

Clinician Level

SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Hospital-based**	Yes
SPECIAL STATUS **Non-patient facing**	Yes
SPECIAL STATUS **Rural**	Yes

Practice Level

SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Non-patient facing**	Yes

If Tyler reports as an individual clinician, he qualifies for 4 special status designations (HPSA, hospital-based, non-patient facing, rural).

However, if the practice reports as a group, the practice only qualifies for 2 special status designations (HPSA, non-patient facing). The 2 other statuses (hospital-based, rural) that he qualifies for individually won't apply to group reporting.

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THE DETAILS
MIPS Payment Adjustments

Who's Eligible for a MIPS Payment Adjustment?

The following will receive a MIPS payment adjustment even if data aren't submitted:	The following will receive a MIPS payment adjustment only if data are submitted:	The following won't receive a MIPS payment adjustment even if data are submitted:
MIPS eligible clinicians who exceed the low-volume threshold as an individual or elect to opt-in	MIPS eligible clinicians below the low-volume threshold as individuals in a practice that is eligible (or opted-in) and reports as a group or APM Entity	Eligible clinicians who don't exceed the low-volume threshold and don't elect to opt-in or otherwise participate at any level
MIPS eligible clinicians in a CMS-approved virtual group	MIPS eligible clinicians below the low-volume threshold as individuals in a practice that is eligible **and** reports an MVP as a subgroup	Ineligible clinician types
		Newly enrolled Medicare providers (on or after January 1, 2026)
Partial QPs that elect to participate in MIPS	MIPS eligible clinicians in a MIPS APM who report via the APP as an individual, group, or APM Entity group	QPs
		Partial QPs that don't elect to participate in MIPS

What happens when more than one final score is associated with a MIPS eligible clinician's TIN/NPI combination?

It's possible to participate in MIPS in multiple ways. If a clinician (identified by a single unique TIN/NPI combination) has more than one MIPS final score, here's how we'll determine which final score and payment adjustment they'll receive:

- If you participate as a virtual group, you'll receive a payment adjustment based on the virtual group's final score, even if you have additional final scores from other participation options.
- If you participate as an individual, group, subgroup and/or an APM Entity reporting the APP, an MVP and/or traditional MIPS, you'll receive a payment adjustment based on the highest available score.

Example Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI reports traditional MIPS as a virtual group and reports the APP as part of an APM Entity.	Virtual group final score
TIN/NPI reports the APP as part of an APM Entity and an MVP as part of a group.	The higher of the two final scores
TIN/NPI reports traditional MIPS as a group and an MVP as a subgroup.	The higher of the two final scores

Refer to Appendix 3 for additional payment adjustment scenarios.

Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 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 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.

Version History

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

Date	Description
02/25/2026	Original Version.

Appendices

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Appendix 1: Examples of Eligibility Status Changing

Appendix 1: Examples of Eligibility Status Changing

Example 1. You join a new practice (establish a new TIN/NPI combination through Medicare Part B claims billing) **between October 1, 2025 - September 30, 2026** (second 12-month segment of the MIPS Determination Period). As a result, **your eligibility at that practice is based solely on this segment.**

Ann, a nurse practitioner and MIPS eligible clinician, joins Integrated Care Associates (TIN) and starts billing covered services under their TIN on November 15, 2026. Ann wasn't included in our evaluation of the first 12-month segment of the MIPS Determination Period at Integrated Care Associates. Neither Ann nor Integrated Care Associates are identified as MIPS APM participants.

Individual (TIN/NPI) Low-Volume Threshold Assessment

First 12-month Segment	Second 12-month Segment
No Medicare Part B claims data billed under Ann's unique TIN/NPI combination associated with Integrated Care Associates.	✓ Charges: billed $92,000 in Medicare Part B covered professional services under the PFS ✓ Patient Count: saw 202 Medicare Part B patients ✓ Covered Services: provided 315 covered professional services to Medicare Part B patients

Group (TIN) Low-Volume Threshold Assessment

First 12-month Segment	Second 12-month Segment
✓ Charges: billed $340,000 in Medicare Part B covered professional services under the PFS ✓ Patient Count: saw 350 Medicare Part B patients ✓ Covered Services: provided 380 covered professional services to Medicare Part B patients	✓ Charges: billed $440,000 in Medicare Part B covered professional services under the PFS ✓ Patient Count: saw 415 Medicare Part B patients ✓ Covered Services: provided 450 covered professional services to Medicare Part B patients

Outcome: Ann is **MIPS eligible as an individual** at Integrated Care Associates because she exceeds all three low-volume threshold criteria during the second 12-month segment of the MIPS Determination Period. Newly established TIN/NPI combinations can only be evaluated in the 2nd 12-month segment of the MIPS Determination Period.

Integrated Care Associates is **MIPS eligible as a group** because the practice exceeds all three low-volume threshold criteria in both segments of the MIPS Determination Period.

Ann is required to participate in MIPS. She can report traditional MIPS as an individual and/or as a group. She can report an MVP as an individual and/or as part of a group or subgroup.

Appendix 1: Examples of Eligibility Status Changing

Example 2. You join a new practice (establish a new TIN/NPI combination through Medicare Part B claims billing) **between October 1 and December 31, 2026.**

- You'll get a neutral payment adjustment if the TIN **doesn't** report as a group.
- You'll receive a payment adjustment based on group-level performance if the TIN reports as a group.

Dr. Ahmed is an optometrist who joins a practice called the Vision Center and started billing claims under their TIN on October 1, 2026. The Vision Center is MIPS eligible as a group (TIN) and will be reporting to MIPS as a group.

Individual (TIN/NPI) Low-Volume Threshold Assessment	
First 12-month Segment	**Second 12-month Segment**
No Medicare Part B claims data billed under Dr. Ahmed's unique TIN/NPI combination associated with the Vision Center.	

Group (TIN) Low-Volume Threshold Assessment	
First 12-month Segment	**Second 12-month Segment**
✓ Charges: billed $350,000 in Medicare Part B covered professional services under the PFS ✓ Patient Count: saw 450 Medicare Part B patients ✓ Covered Services: provided 350 covered professional services to Medicare Part B patients	✓ Charges: billed $325,000 in Medicare Part B covered professional services under the PFS ✓ Patient Count: saw 415 Medicare Part B patients ✓ Covered Services: provided 320 covered professional services to Medicare Part B patients

Outcome: Dr. Ahmed is **ineligible for MIPS** as an **individual** at the Vision Center because he started billing under the practice's TIN beginning on October 1, 2026, after the conclusion of the MIPS Determination Period. The Vision Center is **MIPS eligible as a group** and will be reporting as a group.

Dr. Ahmed will participate in MIPS as part of a group and will receive a MIPS payment adjustment based on the group's final score.

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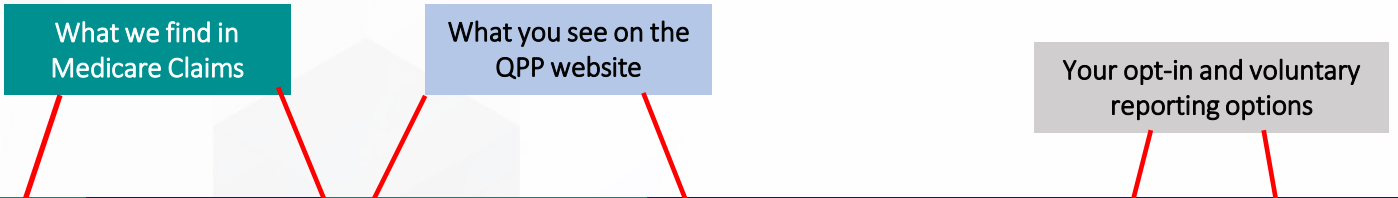
Appendix 2A: Participation Scenarios for Individuals

Appendix 2A: Participation Scenarios for Individuals[3]



1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
No Medicare Part B claims billed under TIN/NPI combination	**N/A -** Not found in participation status tool	**No Medicare Part B claims billed** under TIN/NPI combination[4]	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**

[3]Individual is an eligible clinician type, enrolled in Medicare before the performance period, is not a Qualifying APM Participant, etc.

[4]If a clinician doesn't bill any Medicare Part B claims under a practice in the second 12-month segment of the MIPS Determination Period, we'll remove their association with that practice from our eligibility and submission systems, including the lookup tool, when final eligibility status is posted. Because of this, these clinicians wouldn't have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these clinicians can't choose to voluntarily report.

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
No Medicare Part B claims billed under TIN/NPI combination	**N/A -** Not found in participation status tool	**Exceeded all 3** low-volume threshold criteria as an individual	**Eligible** as an individual (**Required** to report)	No	No
Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	No
		Exceeded all 3 low-volume threshold criteria	**Ineligible** as an individual	No	**Yes**

[3]Individual is an eligible clinician type, enrolled in Medicare before the performance period, is not a Qualifying APM Participant, etc.

[4]If a clinician doesn't bill any Medicare Part B claims under a practice in the second 12-month segment of the MIPS Determination Period, we'll remove their association with that practice from our eligibility and submission systems, including the lookup tool, when final eligibility status is posted. Because of this, these clinicians would not have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these clinicians can't choose to voluntarily report.

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -**Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**

[3]Individual is an eligible clinician type, enrolled in Medicare before the performance period, is not a Qualifying APM Participant, etc.

[4]If a clinician doesn't bill any Medicare Part B claims under a practice in the second 12-month segment of the MIPS Determination Period, we'll remove their association with that practice from our eligibility and submission systems, including the lookup tool, when final eligibility status is posted. Because of this, these clinicians would not have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these clinicians can't choose to voluntarily report.

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
Exceeded all 3 low-volume threshold criteria as an individual	**Eligible** as an individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as an individual	**Eligible** as an individual (**Required** to report)	No	No

[3]Individual is an eligible clinician type, enrolled in Medicare before the performance period, is not a Qualifying APM Participant, etc.

[4]If a clinician doesn't bill any Medicare Part B claims under a practice in the second 12-month segment of the MIPS Determination Period, we'll remove their association with that practice from our eligibility and submission systems, including the lookup tool, when final eligibility status is posted. Because of this, these clinicians would not have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these clinicians can't choose to voluntarily report.

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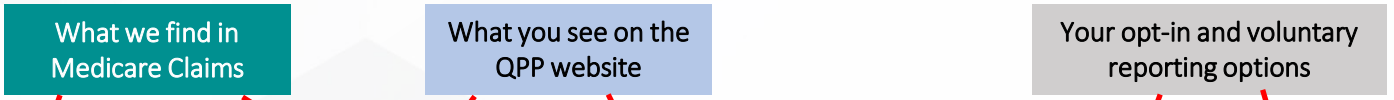
Appendix 2B:
Participation Scenarios for Groups

Appendix 2B: Participation Scenarios for Groups



1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
No Medicare Part B claims billed under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group (Can **choose** to participate as a group)	No	No

[5]If there are no Medicare Part B claims billed by a TIN in the second 12-month segment of the MIPS Determination Period, that TIN (or practice) will be removed from our eligibility and submission systems for the related performance year, including the lookup tool, when final eligibility status is posted. Because of this, the group won't have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these groups can't choose to voluntarily report.

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as a Group	Can Choose to Voluntarily Report as a Group?
Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**

[5]If there are no Medicare Part B claims billed by a TIN in the second 12-month segment of the MIPS Determination Period, that TIN (or practice) will be removed from our eligibility and submission systems for the related performance year, including the lookup tool, when final eligibility status is posted. Because of this, the group won't have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these groups can't choose to voluntarily report.

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	Yes	**Yes**

[5]If there are no Medicare Part B claims billed by a TIN in the second 12-month segment of the MIPS Determination Period, that TIN (or practice) will be removed from our eligibility and submission systems for the related performance year, including the lookup tool, when final eligibility status is posted. Because of this, the group won't have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these groups can't choose to voluntarily report.

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2024 - 9/30/2025)	Initial MIPS Eligibility Status	2nd Segment (10/1/2025 - 9/30/2026)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2026)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group	No	**Yes**

[5]If there are no Medicare Part B claims billed by a TIN in the second 12-month segment of the MIPS Determination Period, that TIN (or practice) will be removed from our eligibility and submission systems for the related performance year, including the lookup tool, when final eligibility status is posted. Because of this, the group won't have access to performance feedback, which is a primary benefit of voluntary reporting. For these operational reasons, these groups can't choose to voluntarily report.

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Appendix 3: Which MIPS Payment Adjustment Is Applied in the 2028 Payment Year?

Appendix 3: Which MIPS Payment Adjustment is Applied in the 2028 Payment Year?

2026 Performance Scenario	2028 MIPS Payment Adjustment
Clinician has a 2026 final score under TIN A. Clinician continues to bill under TIN A in the 2028 payment year.	Clinician will receive a payment adjustment for covered professional services under their TIN A/NPI combination based on 2026 final score attributed to that TIN A/NPI combination.
Clinician has a single 2026 final score, received at TIN A and didn't practice at any other TIN in 2026. Clinician leaves TIN A and joins TIN B in 2028 payment year and begins to bill under TIN B.	Clinician will receive a payment adjustment for covered professional services under their TIN B/NPI combination based on 2026 final score attributed to their TIN A/NPI combination.
Clinician has a single 2026 final score, received at TIN A. The clinician then joined another TIN, TIN B in 2028. The clinician begins to bill under TIN B in 2028, in addition to TIN A.	Clinician will receive a payment adjustment under both TIN/NPI combinations based on their TIN A score.
Clinician has two 2026 final scores under two TINs (TIN A and TIN B). The clinician joins TIN C in the 2028 payment year and begins to bill under TIN C. (Doesn't bill under TIN A or TIN B.)	Clinician will receive a payment adjustment for covered professional services under their TIN C/NPI combination based on their higher 2026 final score – either attributed to their TIN A/NPI combination or TIN B/NPI combination.

Appendix 3: Which MIPS Payment Adjustment is Applied in the 2028 Payment Year? (Continued)

2026 Performance Scenario	2028 MIPS Payment Adjustment
Clinician has two 2026 final scores under two TINs (TIN A and TIN B). • Clinician has a 2026 final score under TIN A . • Clinician has a 2026 final score under TIN B. Clinician bills under TIN A and TIN B in the 2028 payment year.	Clinician will receive a payment adjustment for covered professional services under their TIN A/NPI combination based on 2026 final score attributed to that TIN A/NPI combination. Clinician will receive a payment adjustment for covered professional services under their TIN B/NPI combination based on 2026 final score attributed to that TIN B/NPI combination.
Clinician billed under 2 TINs (TIN A and TIN B) for the 2026 performance year. • Clinician has a 2026 final score under TIN A. • Clinician wasn't eligible TIN B (no final score received). Clinician only bills under TIN B in the 2028 payment year.	Clinician won't receive a payment under his TIN B/NPI combination in the 2028 payment year because he wasn't eligible under his under his TIN B/NPI combination **(no final score received)** in the 2026 performance year.
Clinician billed under TIN A for the 2026 performance year. • Clinician wasn't eligible under TIN A (no final score received). Clinician bills under TIN B in the 2028 payment year.	Clinician won't receive a payment under his TIN B/NPI combination in the 2028 payment year because he wasn't eligible (**no final score received**) in the 2026 performance year.